



PARLIAMENT OF NEW SOUTH WALES

# COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

REPORT 4/55 – JUNE 2014

REVIEW OF THE 2012-2013 ANNUAL REPORT OF THE HEALTH CARE COMPLAINTS  
COMMISSION



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The motto of the coat of arms for the state of New South Wales is “Orta recens quam pura nites”. It is written in Latin and means “newly risen, how brightly you shine”.

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# Membership

|                 |                                                                                                                                                                                                                     |
|-----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CHAIR           | Mr Donald Page MP, Member for Ballina (from 14 May 2014)<br>Mrs Leslie Williams MP, Member for Port Macquarie (until 6 May 2014)                                                                                    |
| DEPUTY CHAIR    | Mrs Roza Sage MP                                                                                                                                                                                                    |
| MEMBERS         | Mr Andrew Rohan MP<br>Dr Andrew McDonald MP<br>The Hon Catherine Cusack MLC (until 15 May 2014)<br>The Hon. Natasha Maclaren-Jones MLC (from 14 May 2014)<br>The Hon. Paul Green MLC<br>The Hon. Helen Westwood MLC |
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# Terms of Reference

The Committee on the Health Care Complaints Commission is a current joint statutory committee, established 13 May 1994, re-established 22 June 2011.

The Committee monitors and reviews the Commission's functions, annual reports and other reports it makes to Parliament. The Committee is not authorised to re-investigate a particular complaint; or to reconsider a decision to investigate, not to investigate or to discontinue investigation of a particular complaint; or to reconsider the findings, recommendations, determinations or other decisions of the Commission, or of any other person, in relation to a particular investigation or complaint.

The terms of reference for the Committee are set out in Part 4 of the Health Care Complaints Act 1993, sections 64-74.

The functions of the Committee are as follows:

(1) The functions of the Joint Committee are as follows:

(a) to monitor and to review the exercise by the Commission of the Commission's functions under this or any other Act,

(a1) without limiting paragraph (a), to monitor and review the exercise of functions by the Health Conciliation Registry,

(b) to report to both Houses of Parliament, with such comments as it thinks fit, on any matter appertaining to the Commission or connected with the exercise of the Commission's functions to which, in the opinion of the Joint Committee, the attention of Parliament should be directed,

(c) to examine each annual and other report made by the Commission, and presented to Parliament, under this or any other Act and to report to both Houses of Parliament on any matter appearing in, or arising out of, any such report,

(d) to report to both Houses of Parliament any change that the Joint Committee considers desirable to the functions, structures and procedures of the Commission,

(e) to inquire into any question in connection with the Joint Committee's functions which is referred to it by both Houses of Parliament, and to report to both Houses on that question.

(2) Nothing in this Part authorises the Joint Committee:

(a) to re-investigate a particular complaint, or

(b) to reconsider a decision to investigate, not to investigate or to discontinue investigation of a particular complaint, or

(c) to reconsider the findings, recommendations, determinations or other decisions of the Commission, or of any other person, in relation to a particular investigation or complaint.

(3) The functions of the Joint Committee may be exercised in respect of matters occurring before or after the commencement of this section.

## Chair's Foreword

I am pleased to present the Committee's Review of the Health Care Complaints Commission's (HCCC) Annual Report 2012-2013 pursuant to the Committee's responsibilities under section 65 of the *Health Care Complaints Act 1993* to examine all reports of the Commission. This is the Committee's third review in the 55th Parliament.

Firstly, the Committee took this opportunity to examine and review complaint trends as well as the complaint handling processes. In its examination of the complaint trends, the Committee found that 'communication issues' continue to be the second most common subject of complaint and that the Commission is working with other bodies to deal with this matter. Moreover, the Committee also found that there is a need for a set of policies to be implemented to address the issues that are present in three per cent of Australia's medical workforce, which over the last decade, accounted for 49 per cent of complaints.

As for the complaint handling processes, the Committee stated that the Commission could enhance its complaint handling process by examining options for developing a system for obtaining feedback about the complaints it refers to other bodies for resolution. The Committee noted that the Commission made significant progress in relation to timeliness of assessing complaints during the last year and that it has updated its website.

Secondly, the Committee also examined the Commission's community outreach efforts such as its outreach to the culturally and linguistically diverse members of the community of NSW, wishing to make a complaint and its webinars to health consumers and health professionals, covering specific topics relevant to them. The Committee noted the Commission's work with researchers and institutions as a way of sharing and learning about best-practice approaches in complaint-handling. The Committee was pleased to find that additional funding provided to the Commission has led to concrete results, enhanced service delivery and led to greater satisfaction rates among the complainants.

Thirdly, the Committee also found that the legislative changes to the *Health Care Complaints Act* have been useful to the Commission in handling complaints and that the Commission has made positive changes to 'handling complaints that are made as a result of extraordinary circumstances' as well as introduced the auditing of its recommendations.

This report reflects on the last annual report provided by the Commission, together with responses received to questions on notice and transcripts of evidence from a hearing with the Commissioner held at Parliament House on 16 April 2014.

I would like to thank the Commissioner and his staff for providing information in a timely way, together with fellow Committee Members for their ongoing interest and involvement in the work of the Committee.

**Don Page MP**  
Chair

# List of Findings and Recommendations

RECOMMENDATION 1 \_\_\_\_\_ 8

That the Commission and the Ministry of Health devise policies to enhance the capacity of the three per cent of Australia’s medical workforce – which over the last decade accounted for 49 per cent of complaints – and thereby reduce the number of complaints.

RECOMMENDATION 2 \_\_\_\_\_ 8

That the Commission develop a system for obtaining feedback about the complaints it refers to other bodies for resolution and thereby ensure that each complaint is addressed.

RECOMMENDATION 3 \_\_\_\_\_ 12

That the Commission conduct a cost/benefit analysis before accepting any request to support a research project, enhancing the value it receives for supporting these.

RECOMMENDATION 4 \_\_\_\_\_ 12

That the Commission explore options for creating a user-friendly method for collecting data on the profile of customers and professionals who access its webinars, in order to better target and enhance its promotional work.

RECOMMENDATION 5 \_\_\_\_\_ 16

That the Commission outline the rationale for a wider application of the recommendations it makes to a Local Health District when reporting these to the Department of Health, in order to address the same policy issues, which may be present in other Local Health Districts.



# Chapter One – Introduction

- 1.1 Pursuant to section 65 of the *Health Care Complaints Act 1993* ('the Act'), the Joint Committee on the Health Care Complaints Commission ('the Committee') is required 'to examine each annual report made by the Health Care Complaints Commission ('the Commission'), and present to Parliament, under this or any other Act and to report to both Houses of Parliament on any matter appearing in, or arising out of, any such report'.<sup>1</sup> Section 95 of the Act outlines the content the Commission must include in its annual report.<sup>2</sup>
- 1.2 The functions of the Committee include examining each annual and other report of the Commission and reporting to both Houses of Parliament on any matter appearing in, or arising out of such reports. This review considers the 2012-2013 annual report of the Commission.
- 1.3 As a part of the review process, a public hearing was held at Parliament House on 16 April 2014. Evidence was taken from three witnesses from the Commission. This comprised of the Commissioner, Mr Kieran Pehm; Director of Investigations, Mr Tony Kofkin; and Director of Proceedings, Ms Karen Mobbs.
- 1.4 Prior to the hearing, the Committee provided the Commission with a series of questions on matters arising out of the annual report. The Commission provided responses to the questions on 7 April 2014.
- 1.5 During the public hearing, the Commissioner also agreed to provide a response to an additional question that was taken on notice, which was subsequently provided to the Committee.
- 1.6 The responses to the questions, together with the transcript of evidence taken on the day of the hearing, are reproduced as appendices to this report, and are also available on the Committee's webpage.
- 1.7 This report is comprised of five chapters. This chapter outlines the basis for the inquiry. Chapter Two considers complaint trends reported in 2012-13 as well as changes to the complaint handling processes implemented by the Commission over the same period. Chapter Three discusses the Commission's outreach activities, including the provision of its webinars<sup>3</sup>, support of research projects and work with other relevant bodies. Chapter Four considers the impact of the recent legislative changes, new assessment policies as well as the new process of auditing recommendations made to the health services by the Commission. Chapter Five discusses corporate governance of the Commission.

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<sup>1</sup> *Health Care Complaints Act 1993*, s65

<sup>2</sup> *Health Care Complaints Act 1993*, s95

<sup>3</sup> A webinar is a web-based seminar – a lecture, a presentation, or workshop – that is transmitted over the web and usually provides a platform for interaction between the presenter and the audience.

## Chapter Two – Complaint trends and handling

- 2.1 This chapter considers complaint trends reported in 2012-13 as well as changes to the complaint handling processes implemented by the Commission over the same period.
- 2.2 The Commission is the principal authority that receives complaints about both individual health practitioners and health organisations. Complaints about individual practitioners can be about both registered and unregistered practitioners.<sup>4</sup>
- 2.3 In New South Wales complaints about individual practitioners or health care organisations can be lodged with one of four government authorities, depending on the nature of the complaint. The four government agencies are:
- the Australian Health Practitioner Regulation Agency (AHPRA);
  - the Health Professional Councils Authority (HPCA), or by directly dealing with any one of 13 councils with specific responsibility regulating allied health professionals, including chiropractic, dental, nursing, optometry and psychology;
  - NSW Fair Trading; and
  - the Commissioner.<sup>5</sup>
- 2.4 The Commission stated that in 2012-13 there was an increase of 5.9 per cent in incoming complaints (compared to the previous year).<sup>6</sup> Overall, the Commission reported that ‘the complaints about health service providers have increased by 35.5 per cent over the past five years from 3,360 in 2008-09 to 4,554 in 2012-13’.<sup>7</sup> The Commission noted that the number of finalised complaints also increased by 6.9 per cent from the last year.<sup>8</sup>
- 2.5 Yet, the Commission noted that its data is ‘not a comprehensive indicator of the overall standard of health care delivery in NSW’ and that there is a need to contextualise it:

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<sup>4</sup> Committee on the Health Care Complaints Commission, Review of the 2011-2012 Annual Report of the Health Care Complaints Commission, October 2013, p2.

<sup>5</sup> Committee on the Health Care Complaints Commission, Review of the 2011-2012 Annual Report of the Health Care Complaints Commission, October 2013, p2.

<sup>6</sup> HCCC Annual Report, 2012-2013, p29.

<sup>7</sup> HCCC Annual Report, 2012-2013, p4.

<sup>8</sup> HCCC Annual Report, 2012-2013, p6.

Often, complaints are addressed by the relevant health service provider directly without the Commission being involved. The number of complaints to the Commission is relatively small considering the volume of services provided.<sup>9</sup>

### Issues raised in complaints

- 2.6 In 2012-13, the Commission received 4,554 complaints, raising 8,345 issues. This constitutes 'an average of 1.8 issues per complaint, the same as the year before'.<sup>10</sup>
- 2.7 The most common issue raised by complainants was treatment (40 per cent), which includes alleged wrong and inadequate diagnoses or treatment, or unexpected treatment outcomes and complications.<sup>11</sup> Although lower than in the previous year (46.2 per cent), 'treatment' has been consistently reported as the most complained issue in the last five years.<sup>12</sup>
- 2.8 As was the case in previous years, communication issues (with 20.7 per cent), which include the provision of wrong and inadequate information as well as attitude and manner of a health service provider, were the second most common subject of a complaint. In fact, compared to the previous year, there has been an increase in the proportion of 'communication as an issue in complaints'.<sup>13</sup> 'The majority of communication-related complaints concerned the attitude and manner of the health practitioner'.<sup>14</sup>
- 2.9 The professional conduct of a health service provider (with 12 per cent) was the third most commonly complained about matter, which is related to a practitioner's competence and impairment as well as assault, fraud and inappropriate disclosure of information.<sup>15</sup>
- 2.10 During the public hearing, the Committee inquired whether the Commission is active in the area of promoting better communication between the practitioner and complainants. The Commissioner advised that one of the ways of enhancing communication between the practitioner and complainants is the project the Commission is working on with the Clinical Excellence Commission to 'reinvigorate the open disclosure process'.<sup>16</sup>

**Mr PEHM:** ...We are on a working party with the Clinical Excellence Commission to reinvigorate the open disclosure process. Open disclosure is one of those things that was mandated and became policy of the Department way back in 2007.

The working group now is drafting more detailed guidelines about how to do it and what sort of support is available. There are a few missed steps along the way. They rolled out quite extensive training to practitioners with role playing. The trouble with

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<sup>9</sup> HCCC Annual Report, 2012-2013, p16

<sup>10</sup> HCCC Annual Report, 2012-2013, p16.

<sup>11</sup> HCCC Annual Report, 2012-2013, p17.

<sup>12</sup> HCCC Annual Report, 2012-2013, p16.

<sup>13</sup> HCCC Annual Report, 2012-2013, p16.

<sup>14</sup> HCCC Annual Report, 2012-2013, p17.

<sup>15</sup> HCCC Annual Report, 2012-2013, p17.

<sup>16</sup> Transcript of evidence, 16 April 2014, p6.

training is if it is not used and it does not come up it lapses within the next six months or so and you forget all that. The scheme now is to have an expert adviser available to clinicians in this situation so that a person can help organise a conference and give them advice about how to participate so that they do not feel exposed or vulnerable as well.<sup>17</sup>

- 2.11 Furthermore, the Committee inquired whether any hospitals in New South Wales considered having on-call specialists to deal with complaint handling, a practice that already exists in the United States. The Commissioner advised that this is one of the proposals for the new guidelines, which are being drafted in consultation with the Local Health Districts:<sup>18</sup>

**Mr PEHM:** That is the proposal in these new guidelines that are being drafted, which should be finalised shortly. That has been subject to consultation with all the LHDs [local health districts], and they are basically on board with it, so it will happen. I do not think it currently exists. At the moment directors of clinical governance and complaint-handling staff tend to be the ones that take responsibility for open disclosure.

**Dr ANDREW McDONALD:** Or do not.

**Mr PEHM:** It varies. Sometimes they tell us it is a mistake to even have the practitioner involved in it because of all the anxiety on their part and the complainants feeling it is going to be inflammatory. I think that idea of having an expert who is very familiar with the process and knows about the sensitivities involved and how to keep people on a reasonable keel is really crucial. I think that is one of the key parts of this new process that should be starting soon.<sup>19</sup>

## Profile of practitioners most at risk of a complaint

- 2.12 In 2012-13, the Commission received 13 per cent more complaints about individual health practitioners than in the previous year. Medical practitioners, dental practitioners, nurses and midwives, pharmacists and psychologists were the health professional most commonly complained about, accounting for 91.7 per cent of all complaints about individual practitioners in 2012-13.<sup>20</sup>
- 2.13 Medical practitioners remain the most commonly complained about profession. Moreover, in 2012-13, the complaints about medical practitioners increased by 8.6 per cent. As a result, complaints about medical practitioners made up 54.8 per cent of all complaints about health practitioners in 2012-13.<sup>21</sup> The Commission states that the higher number of complaints about medical practitioners can be attributed to the high number of patient-practitioner interactions in the primary health care sector.<sup>22</sup>
- 2.14 In line with the previous year, surgeons were the second most complained about type of practitioner. According to the Commission, this is due mainly to situations

<sup>17</sup> Transcript of evidence, 16 April 2014, p6.

<sup>18</sup> Transcript of evidence, 16 April 2014, p7.

<sup>19</sup> Transcript of evidence, 16 April 2014, p7.

<sup>20</sup> HCCC Annual Report, 2012-2013, p17.

<sup>21</sup> HCCC Annual Report, 2012-2013, p18.

<sup>22</sup> HCCC Annual Report, 2012-2013, p18.

where ‘complications or poor outcomes are suffered that can have a great impact on the patient’s life’.<sup>23</sup>

- 2.15 There was a decrease of 10.4 per cent of complaints received about dental practitioners (compared to the previous year). The Commission explained that this can be attributed to the end of the Medicare dental scheme in late 2012, which had given people with chronic illness access to free dental treatment and had attracted a large number of complaints.<sup>24</sup>
- 2.16 The most significant change from the previous year was the significant increase of 64.5 per cent of complaints received about nurses and midwives. The Commission explained that this has been mainly driven by mandatory notifications made to the Australian Health Practitioner Regulation Agency and referred to the Commission, deeming these as complaints.<sup>25</sup>
- 2.17 At the public hearing, the Committee was interested in finding out about the characteristics that made a practitioner subject to a greater risk of complaint. The Commissioner advised that one of the research projects, which the Commission supported, was to examine the profile of practitioners most at risk.<sup>26</sup> As part of the response to the questions taken on notice, the Commission provided the paper on the study sample, which consisted of nearly 19,000 formal health care complaints lodged against doctors in Australia between 2000 and 2011.<sup>27</sup>
- 2.18 One of the key findings of this research report was that ‘the ageing male practitioner is particularly prone to complaints’.<sup>28</sup> In fact, 79 per cent of the doctors names in complaints were male, 47 per cent were general practitioners and 14 per cent were surgeons.<sup>29</sup> The authors noted that ‘the distribution of complaints was highly skewed as three per cent of Australia’s medical workforce accounted for 49 per cent of complaints and one per cent accounted for a quarter of complaints’.<sup>30</sup> Effectively, a small group of doctors accounts for half of all patient complaints lodged with Australian Commissions.<sup>31</sup>

## Complaints about health organisations

- 2.19 The Committee also reviewed the results of statistical analysis carried out by the Commission on complaints about health organisations. Overall, there was an

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<sup>23</sup> HCCC Annual Report, 2012-2013, p18.

<sup>24</sup> HCCC Annual Report, 2012-2013, p18.

<sup>25</sup> HCCC Annual Report, 2012-2013, p18.

<sup>26</sup> Transcript of evidence, 16 April 2014, p3.

<sup>27</sup> M. M. Bismark, M. J. Spittal, L. C. Gurrin, M. Ward, D. M. Studdert, Identification of doctors at risk of recurrent complaints: a national study of healthcare complaints in Australia, April 2014, p3. *(Please note that a copy of the report is provided in chapter of this report).*

<sup>28</sup> M. M. Bismark, M. J. Spittal, L. C. Gurrin, M. Ward, D. M. Studdert, Identification of doctors at risk of recurrent complaints: a national study of healthcare complaints in Australia, April 2014, p3.

<sup>29</sup> M. M. Bismark, M. J. Spittal, L. C. Gurrin, M. Ward, D. M. Studdert, Identification of doctors at risk of recurrent complaints: a national study of healthcare complaints in Australia, April 2014, p3.

<sup>30</sup> M. M. Bismark, M. J. Spittal, L. C. Gurrin, M. Ward, D. M. Studdert, Identification of doctors at risk of recurrent complaints: a national study of healthcare complaints in Australia, April 2014, p1.

<sup>31</sup> M. M. Bismark, M. J. Spittal, L. C. Gurrin, M. Ward, D. M. Studdert, Identification of doctors at risk of recurrent complaints: a national study of healthcare complaints in Australia, April 2014, p1.

increase of 5.7 per cent (from the previous year) in complaints about health organisations.<sup>32</sup>

- 2.20 In line with the previous year, public hospitals generated the highest number of complaints, reflecting the volume and nature of services provided. In 2012-13, complaints about the public hospitals increased by 9.3 per cent.
- 2.21 The second and third categories which received the largest number of complaints are correction and detention facilities, which increased by 9.4 per cent. The figure relating to the medical centres remained stable compared to the previous year.<sup>33</sup>
- 2.22 Of complaints received about hospitals, issues relating to treatment accounted for over half of the complaints about public hospitals while 43.1 per cent of complaints about treatment accounted for complaints about private hospitals.<sup>34</sup>

### Complaints referred to other organisations

- 2.23 The Commission also reported that 19.5 per cent of complaints were referred to the relevant professional council to take appropriate action, 5.5 per cent were referred to the relevant public health organisations to try to resolve the complaint locally, and 2.1 per cent were referred to another more appropriate body for their management.<sup>35</sup> The Committee was interested in finding out more about the process of referral to other organisations:

**CHAIR:** ... I note in the report that a substantial number of complaints are referred to other areas, such as your resolution service. You say that 5.5 per cent were referred to public health organisations. In relation to those referrals to other bodies, do you get feedback about where those complaints finish up?

**Mr PEHM:** No. We contact the public health organisation and ask if they are prepared to engage in local resolution with the complainant. We do not get feedback on every process. We will get the odd one where the complainant will come back and say, "No, I am still unhappy".

- 2.24 While the Commission does not obtain feedback about every complaint, it considers that the complaints it refers to Local Health Districts for local resolution are handled well.<sup>36</sup>
- 2.25 The Committee also inquired whether the complaints that are referred to other bodies are considered as part of the 94.5 per cent of complaints finalised. The Commissioner stated that it is the case.<sup>37</sup>

### Discontinued complaints

- 2.26 In its annual report, the Commission stated that in 2012-13, it discontinued 47.3 per cent of complaints.<sup>38</sup> The Committee was interested in reasons behind such a

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<sup>32</sup> HCCC Annual Report, 2012-2013, p19.

<sup>33</sup> HCCC Annual Report, 2012-2013, p20

<sup>34</sup> HCCC Annual Report, 2012-2013, p20.

<sup>35</sup> HCCC Annual Report, 2012-2013, p29.

<sup>36</sup> Transcript of evidence, 16 April 2014, p9.

<sup>37</sup> Transcript of evidence, 16 April 2014, p5.

high number of complaints being discontinued. The Commissioner stated that the reason for the discontinuation of a high number of complaints is that 'that they are not serious enough to require investigation'.<sup>39</sup>

## COMPLAINT HANDLING –AN UPDATE

### Efficiency in complaint handling

- 2.27 In its annual report, the Commission stated that 94.5 per cent of assessments were finalised within the 60-day period, which is 10 per cent more than a couple of years ago. According to the Commission, the average time to assess a complaint was reduced by three days to 40 days.<sup>40</sup>

### User-friendliness and complaint-handling

- 2.28 In its response to the Questions on Notice, the Commission stated that 'the vast majority of inquiries made to the Commission are made by phone, which accounted for 94.7 per cent of all inquiries received in 2012-13. Nevertheless, the Commission noted that in the period from 2008-09 to 2012-13, 'the proportion of complaints submitted via electronic means has significantly increased from 3.0 per cent of all complaints being received electronically in 2008-09 to 50.4 per cent in 2012-13'.<sup>41</sup>
- 2.29 Moreover, the Commission advised that it has continued with the improvement of its website as well as the online complaint form, ensuring that it is easily accessible via computer and electronic mobile devices.<sup>42</sup>

## COMMITTEE COMMENT

- 2.30 The Committee found that 'communication issues' continue to be the second most common subject of complaint and that the Commission is working with other bodies to deal with this matter. The Committee acknowledges that the Commission is active in the area of promoting better communication between the practitioners and the complainants, mainly through its work with the Clinical Excellence Commission to 'reinvigorate the open disclosure processes' as well as its work on the guidelines that are being developed in cooperation with the Local Health Districts. The Committee will continue to monitor developments in this area and report on these in its future reports.
- 2.31 The Committee noted the findings of the research paper, provided by the Commission, in particular the fact that three per cent of Australia's medical workforce accounted for 49 per cent of complaints and one per cent accounted for a quarter of complaints. The Committee considers that there is a need for a set of policies to be implemented to address the issues that are present in three per cent of Australia's medical workforce, which over the last decade, accounted for 49 per cent of complaints.

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<sup>38</sup> HCCC Annual Report, 2012-2013, p29.

<sup>39</sup> Transcript of evidence, 16 April 2014, p5.

<sup>40</sup> HCCC Annual Report, 2012-2013, p5.

<sup>41</sup> HCCC, Response to the Questions on Notice, 7 April 2014, p6.

<sup>42</sup> HCCC, Response to the Questions on Notice, 7 April 2014, p6.

- 2.32 The Committee found that the Commission considers complaints that it refers to other bodies as 'finalised'. Yet, the Committee found that the Commission does not obtain any feedback from those bodies about the final outcome of the complaint. The Committee considers that – in order to deliver the best customer service possible – the Commission could examine options for developing a system for obtaining feedback about the complaints it refers to other bodies for resolution.
- 2.33 The Committee noted that the Commission made significant progress in relation to timeliness of assessing complaints during the last year. The Committee is pleased that the Commission improved its efficiency in complaint handling. The Committee will continue monitoring the Commission's timeliness and quality in assessing complaints.
- 2.34 The Committee acknowledges that the Commission implemented the recommendation No. 9 from the Committee's last report and has updated its website. The Committee is pleased that this update has played a role in increasing the number of complaints being received electronically.

## RECOMMENDATION 1

**That the Commission and the Ministry of Health devise policies to enhance the capacity of the three per cent of Australia's medical workforce – which over the last decade accounted for 49 per cent of complaints – and thereby reduce the number of complaints.**

## RECOMMENDATION 2

**That the Commission develop a system for obtaining feedback about the complaints it refers to other bodies for resolution and thereby ensure that each complaint is addressed.**



## Chapter Three – Community outreach

- 3.1 This chapter discusses the Commission's outreach activities, including the provision of its webinars, support of research projects and work with other relevant bodies.
- 3.2 In its latest annual report, the Commission outlined a number of systems and tools in place, ensuring that it remains accessible to the members of the community wishing to make a complaint.
- 3.3 During the public hearing, the Committee was interested in finding out more about Commission's accessibility to the members of the public. In particular, the Chair inquired about the illustrated factsheets and how these are accessed by people with an intellectual disability and people with low literacy level.<sup>43</sup> The Commissioner outlined how this information was created and how it is accessed by people with an intellectual disability and people with low literacy levels:
- Mr PEHM:** The Council for Intellectual Disability is one of the members of our Consumer Consultative Committee, so we worked on that resource with them. It is certainly available through their outlets and so on and on the Commission's website.
- CHAIR:** I assume that because you work with that group you would receive feedback on the appropriateness of that brochure from those people?
- Mr PEHM:** It was a joint development with them. They were the authors of it as much as we were and, yes, they are quite happy with the final outcome.<sup>44</sup>
- 3.4 In addition to enhancing accessibility of its services by people with an intellectual disability and people with low literacy levels, the Commissioner also stated that its complaint form is available in 20 community languages, and that people with a hearing impairment can contact the Commission using a teletypewriter number or through the National Relay Service.<sup>45</sup>
- 3.5 Moreover, the Commission stated that its information film 'What happens with health care complaints' was updated and is available in the Australian sign language AUSLAN, as well as with Arabic and Chinese subtitles and that it was promoted to media, targeting Arabic and Chinese communities in NSW, as well as the Local Health Districts. The Commission noted that it received a certificate of commendation for this resource at the 2013 NSW Multicultural Health Awards.<sup>46</sup>
- 3.6 In its annual report, the Commission also stated that it continued its support of relevant research projects, mainly through the provision of information and data, which is provided in a form in which the complainants or practitioners are not identified.<sup>47</sup> During the public hearing, the Committee was interested in finding

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<sup>43</sup> HCCC Annual Report, 2012-2013, p9.

<sup>44</sup> Transcript of evidence, 16 April 2014, p2.

<sup>45</sup> HCCC Annual Report, 2012-2013, p9.

<sup>46</sup> HCCC Annual Report, 2012-2013, p9.

<sup>47</sup> HCCC Annual Report, 2012-2013, p11 and Transcript of evidence, 16 April 2014, p2.

out to what extent the research projects the Commission supports have been beneficial to the Commission:

**CHAIR:** Have there been some examples from those research projects where you may have used the outcomes to change or develop new policies or maybe to change your procedures in the way that you operate as a result of them?

**Mr PEHM:** The middle one we quote on page 11, a research project by the University of Melbourne, looked at whether a particular kind of medical practitioner was more likely to attract complaints. They published the results of that. It was not really a surprise to us what their research identified, so it was not the sort of project that required change. They did recommend that past complaints were a likely indicator of future complaints. The commission already has a process which is specific in the Act to look back at past complaints whenever a new complaint is received by a practitioner, so we pretty much had that covered.<sup>48</sup>

3.7 The Commissioner also stated that the Commission continued promoting its work among health consumers and health professionals. Activities in this area include 59 presentations to community groups and health services providers and delivery of six webinars for health consumers and health practitioners, covering specific topics relevant to them.<sup>49</sup> During the public hearing, the Committee was interested in finding out more about the webinars, in particular to what extent these are accessed by the rural population:

**The Hon. PAUL GREEN:** Where are the webinars being received mostly? Are they city-wide, rural, regional or just generally everywhere?

**Mr PEHM:** We only get email addresses so it would be hard to say. People log in through the internet and all we have is the email address.

**The Hon. PAUL GREEN:** It would be prudent to get that information to know who is partaking of these seminars for future use.

**Mr PEHM:** It would not hurt. We could look at that as part of the registration login. It is always a balancing act in collecting demographic data. For something that you want to be quick and accessible, do you put up barriers that might put people off? But we can have a look at that.

**CHAIR:** I guess your interest is because of our first inquiry with regard to regional access.

**Mr PEHM:** It is very convenient for regional people. From the questions that come from people there are certainly regional practitioners listening because from the questions they ask it is clear where they are from. It is much easier to do these webinars than it is to travel out to those places and we get a broader mix.<sup>50</sup>

3.8 The Commission also stated that it continued working together with Local Health Districts (LHDs), the Ministry for Health, the Clinical Excellence Commission as well as other health complaints bodies. The Commission's annual report outlined that in 2012-2013, the:

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<sup>48</sup> Transcript of evidence, 16 April 2014, p2.

<sup>49</sup> HCCC Annual Report, 2012-2013, p9.

<sup>50</sup> Transcript of evidence, 16 April 2014, p4.

- Commissioner attended a meeting of the Australian and New Zealand health complaints commissioners in Adelaide;
- Director of Assessments and Resolution attended a complementary meeting of senior operational staff of complaint bodies in Canberra to discuss emerging issues and best practice approaches in complaint- handling; and
- Commission was approached by the Australian Health Practitioners Regulation Agency as well as the Queensland Department of Health to discuss best practice complaint-handling.<sup>51</sup>

3.9 The Commission also provided an update in relation to the quality of its customer service. According to its latest annual report, the complainants' satisfaction with the assessment of complaints increased from 47.2 per cent last year to 73.7 per cent this year. The Commission stated that the additional funding has helped the Commission to enhance the level of its service.<sup>52</sup> The Commission also stated that its Resolution Service recorded a satisfaction rate of 78.2 per cent from complainants.<sup>53</sup>

## COMMITTEE COMMENT

- 3.10 The Committee is pleased with the Commission enhancing its outreach to the culturally and linguistically diverse members of the community of NSW, wishing to make a complaint. The Committee congratulates the Commission for receiving a certificate of commendation for its information film 'What happens with health care complaints' at the 2013 NSW Multicultural Health Awards.
- 3.11 The Committee acknowledges the importance of supporting research projects, which the Commission does via the provision of information and data to researchers, as these are important in contributing to the knowledge in the area of health care complaints. Given that support to research projects implies investment of Commission's staff time in liaising with and supervising researchers in accessing the relevant information, the Committee considers that the Commission should investigate having a system that would allow it to conduct a quick cost/benefit analysis before accepting any request to support a research project.
- 3.12 The Committee welcomes and supports the Commission's work in relation to delivering its webinars to health consumers and health professionals, covering specific topics relevant to them. The Committee considers that it would be useful to obtain a profile of who is accessing the webinars, as it would uncover where additional promotional work of Commission's work may be required. The Committee acknowledges that obtaining this sort of data should not be at the expense of user-friendliness of webinars.
- 3.13 The Committee acknowledges and supports the Commission's work with relevant bodies and institutions as a way of sharing and learning about best-practice approaches in complaint-handling.

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<sup>51</sup> HCCC Annual Report, 2012-2013, p10.

<sup>52</sup> HCCC Annual Report, 2012-2013, p4.

<sup>53</sup> HCCC Annual Report, 2012-2013, p4.

- 3.14        The Committee is pleased that additional funding provided to the Commission has led to concrete results, enhanced service delivery and led to greater satisfaction rates among the complainants.

### RECOMMENDATION 3

**That the Commission conduct a cost/benefit analysis before accepting any request to support a research project, enhancing the value it receives for supporting these.**

### RECOMMENDATION 4

**That the Commission explore options for creating a user-friendly method for collecting data on the profile of customers and professionals who access its webinars, in order to better target and enhance its promotional work.**

## Chapter Four – Legislative and Policy Changes

- 4.1 This chapter discusses the impact of the recent legislative changes, new assessment policies as well as the new process of auditing recommendations made to the health services by the Commission.

### The impact of the recent legislative changes

- 4.2 Legislative changes of the *Health Care Complaints Act* in May 2013 broadened the Commission's role and provided it the power to initiate complaints against health service providers, without first requiring a complaint to trigger an investigation.<sup>54</sup>

- 4.3 During the public hearing, the Commissioner provided an update in relation to occasions when the Commission used its new powers:<sup>55</sup>

**Mr PEHM:** There is one that has been made public by the Australian Vaccination Network, which I am pretty sure we will be finalising pretty shortly. There have not been a great number, because generally you have got a complainant. But there have been situations where the complainants have been reluctant for fear of retribution and whatever, and they are in a position to provide us with enough evidence to go forward. So we have done that a couple of times. I have not got exact figures or particular situations in mind.<sup>56</sup>

- 4.4 The Commission advised that the new powers have been useful in effectively and efficiently handling complaints:

**Mr KOFKIN:** It is really useful for unregistered practitioners where there is a prohibition order. In the past we maybe had some information where a practitioner would be breaching a prohibition order but without a complaint we could not action it. Now we can use that information or that intelligence and then make our own complaint and carry out our investigations. In these circumstances it is really useful.

**Ms MOBBS:** I think also in terms of saving time. There has been one matter where it had progressed quite a long way in the legal process and there was an admission of possible other conduct. Rather than having to go out and waste time in hunting a complainant down, it was able to be progressed much more quickly to then join it up with the current proceedings. It is certainly useful from that perspective.<sup>57</sup>

### Mandatory reporting – an update

- 4.5 Following the amendments to the Health Practitioner Regulation National Law, which came into effect in 2010, it is mandatory for registered health practitioners and their employers to report certain types of notifiable conduct when they have a reasonable belief that a fellow practitioner or employee has engaged in certain

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<sup>54</sup> HCCC Annual Report, 2012-2013, p5.

<sup>55</sup> Transcript of evidence, 16 April 2014, p8.

<sup>56</sup> Transcript of evidence, 16 April 2014, p8.

<sup>57</sup> Transcript of evidence, 16 April 2014, p8.

types of problematic behaviour. The Committee was interested in effects of these changes:<sup>58</sup>

**Dr ANDREW McDONALD:** Have you noticed that mandatory reporting has led to an increase in reports?

**Mr PEHM:** It has been in for a fairly short time, but yes. I have not got exact figures on it but I assess all the complaints, so I see them. Where there has been a particular increase, it has been with reports from employers. They have an obligation to report as well and, of course, the liability for employers is potentially more serious; medical practitioners not so much.<sup>59</sup>

- 4.6 In its response to the Questions on Notice, the Commission advised that ‘since mandatory notifications were legally deemed to be complaints from June 2012, the Commission has treated them as normal complaints and has not been tracking this cohort of complaints separately’. Nevertheless, the Commission advised that the health professional councils provide information about the number of mandatory notifications in their annual reports. It stated that the councils registered 231 mandatory notifications in 2012-13, which – due to the co-regulatory arrangements – were notified to the Health Care Complaints Commission and dealt with as formal complaints.<sup>60</sup>

### New assessment process policies

- 4.7 At the public hearing, the Committee also inquired how a serious complaint, resulting in a traumatic outcome and/or death is handled by the Commission. The Committee was particularly interested to what extent the Commission could implement the Committee’s recommendation made in its last report for the Commission to formulate ‘a protocol to deal with complaints made as a result of extraordinary circumstances, such as fatality, that investigation of that complaint be expedited as a matter of priority, and that there be an increased engagement with the affected parties’.<sup>61</sup>
- 4.8 The Commission advised that the recommendations, arising out of the Committee’s most recent inquiry, allowed the Commission to change its assessment processes to better identify those serious issues:<sup>62</sup>

**Mr PEHM:** ..They are specifically identified now in the database and in the assessment plan that is given to the officers. They will talk to the parties in those cases...

**Mr KOFKIN:** For a number of years, about three years, when we get a complaint to the investigation division where there is an adverse outcome such as death or life-changing injuries, et cetera, we have been visiting the complainant and the family members. It would be me as the director and the investigator. Wherever they are in

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<sup>58</sup> Committee on the Health Care Complaints Commission, Review of the 2011-2012 Annual Report of the Health Care Complaints Commission, October 2013, p11.

<sup>59</sup> Transcript of evidence, 16 April 2014, p12.

<sup>60</sup> HCCC, Response to the Questions on Notice, 7 April 2014, p.1.

<sup>61</sup> Committee on the Health Care Complaints Commission, Inquiry into Health Care Complaints and Complaint Handling in NSW, August 2013, vii

<sup>62</sup> Transcript of evidence, 16 April 2014, p12.

the State we will go and visit. We will set aside as long as they need; a whole afternoon or a whole day if necessary. At that point it is not about going into detail about the investigation because it is quite early. It is about explaining the process, managing expectations, letting the parties know that we are independent, impartial, open and transparent and then formulating a contract in terms of how often we are going to update them, at what stages we are going to update them and making sure we get a single point of contact.

... But certainly from my experience, every time we go out and visit it really does allay a lot of their fears and the feedback we get is really good.<sup>63</sup>

## Introduction of auditing of recommendations made by the Commission

- 4.9 In its latest annual report, the Commission outlined that it initiated auditing of public hospitals to ensure compliance with its recommendations.<sup>64</sup> At the hearing, the Commissioner provided an update in relation to the implementation of the audits:

**Mr KOFKIN:** ... What we have found from the LHDs is that they value us coming along because it gives them the opportunity to reassess where they are and to see how they are travelling. It also gives them an opportunity to promote to us in terms of how that incident two or three years ago has not only led to a change in policy but sometimes cultural differences as well. And, understandably, it often leads to a diversion of resources to a particular area where there was previously a need but where resources had not been diverted. It is something we will continue to do. I think two a year is enough for us, in terms of capacity.<sup>65</sup>

- 4.10 The Committee was interested in finding out whether the recommendations made to one LHD are shared with other LHDs, especially given the positive outcomes of the auditing. However, the Commission advised that all reports with recommendations are provided to the Clinical Excellence Commission for them to distribute, as well as to the Director General of the Health Department, so that they can 'look at the potentially wider application'.<sup>66</sup>

## COMMITTEE COMMENT

- 4.11 The Committee is pleased that the legislative changes to the *Health Care Complaints Act* have been useful to the Commission in handling complaints.
- 4.12 The Committee acknowledges that the Commission has done considerable work in implementing recommendation in relation to 'handling complaints that are made as a result of extraordinary circumstances', which the Committee made in its last report. The Committee is pleased with the positive impact this has had on the Commission as well as on the complainants.
- 4.13 The Committee is pleased that the auditing of Commission's recommendations has been welcomed by the LHDs. The Committee also noted that the Commission shares the recommendations it makes with the Clinical Excellence Commission as

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<sup>63</sup> Transcript of evidence, 16 April 2014, p12.

<sup>64</sup> HCCC Annual Report, 2012-2013, p44.

<sup>65</sup> Transcript of evidence, 16 April 2014, p17.

<sup>66</sup> Transcript of evidence, 16 April 2014, p18.

well as with the Health Department. The Committee considers that recommendations made to one LHD, should also be communicated to other LHDs, for their information and potential implementation. The rationale for this is to address the same or similar policy issues, which may be present in other Local Health Districts. That way, the Commission would not need to make the same recommendation twice.

#### RECOMMENDATION 5

**That the Commission outline the rationale for a wider application of the recommendations it makes to a Local Health District when reporting these to the Department of Health, in order to address the same policy issues, which may be present in other Local Health Districts.**



## Chapter Five – Corporate governance

- 5.1 This chapter considers the corporate governance of the Commission.
- 5.2 The Commission reported on its overall financial situation, stating that its 'net result before capital was a surplus of \$12,000, which was \$266, 000 higher than budgeted:
- A higher than budgeted other income of \$236,000, which mainly related to recovered legal costs, and savings to employee related expenses, including a long service leave actuarial adjustment of \$75,000, had a significant impact on the overall result.<sup>67</sup>
- 5.3 As at 30 June 2013, the Commission employed a total of 86 staff, up from the 84 recorded at 30 June 2012. The Commission reported that there was an increase in the number of full time equivalent staffing from 70.8 in 2011-12 to 76.2 in 2012-13.<sup>68</sup> At the public hearing, the Commissioner noted how additional funding has helped the Commission, and advised that the resources it has at the moment are sufficient, but may not be in the future:
- The Hon. PAUL GREEN:** In previous inquiries, we have asked about the resources needed to resource your manpower. How is it going and what is the outlook?
- Mr PEHM:** We received quite a substantial budget increase about two or three years ago from the incoming Government of that time. I think you can see the numbers are continuing to increase. We have been coping fairly well but I think it is starting to get a bit tight again and we might raise that this next round.<sup>69</sup>
- 5.4 The Commission reported on employment and movement in salaries and allowances.<sup>70</sup> It stated that 'staff employed under the Crown Employees (Public Service Conditions of Employment) Award 2009 received a 2.5% increase in salary and related allowances on 1 July 2012', but that the 'planned increase of staff salaries as at 1 July 2013 had not been implemented on that date due to an ongoing appeal by the NSW Government before the High Court regarding the question whether or not the 2.5 % increase incorporates a mandated 0.25% increase in superannuation'. The Commission notes that it will pay any increase retrospectively after the decision has been finalised.<sup>71</sup>
- 5.5 In its annual report, the Commission stated that in 2012-13, staff attended a 'total of 287 days of training in the areas of information technology, organisational development, risk management and technical skills'.<sup>72</sup>

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<sup>67</sup> HCCC Annual Report, 2012-2013, p67.

<sup>68</sup> HCCC Annual Report, 2012-2013, p59.

<sup>69</sup> Transcript of evidence, 16 April 2014, p17.

<sup>70</sup> HCCC Annual Report, 2012-2013, p60.

<sup>71</sup> HCCC Annual Report, 2012-2013, p60.

<sup>72</sup> HCCC Annual Report, 2012-2013, p60.

- 5.6 The Commission reported that it received very positive results in the Public Service Commission's 2012 People Matter Survey, with 100 per cent of the Commission staff who responded to the survey expressing satisfaction with the workplace:

The Health Care Complaints Commission received very positive results in the survey with 100% of the Commission staff who responded agreeing that: they are proud to work for the NSW Public Sector; they have the skills to do their job effectively; they understand how their work contributes to the Commission's objectives; their team strives to achieve customer satisfaction; and their team treats customers and clients with respect.<sup>73</sup>

- 5.7 The Commission also reported that 'none of the participating staff members had experienced or witnessed any bullying or harassment in the workplace in the past 12 months'.<sup>74</sup>

## COMMITTEE COMMENT

- 5.8 The Committee noted an increase of 5.4 full time equivalent staffing employed by the Commission from the previous year. The Committee is pleased that, as a result of additional funding, the Commission was in the position to employ additional staff to effectively deal with the health care complaints.
- 5.9 The Committee noted that the Commission will pay any increase of staff salaries as at 1 July 2013 retrospectively, once the decision regarding the question whether or not the 2.5 % increase incorporates a mandated 0.25% increase in superannuation is finalised.
- 5.10 The Committee found that the Commission continued to invest in staff development. The Committee welcomes and supports the Commission's approach to staff development.
- 5.11 The Committee noted that none of the staff members participating in the Public Service Commission's 2012 People Matter Survey, had experienced or witnessed any bullying or harassment in the workplace in the past 12 months. The Committee is pleased that the Commission is a safe and healthy working environment, free from bullying and harassment.

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<sup>73</sup> HCCC Annual Report, 2012-2013, p61.

<sup>74</sup> HCCC Annual Report, 2012-2013, p61.

## Chapter Six – Response to Questions on Notice

Our reference: AF 2204

Contact person: Katja Beitat,  
Phone: [REDACTED]  
Email: [REDACTED]



Mrs Leslie Williams MP  
Chair  
Joint Parliamentary Committee on the Health Care Complaints Commission  
Parliament of NSW  
Macquarie Street  
Sydney NSW 2000

Submitted by email to: [hccc@parliament.nsw.gov.au](mailto:hccc@parliament.nsw.gov.au)

### Response to questions on notice – review of the 2012-13 annual report of the Health Care Complaints Commission

Thank you for your letter of 28 March 2014 enclosing questions on notice for the Committee's forthcoming hearing on Wednesday, 16 April 2014.

The Commission's response to the questions on notice is attached. Please note that the response to question 5 contains complaint-related information and I request the Committee to direct that this part of the Commission's submission be treated confidential under section 72(1)(b) of the *Health Care Complaints Act*.

Yours sincerely,

[REDACTED]

Kieran Pehm  
Commissioner

07 APR 2014

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Response to questions on notice  
Review of the 2012-13 Annual Report of the Health Care Complaints Commission

**Question 1**

The Commission saw a 10.3% increase in the number of written complaints compared to the previous year. What proportion of these were mandatory notifications which were legally deemed as complaints as of June 2012?

**Response**

Since mandatory notifications were legally deemed to be complaints from June 2012, the Commission has treated them as normal complaints and has not been tracking this cohort of complaints separately. However, the health professional Councils include information about the number of mandatory notifications in their annual reports. In total, the Council registered 231 mandatory notifications in 2012-13, which due to the co-regulatory arrangements were notified to the Health Care Complaints Commission and dealt with as formal complaints.

For the Committee's convenience, the relevant information for the 2012-13 year has been replicated in the table below.

**Table 1: Number of mandatory notifications received as reported in health professional Councils' annual reports for the 2013 year**

| Council                                                                          | Mandatory notifications 2012-13 |
|----------------------------------------------------------------------------------|---------------------------------|
| Aboriginal and Torres Strait Islander Health Practice Council of New South Wales | -                               |
| Chinese Medicine Council of New South Wales                                      | 1                               |
| Chiropractic Council of New South Wales                                          | -                               |
| Dental Council of New South Wales                                                | 3                               |
| Medical Council of New South Wales                                               | 87                              |
| Medical Radiation Practice Council of New South Wales                            | 3                               |
| Nursing and Midwifery Council of New South Wales                                 | 120                             |
| Occupational Therapy Council of New South Wales                                  | 1                               |
| Optometry Council of New South Wales                                             | -                               |
| Osteopathy Council of New South Wales                                            | 1                               |
| Pharmacy Council of New South Wales                                              | 4                               |
| Physiotherapy Council of New South Wales                                         | 3                               |
| Podiatry Council of New South Wales                                              | -                               |
| Psychology Council of New South Wales                                            | 8                               |
| <b>Total</b>                                                                     | <b>231</b>                      |

Data provided by David Rhodes, Assistant Director, Allied Health, Nursing and Midwifery, Health Professional Councils Authority

Response to questions on notice  
Review of the 2012-13 Annual Report of the Health Care Complaints Commission

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## Question 2

Can you provide additional information about the University of Sydney research project that is comparing complaint handling in NSW to other Australian jurisdictions?

### Response

The research project is titled *National registration of health practitioners: a comparative study of the complaints and notification system under the national system* and aims to:

- analyse the different processes of health practitioner complaint handling, including investigation and disciplinary procedures by the Health Professional Council Authority (HPCA) in co-regulation with the NSW Health Care Complaints Commission (HCCC) and nationally through the Australian Health Practitioner Regulation Agency (AHPRA)
- provide advice on best practices in relation to the receipt, assessment, method for resolution and outcomes, in order to establish which system offers the most effective and efficient system for managing complaints/notifications involving health professionals
- ascertain complainants' perceptions and experiences of the processes in the two different complaint notification systems.

The project consists of five studies, each of which is briefly explained below based on information provided by the research coordinator Claudette Satchell.

### Study I: Comparative Analysis of Health Complaints Data

Contact: Patrick Kelly, School of Public Health, University of Sydney

Study I comprises the collation and analysis of health complaints data, including matters that were investigated and their outcomes, for the period 1<sup>st</sup> Jul 2012 to 30<sup>th</sup> Jun 2014. Data access is facilitated through AHPRA, HPCA and the NSW HCCC and comparisons will be made between the NSW and National data sets. Data will be collected for complaints made against the following five health practitioner groups: dentistry, medicine, nursing and midwifery, pharmacy and psychology. These professions are selected as they represent key members of the health workforce within Australia and because of their differing models for receiving notifications under the national scheme. Medicine, nursing and midwifery and dentistry have state and territory Boards in all jurisdictions that will have notifications committees for receiving and processing complaints; psychology has a hybrid model of regional Boards; and pharmacy only has a national Board with a notifications committee. The following information will be collected for each complaint:

- Type of complaint (e.g. boundary violations, financial irregularities, fraud, assault, poor performance, medication irregularities)
- Complaint assessment process (undertaken by the AHPRA or HPCA staff and/or national Board notifications committees).
- Outcomes of assessment (e.g. decisions to refer or not proceed).
- Methods used for complaint resolution: investigation and conciliation/mediation as well as the categories and types of complaints that fit into the different resolution methods.
- Outcome of complaint, by broad headings (e.g. prosecution, suspension, resolution, letter to respondent, letter to complainant, refer to impaired panel, refer for competence assessment).

Response to questions on notice  
Review of the 2012-13 Annual Report of the Health Care Complaints Commission

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- Panel/Professional Standards Committee (PSC)/ Tribunal decisions (by broad headings). The outcomes of Panel/PSC/Tribunal decisions will be recorded by matching complaints and complaint type to determinations. The Tribunal and PSC decisions are recorded and kept on file in both the national and NSW offices and it will be necessary to track backwards to identify the number of complaints of a particular type that go to disciplinary hearing.
- Demographic information (e.g. gender, age, state/territory).

**Study II: Case studies on the life of a complaint**

Contact: Marie Nagy, School of Nursing, University of Sydney

Study II tracks a number of selected paired complaints from NSW and the national scheme from initial receipt of the notification to finalisation. It will give insight both into the decision making processes and the complexity of working in a protective jurisdiction. These complaints will be selected through negotiation with the notifications bodies and will be given a code number (potentially identifiable) to allow tracking the complaint journey. Data will be de-identified for Study II because comparisons will need to be made between the two processes, it would be undesirable to make comparisons between the outcomes. The study will be able to make general observations about how different categories of complaints are handled and their outcomes. The same complaints will be tracked across all five professional groups.

**Study III: Surveys of Key Personnel and Quasi-Judicial Decision-Makers**

Contact: Claudette Satchell, School of Nursing, University of Sydney

Study III comprises surveys of AHPRA, HPCA and HCCC staff, as well as Panel, Tribunal and Committee members involved in complaint/notifications handling and management from both systems to determine their priorities and decision making processes. This process will survey the following aspects of complaint handling and quasi-judicial decision making through a series of open-ended questions:

Factors taken into account on receipt of a complaint in terms of preliminary assessment. i.e. what factors would be most likely to lead to the range of decisions available from declining to accept a complaint through referral for investigation.

Factors taken into account at disciplinary hearings i.e. what factors might lead to the range of decisions available from imposing conditions through the Panel to referral to a Tribunal;

The results of this survey will be compared with and analysed against best practice criteria for notifications/ complaints handling.

**Study IV: Complainant Follow-up Questionnaire**

Contact: Suzanne Pierce, School of Public Health, University of Sydney

Complainants will be followed-up through an anonymous process whereby AHPRA and HPCA/HCCC will send out a questionnaire to complainants with the letters of advice about the outcome of a completed complaint.

Complainants will be asked to complete a questionnaire on their experiences and perceptions of the complaints handling process. These would be compared with and analysed against best practice criteria for notifications/complaints handling. This study will involve every matter that is closed during the period July 2013 to July 2014. In addition, a

REVIEW OF THE 2012-2013 ANNUAL REPORT  
RESPONSE TO QUESTIONS ON NOTICE

Response to questions on notice  
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notice is placed on both the AHPRA and HPCA/HCCC websites seeking voluntary input from other complainants whose matters are completed. The questionnaire will take care to differentiate between experiences of processes and satisfaction about outcomes.

**Study V: Theoretical comparison of governance models**

Contact: Belinda Bennett, Health Law Research Centre, Queensland University of Technology

Study V will be a theoretical and analytical article which will mainly focus on the regulatory laws for notification and complaint handling and the various models in existence and/or previously suggested.

- Productivity Commission recommended model
- actual models – AHPRA, NSW
- newly established models – QLD
- comparison between AHPRA, NSW and QLD models
- best practice model

After model-mapping, outcomes from the other studies will be used to assess pros and cons of AHPRA and NSW complaints systems.



Response to questions on notice  
Review of the 2012-13 Annual Report of the Health Care Complaints Commission

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**Question 3**

Has there been an increase in complaints referred to the Commission's Resolution Service over recent years? Can you comment on trends in the number and type of referrals to this service?

Response

On average over the past five years – 2008-09 to 2012-13 – the Commission referred 696 complaints annually to its Resolution Service, ranging from 615 in 2011-12 to 735 in 2009-10. The actual numbers vary from year to year and other than a slight decrease in the overall proportion of complaints that are assessed as being suitable for resolution, no clear trend can be established.

The decision to refer a complaint to the Resolution Service is made by assessing each individual complaint taking into account whether the patient has an ongoing relationship with the health service provider and evaluating the prospects that a resolution of the issues can be achieved. Given that resolution processes are voluntary and rely on the consent of both parties to engage in the process, complaints where one party refuses to engage, or makes it clear that resolution is not desired, will not be referred to the Resolution Service.

Response to questions on notice  
Review of the 2012-13 Annual Report of the Health Care Complaints Commission

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**Question 4**

It is stated that people can call, email or make inquiries online to the Commission. Are there comparative statistics available about how people access the Commission to make complaints and are there any notable trends over the past five years?

Response

The vast majority of inquiries to the Commission are made by phone. Phone inquiries accounted for 94.7% of all inquiries received in 2012-13, a slightly smaller proportion compared to the previous four years in which between 95.1% to 96.0% of inquiries were made by phone.

In 2012-13, 3.2% of inquiries were made via email or by using the Commission's online inquiry form, up from 1.4% in 2008-09. A small number of inquiries are made by people visiting the Commission.

Given the legislative requirement for complaints to be made in writing, in 2012-13, almost half of all complaints were made using the Commission's printed complaint form or writing a letter (49.3%), followed by electronic submission via email (26.5%) or using the Commission's online complaint form (23.9%).

In the period from 2008-09 to 2012-13, the proportion of complaints submitted via electronic means has significantly increased from 3.0% of all complaints being received electronically in 2008-09 to 50.4% in 2012-13. The Commission has worked and continues to work on improving its website and online complaint form to be easily accessible via computer and electronic mobile devices.

# Chapter Seven – Transcript of Proceedings

## REPORT OF PROCEEDINGS BEFORE

## COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

### REVIEW OF THE 2012-13 ANNUAL REPORT OF THE HEALTH CARE COMPLAINTS COMMISSION

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At Sydney on Wednesday 16 April 2014

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The Committee met at 10.30 a.m.

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### PRESENT

Mrs L. G. Williams (Chair)

#### Legislative Council

The Hon. P. Green

The Hon. H. Westwood

#### Legislative Assembly

Dr A. D. McDonald

**CHAIR:** I declare the meeting open. In accordance with section 65 (1) (c) of the Health Care Complaints Act 1993, it is a function of the Joint Parliamentary Committee on the Health Care Complaints Commission to examine each annual report of the commission and to report on it and any matters arising out of it to the Parliament. The Committee welcomes the Commissioner and staff here today for the purpose of giving evidence on matters relating to the 2012-13 Annual Report of the Health Care Complaints Commission.

**KIERAN PEHM**, Commissioner, Health Care Complaints Commission, and

**TONY KOFKIN**, Director of Investigations, Health Care complaints Commission, sworn and examined:

**KAREN MOBBS**, Director of Proceedings, Health Care Complaints Commission, affirmed and examined:

**CHAIR:** Commissioner, I am advised that you have been issued with the Committee's terms of reference and with Standing Orders 291, 292 and 293, which relate to the examination of witnesses.

**Mr PEHM:** That is correct.

**CHAIR:** The Committee has received the written responses from the commission in response to questions that were put on notice. Are you satisfied that these responses form part of your evidence here today?

**Mr PEHM:** Yes, I am happy for that, with the note that question No. 5 contains confidential complaint information that we have suggested the Committee not make it public.

**CHAIR:** We have noted that, thank you. We have put the questions we have prepared into sections relating to outreach and accountability, the complaints process and so on. In terms of outreach and accountability, I have a question about people with an intellectual disability and people with low literacy levels. On page 9 of the report you talk about a simply illustrated facts sheet you have published. How is that information accessed?

**Mr PEHM:** The Council for Intellectual Disability is one of the members of our Consumer Consultative Committee, so we worked on that resource with them. It is certainly available through their outlets and so on and on the Commission's website.

**CHAIR:** I assume that because you work with that group you would receive feedback on the appropriateness of that brochure from those people?

**Mr PEHM:** It was a joint development with them. They were the authors of it as much as we were and, yes, they are quite happy with the final outcome.

**CHAIR:** You also state on page 11 of the report that you support relevant research projects. Could you explain to the Committee how you support these projects? Is it through the provision of information or expertise?

**Mr PEHM:** It varies. We get applications for access to commission data. The most extensive one we are doing at the moment is a five-part project comparing New South Wales's complaint handling to other jurisdictions. That involves extensive access to our data and looking at timeframes, the types of decisions made and the discretions exercised. That is the main way in which we cooperate. The researchers come with a project and we let them have supervised access to the data, sign confidentiality agreements and so forth. We de-identify it so that complainants or practitioners are not identified.

**CHAIR:** Have there been some examples from those research projects where you may have used the outcomes to change or develop new policies or maybe to change your procedures in the way that you operate as a result of them?

**Mr PEHM:** The middle one we quote on page 11, a research project by the University of Melbourne, looked at whether a particular kind of medical practitioner was more likely to attract complaints. They published the results of that. It was not really a surprise to us what their research identified, so it was not the sort of project that required change. They did recommend that past complaints were a likely indicator of future complaints. The commission already has a process which is specific in the Act to look back at past complaints whenever a new complaint is received by a practitioner, so we pretty much had that covered.

**Dr ANDREW McDONALD:** What characteristics did you find made them of greater risk of complaints?

**Mr PEHM:** The ageing male practitioner is particularly prone.

**Dr ANDREW McDONALD:** I am an ageing male practitioner—I agree.

**Mr PEHM:** Male practitioners aged 55 to 65, but younger women practitioners were less likely to receive complaints. That is all I can remember off the top of my head.

**Dr ANDREW McDONALD:** I agree. One of the things they are doing in England, which is different from Australia, is recertification over time and this opens the Pandora's box because ageing male practitioners often do not realise that they are, in fact, impaired. Does that open the door to the recertification discussion?

**Mr PEHM:** Potentially, yes, although I am not—

**Dr ANDREW McDONALD:** It is not in your area?

**Mr PEHM:** It is not specifically our bailiwick but certainly the ageing practitioner who does not appreciate that their practice is out of date and does not keep up to date with continuing education, and you mentioned impairment as well, does not really realise he is becoming impaired and there is a bit of denial about that. I think the complaints are pretty clear that is a cohort of concern.

**Dr ANDREW McDONALD:** I have not heard that disseminated to the profession. I would have thought that the Australian Medical Association [AMA] would be quite positive about that sort of information being disseminated.

**Mr PEHM:** We meet regularly with the AMA. In fact, we have another meeting coming up in a few weeks. We could certainly do that. I would be surprised if they were not generally aware, although perhaps there are no specific publications.

**Dr ANDREW McDONALD:** I think it is a matter of getting it out there. As you know, the profession is not particularly good at self-regulation. But if it were known that they are a high-risk group, in the same way that P-platers are known to be high-risk drivers—

**CHAIR:** They might seek to address some of the issues.

**Mr PEHM:** The insurers are probably pretty well aware, just from the nature of claims.

**The Hon. HELEN WESTWOOD:** Is there a profile of the medical practitioners where there have been complaints? Do you keep profiles as to the age, gender, ethnicity, whether they were trained in Australia or overseas—that sort of profile?

**Mr PEHM:** We do not. That is part of what this research project was looking at and certainly age was a factor. Ethnicity did not stand out from the research as a factor. I know there is always some public concern about overseas qualified doctors but that certainly was not something that they picked up. We have not researched our data but I do not think it is a particular issue that emerges from our data.

**CHAIR:** Are the results of that research project public?

**Mr PEHM:** That is public and we can send you a copy.

**CHAIR:** Thank you. The other question I had with regard to the outreach and accountability was with regard to the webinars. To what extent do you promote that resource?

**Mr PEHM:** They have been a big success and are very well subscribed. We promote them through the usual outlets—colleges, educational institutes, the local health districts for practitioners—and through the consumer groups for consumers.

**The Hon. PAUL GREEN:** What are you doing to evaluate who is using them, how often they are used and why they are so successful?

**Mr PEHM:** After each webinar we survey the participants and they evaluate the quality of the webinar. The feedback from that has been positive and they suggest new topics we might cover. We have done such things as the informed consent processes and health literacy. We also get guest speakers to do webinars on topics of interest.

**The Hon. PAUL GREEN:** Where are the webinars being received mostly? Are they city-wide, rural, regional or just generally everywhere?

**Mr PEHM:** We only get email addresses so it would be hard to say. People log in through the internet and all we have is the email address.

**The Hon. PAUL GREEN:** It would be prudent to get that information to know who is partaking of these seminars for future use.

**Mr PEHM:** It would not hurt. We could look at that as part of the registration login. It is always a balancing act in collecting demographic data. For something that you want to be quick and accessible, do you put up barriers that might put people off? But we can have a look at that.

**CHAIR:** I guess your interest is because of our first inquiry with regard to regional access.

**Mr PEHM:** It is very convenient for regional people. From the questions that come from people there are certainly regional practitioners listening because from the questions they ask it is clear where they are from. It is much easier to do these webinars than it is to travel out to those places and we get a broader mix.

**The Hon. PAUL GREEN:** In relation to feedback in another area, not health, it was pleasing to see that a manager said, "Let's all do dinner together and then we will watch the webinar". It showed team building and relationship building and was a very smart use of something that would possibly be tedious but became an opportunity to build confidence and strength.

**Mr PEHM:** It is a permanent resource too. The recording goes up on the website and they do not have to be there for the actual delivery; they can link in later and have a look at them all. We have had very good feedback about those.

**CHAIR:** I note in your report that you talk about a representative from the Commission attending a meeting in Canberra to discuss emerging issues. What do you generally consider to be some of the issues for the Commission in the future?

**Mr PEHM:** I am struggling with who attended the meeting in Canberra. That would be the national commissioners' conference?

**CHAIR:** Yes.

**Mr PEHM:** I suppose the real emerging issue is not so much an issue for New South Wales because New South Wales is a leader in this area but it is useful for us to attend and I think it benefits the others. Queensland has just gone down a similar path to New South Wales but, in fact, has given its Ombudsman, the equivalent of our commissioner, more power than we have in New South Wales. The issue is one of balance between self-regulation by the boards, which is the prevalent system nationally, to a system of co-regulation, which now is the position in New South Wales and will be the position in Queensland from July this year.

There have been some reviews of AHPRA [Australian Health Practitioner Regulation Agency]. The Victorian Upper House committee delivered a report three or four weeks ago that suggested the Health Minister in Victoria investigate the New South Wales system and look at it in terms of benchmarking with AHPRA. That committee found concerns about delays and lack of responsiveness to consumers to be the main concerns. The meetings of the national commissioners discussed, among other things, that issue of the inter-relationship between the commissioners and the national boards and whether there is an appropriate balance of power, I guess, between them.

**Dr ANDREW McDONALD:** My understanding was that in New South Wales the Health Care Complaints Commission was split into a white hat—black hat, in pejorative terms, of the Clinical Excellence Commission looking at the system error and the Health Care Complaints Commission looking more at individual consumer issues. Queensland stayed together and the HQCC [Health Quality and Complaints Commission] was similar to the previous system. But Queensland is now going to replicate the New South Wales system.



**Mr PEHM:** Queensland went to a system after the Patel publicity that set up a single organisation which did the functions of both the Health Care Complaints Commission and the Clinical Excellence Commission and had a quality improvement role and a complaints role.

**Dr ANDREW McDONALD:** Yes, the HQCC.

**Mr PEHM:** A whistleblower in Queensland who worked for the medical board complained that the board was not investigating things properly and was covering things up and there were delays. There was an inquiry by a retired judge there who found significant concern about the delay, in particular, and also specific concern about a number of cases. As a result of that the Minister decided to go with a model which pretty much resembled New South Wales'. I am not sure what is happening to the quality function. I think that might just be residing back in the Department of Health up there rather than setting up another separate distinct commission. But the new ombudsman role in Queensland does not have a quality improvement function, and there is the National Commission of Safety and Quality in Health Care.

**CHAIR:** On page 6 of your report you talk about the number of complaints that have been finalised. What does "finalise" mean?

**Mr PEHM:** Closed, finished at all the various stages of the process, whether after assessment, discontinued, no further action is taken. If the matter is referred for resolution and it resolves it is finished, and if it does not resolve and there is no prospect then it is closed as well. At the end of an investigation a matter can be finalised by taking no action or by making comments or sending it to the relevant professional council and it would be closed once that is done. A small number of matters that flow from investigations into prosecution would be closed at the end of the prosecution when the disciplinary body makes its final decision. The complaints finalised combine all of the assessments, resolutions, investigation and legal matters that are finalised.

**Dr ANDREW McDONALD:** Page 29 of your report shows an increase in discontinued complaints. There may be reasons for that, but nearly 50 per cent are discontinued. What are the common reasons for discontinuation?

**Mr PEHM:** There are a variety of reasons. I guess the vast majority are complaints that are not serious enough to require investigation in that the practitioner or the health organisation does not pose a risk to public health and safety or does not require conditions on their registration. They are the matters that get investigated and there are a fairly small number of those, about 200 or 250 out of 4,000.

**Dr ANDREW McDONALD:** The "not serious enough to warrant investigation" are the most common but are still relevant to the person?

**Mr PEHM:** Yes. Where I suppose there is no serious conduct that needs investigation, and the complainant has an ongoing relationship with the practitioner—this is particularly important in rural areas where they are going to have a need to continually access the service—they are the sorts of matters we will assess for resolution. Resolution will involve one of our resolution officers trying to get explanations for the complainant and restore the trust.

**Dr ANDREW McDONALD:** They are the ones that have been resolved but I am talking about the discontinued matters.

**Mr PEHM:** The discontinued ones are where the complainant is not interested in resolution. They want someone prosecuted or they want some serious action taken. It is not from our objective assessment serious enough for that and we explain that.

**Dr ANDREW McDONALD:** So you make that call saying, "On a prima facie case this person does not represent a risk to public health and safety and we recommend resolution", and they choose to say "No, I am going to sue. I am not happy." Are they discontinued?

**Mr PEHM:** They are discontinued.

**Dr ANDREW McDONALD:** It is your call to discontinue them?

**Mr PEHM:** It is our call because in many cases they will not want to discontinue, they will want investigation and they will insist on that. We will say, "We have had it examined by one of our internal medical advisers. They don't think there are clinical issues here that need investigation. What you suffered was a complication or an outcome of a procedure that is not that uncommon. You signed a consent form that said you had all that explained to you." But people come with a grievance, and they obviously sometimes have terrible physical complications, they have got to live with.

This whole issue of informed consent is a very difficult one—the extent to which people listen to the bad things that might happen, the extent to which that is explained, and the skill of practitioners in explaining that so that people digest it and really understand it. Most people have enormous confidence in the health system. It is perhaps naïve in a way but they are very trusting and they hear, "You will be fine. I have done this 1,000 times and you might be the 1 per cent or 5 per cent that does not turn out fine." That does not really register, I think, until it happens. When the trust is broken the sense of grievance is very strong, which is why we have put a lot of effort into consents and those issues. There are a significant number of complaints about that, but it certainly gives rise to lots of complaints.

**Dr ANDREW McDONALD:** Is it the role of the Health Care Complaints Commission to recommend apologies to patients when harm has occurred, even if it is an accepted complication—for example, a doctor taking out a gall bladder who sections the common bile duct. That does occur, although rare, but it does not mean it is dangerous?

**Mr PEHM:** We always promote apologies, though it is voluntary.

**Dr ANDREW McDONALD:** So advising an apology is acceptable? How do you couch the words for the practitioner to apologise?

**Mr PEHM:** It depends on the circumstances and the receptivity of the practitioner. Some have had considerable experience with the complainant before they have come to us: so they are not interested in them anymore, they say they have explained it. Others are quite good at understanding the impact on complainants and apologising for outcomes that were not necessarily anticipated. It depends, and I do not think you have a one-size-fits-all. Some things we do get from complainants is, "I don't want this kind of apology. It means nothing to me. They're just apologising because the policy says they have to apologise. They haven't

explained to me, they haven't really understood, they haven't appreciated how much I've suffered." Those are the things that are more important to complainants than just a rote sort of apology.

**The Hon. PAUL GREEN:** We have been down this track on previous occasions, and it is something that needed improvement, but a core issue seems to be that people want an acknowledgement that doctors are human and that a mistake had happened, not so much to take the matter further. Has there been any improvement in that area?

**Mr PEHM:** Yes, slow and steady I think. There is an enormous amount of work going into it. We are on a working party with the Clinical Excellence Commission to reinvigorate the open disclosure process. Open disclosure is one of those things that was mandated and became policy of the Department way back in 2007. Practitioners have a lot of issues with it. It is not something that comes easy to them. They are vulnerable when these things go wrong as well. They fear the legal consequences of being sued or whatever. Traditionally the advice then has been, "Make no admissions; just leave it to your insurers". So the complaints have got a legal brick wall.

The policy change was in 2007 to encourage open disclosure. The working group now is drafting more detailed guidelines about how to do it and what sort of support is available. There are a few missed steps along the way. They rolled out quite extensive training to practitioners with role playing. The trouble with training is if it is not used and it does not come up it lapses within the next six months or so and you forget all that. The scheme now is to have an expert adviser available to clinicians in this situation so that a person can help organise a conference and give them advice about how to participate so that they do not feel exposed or vulnerable as well.

**Dr ANDREW McDONALD:** The open disclosure guidelines are still quite legalistic. In fact, that is what puts off the clinicians. They say, "Say sorry but don't admit liability". It is effectively interpreted by clinicians as "Don't say 'I'm sorry. I've made a mistake' or 'I cut the wrong vessel'". What has actually happened is not permissible under the open disclosure guidelines. They say, "I'm sorry", not "I cut the wrong vessel".

**Mr PEHM:** It is even more complicated than that because if it is a serious error you have got the RCA [root cause analysis] process as well. Now, the law privileges RCA investigations, so nothing that is said in those can be used anywhere else. But the open disclosure has got to rely on what actually happened so as to provide a reasonable explanation. You are right; there is this almost schizophrenic thing that practitioners are asked to on the one hand be open and apologise and on the other, because of the fear of prosecution and legal consequences, keep it secret. The new guidelines try to find a way through that will be constructive, we hope, for practitioners to engage more easily and openly with that.

Our experience with complainants is that they are very open to hearing an apology and an explanation in the early days. But if it does not come in the early days they start to think, "I am not being told what has happened. They are covering up. Why can't I get access to that investigation? Why won't they tell me this?" Often by the time they get to us, after six months of frustration trying to find out what happened, it is irresolvable; you cannot restore their trust in the health service provider anymore.

**Dr ANDREW McDONALD:** Some hospitals in the USA have on-call people who are experts in this. Every hospital in the United States has got a roster, from a newborn and intensive care specialist to a geriatrician. But no-one is an expert on how to apologise when things go wrong, which can occur out of hours and an early apology is vital. Has any hospital in New South Wales looked at having an on-call specialist in this sort of stuff?

**Mr PEHM:** That is the proposal in these new guidelines that are being drafted, which should be finalised shortly. That has been subject to consultation with all the LHDs [local health districts], and they are basically on board with it, so it will happen. I do not think it currently exists. At the moment directors of clinical governance and complaint-handling staff tend to be the ones that take responsibility for open disclosure.

**Dr ANDREW McDONALD:** Or do not.

**Mr PEHM:** It varies. Sometimes they tell us it is a mistake to even have the practitioner involved in it because of all the anxiety on their part and the complainants feeling it is going to be inflammatory. I think that idea of having an expert who is very familiar with the process and knows about the sensitivities involved and how to keep people on a reasonable keel is really crucial. I think that is one of the key parts of this new process that should be starting soon.

**The Hon. PAUL GREEN:** It is a good point. The breaking of trust is different to the breaking of a relationship; that is, you may not want the same surgeon to work on you again but you can still have some sort of understanding of their role and their responsibility. Of course, people can walk away saying, "Okay, you said sorry. I am happy with that", whereas others will say, "No, you have broken my trust and the relationship. I am going to take you for everything you've got". So it is great to have someone who understands those situations.

**Mr PEHM:** Our experience seems to be that the trust can be restored if the practitioner is open early and it is got onto quickly. But the longer it goes on, the more delay the higher the emotion.

**The Hon. PAUL GREEN:** Does it change from GPs up through the different systems? Does it get lesser and lesser the higher the specialty goes that someone would be more than likely to say sorry?

**Mr PEHM:** I do not know about that.

**The Hon. PAUL GREEN:** It would be interesting data.

**Mr PEHM:** Part of it depends on the seriousness of the error as well. The more serious it is the more difficult it is and those more serious things tend to be in surgery and those with really catastrophic consequences. Medication errors are a fairly significant cause of complaint and there can be quite harmful side effects from that with GPs prescribing. But I could not say any one type of practitioner is better or worse at it. I think it is almost a personality-type thing. I think there are clinicians that are good at communicating with patients generally in a good bedside manner and getting formal consent and are able to judge the level of the complainant's comprehension and respond to that. They are the sort of people who would be good at open disclosure, except they are the sort of ones that probably open disclosure does not become necessary because the lead-up is so good. It is a mistake to think that open disclosure is a discrete thing that happens when something goes wrong. It really should be part

of the continuum of the practitioner communicating responsively with complainants all the way through their treatment journey.

**The Hon. PAUL GREEN:** We made some laws about self-referrals from the commission about complaints that you were able to—

**Mr PEHM:** Own motion.

**The Hon. PAUL GREEN:** Yes. Have you had any of those situations since?

**Mr PEHM:** Make our own complaints?

**The Hon. PAUL GREEN:** Yes.

**Mr PEHM:** Yes, we have had a few.

**The Hon. PAUL GREEN:** Can you update us?

**Mr PEHM:** There is one that has been made public by the Australian Vaccination Network, which I am pretty sure we will be finalising pretty shortly. There have not been a great number, because generally you have got a complainant. But there have been situations where the complainants have been reluctant for fear of retribution and whatever, and they are in a position to provide us with enough evidence to go forward. So we have done that a couple of times. I have not got exact figures or particular situations in mind.

**The Hon. PAUL GREEN:** But it has been helpful? We did not just make a law that has not been helpful?

**Mr PEHM:** No, it has been used and it is useful, but it is not widely used.

**Mr KOFKIN:** It is really useful for unregistered practitioners where there is a prohibition order. In the past we maybe had some information where a practitioner would be breaching a prohibition order but without a complaint we could not action it. Now we can use that information or that intelligence and then make our own complaint and carry out our investigations. In these circumstances it is really useful.

**Ms MOBBS:** I think also in terms of saving time. There has been one matter where it had progressed quite a long way in the legal process and there was an admission of possible other conduct. Rather than having to go out and waste time in hunting a complainant down, it was able to be progressed much more quickly to then join it up with the current proceedings. It is certainly useful from that perspective.

**The Hon. PAUL GREEN:** I think that was the spirit that we were trying to get it to.

**CHAIR:** We were talking about the number of complaints that were discontinued and we asked what type of complaints they were. I note in the report that a substantial number of complaints are referred to other areas, such as your resolution service. You say that 5.5 per cent were referred to public health organisations. In relation to those referrals to other bodies, do you get feedback about where those complaints finish up?

**Mr PEHM:** No. We contact the public health organisation and ask if they are prepared to engage in local resolution with the complainant. We do not get feedback on every process. We will get the odd one where the complainant will come back and say, "No, I am still unhappy".

**CHAIR:** That would be so if it was referred back to a local health district [LHD]?

**Mr PEHM:** Generally they are public health organisations that we refer back with local resolution. They are pretty good, I think, on the whole. They are not serious matters; they are things like hygiene or cleanliness or a staff member was not as pleasant as they could have been or was rude or playing on the computer when they should have been attending to the patient—that sort of service-type complaint. Generally the LHDs get onto them fairly quickly. They may come back to us as well and say, "No, we do not want this for resolution. We know this complainant and they do not have a stake in the patient's treatment. We tried to deal with them before but they won't accept it". Then we will look possibly at resolution or perhaps discontinuing, depending on the circumstances.

**CHAIR:** On page 29, the graph that you provided shows a decrease in the referrals to the Commission's resolution service but generally an increase in those referred to local resolution.

**Mr PEHM:** Local resolution, that is right.

**CHAIR:** Does that mean that there should be some changes in the amount of support that is there in local LHDs? I think personally it is a good thing that we are getting them back to a local resolution, but do we need them to provide more support to make sure that they are resolved?

**Mr PEHM:** The director of assessments and resolution is currently going around again to the 17 LHDs, both to meet with their executive to see what issues can improve the relationship generally and to do a workshop with the complaint handling staff and any clinical staff who want to attend on issues of how to deal with people and things that come up. We did that last year from about May to December 2012 and we are doing the same again this year. I think the LHDs are fairly responsive to complaints; they all have dedicated complaint handling staff that deal with them. I do not get the impression they are floundering or struggling or not able to cope, and we discuss the referrals with them beforehand. We provide as much support as we can to them and I am not aware that they are under-supported in the LHDs.

**The Hon. HELEN WESTWOOD:** Do you find any difference in the LHDs? Do you find that some handle complaints better than others?

**Mr PEHM:** Yes. There is always variation. It varies at different LHDs over time as well; they might have a manager in complaints that is particularly passionate or dedicated. There is one LHD that was very good. If they got a complaint from us asking for a response they would get straight onto the complainant on the phone saying, "Can we sort this out? Can we have a meeting?" They would come back to us and say, "It has been resolved", which is fantastic. We have a resolved-during-assessment line on the graph; that is where either the practitioner or the health service comes back with an explanation of a complaint and says, "That's fine, I understand that. Good, that is resolved for me". If the health service comes back and says,

"We have spoken to them and we have fixed it all up. They are happy", we will just confirm that with the complainant. This particular LHD, I think about 17 per cent of the complaints we sent to them they would deal with in that way, which was great, and we promoted that to the other LHDs.

**The Hon. HELEN WESTWOOD:** That was my other question. There is a particular cultural practice that is working and you share that—

**Mr PEHM:** Yes, there is variation and it is partly the chief executive's approach and the staffing. I guess that is the whole idea of LHDs, and having so many, they can do things differently. But everywhere there is better or worse. Some might be a bit more rigid than others. On the whole I think they put a lot of genuine effort in and they work pretty hard to resolve things.

**Dr ANDREW McDONALD:** The LHD staff who handle these complaints are usually not clinicians—that is impossible. What tends to happen is you tend to be a clinician or you tend to be an administrator. Have any of the LHDs looked at seconding some of their clinicians as part full-time equivalent [FTE] or for three months to build up the capacity? One of the big problems is that the clinicians do the work and there are two or three people to deal with complaints, whereas it would be better if all the clinicians had some experience of the complaints system.

**Mr PEHM:** I agree. I guess it is one of those resource-cost benefit analysis things, how useful it would be to clinicians to provide that sort of training across the board and how often they would use it.

**Dr ANDREW McDONALD:** I agree with you: if you train and do not use it, it is useless.

**Mr PEHM:** Some clinicians are just instinctively very good at dealing with people and complaint handling and others, with all the training in the world, will struggle to do that.

**The Hon. HELEN WESTWOOD:** Unless it is a dedicated or required position, it is not going to free up a clinician?

**Dr ANDREW McDONALD:** You second them rather than free them up.

**CHAIR:** So they get the experience of understanding the complaint handling?

**Dr ANDREW McDONALD:** Yes.

**Mr PEHM:** All the directors of clinical governance are clinicians of one kind or another and I think probably in all cases are responsible for the complaint handling as well. So there is that level of clinician input.

**Dr ANDREW McDONALD:** Most of them are not active clinicians.

**Mr PEHM:** That is true; they are kind of administrative—

**Dr ANDREW McDONALD:** They were once clinicians.

**Mr PEHM:** Yes, I think that is probably right.

**Dr ANDREW McDONALD:** That brings me to the next point: the effect on health professionals of the Health Care Complaints Commission [HCCC]. As you know, it is career changing for anybody to get a letter from the HCCC, even if it is vexatious. How do you approach a health professional involved in the HCCC? Do you provide counselling or do you recommend they go to counselling? How do you approach the health professional?

**Mr PEHM:** You are absolutely right; it is a terrible concern for a clinician when they do get an approach.

**Dr ANDREW McDONALD:** Do they get a phone call before the letter arrives in serious cases?

**Mr PEHM:** They may do; generally it will be a letter. They are encouraged to consult with their professional indemnity associations or their employer. A particular concern from LHDs is with interns and resident medical officers who go into shock when they get these things. We have sections for respondents on our website about how to deal with a complaint. It says do not panic, keep calm, think through what you need to do and it talks about how to write a response and what sort of things the complainants are looking for. It is a bit awkward for us to get into a sort of counselling role as both the regulator and—

**Dr ANDREW McDONALD:** No, you cannot. Do any local health districts [LHDs] have counsellors?

**Mr PEHM:** It has been a constant issue from the LHDs. I think it is exemplified in some work of the Committee a while ago where the LHDs wanted the Commission to notify them of every complaint against a clinician in their area. The clinician lobby groups resented this because they feared, "A complaint being notified to my employer is going to result in some unjust retribution towards me."

**Dr ANDREW McDONALD:** Especially if they are a visiting medical officer [VMO] and have got nothing to do with the hospital.

**Mr PEHM:** The employer wants it from a risk management point of view and to provide assistance to the clinician. I guess there are those two competing things. The clinician did not want it notified. Once the matter is serious enough to investigate, then the employer would be notified. Sorry, I have lost the original question now.

**Dr ANDREW McDONALD:** It was about the effect of the Health Care Complaints Commission [HCCC] letter on practitioners.

**Mr PEHM:** The effect can be significant. We give as much advice as we can reasonably give. It is in our interests to get a sensible response as well. I do not know that there is a whole lot more that we could do there. I think there is a cultural problem too. I think clinicians have got to get used to dealing with complaints as just an outcome of business. These things are going to happen. You are going to have adverse side effects now and then; you need to recognise that and deal with them. I think clinicians have got a bit of a culture of perfection or something.



**Dr ANDREW McDONALD:** They have certainly got a culture of perfection.

**Mr PEHM:** Yes, but when you have that culture anything that goes wrong becomes a challenge to your esteem. It is tied up with the whole way medical practitioners interrelate and who is going to give them work and are they going to get referrals if people know there are complaints about them. It is their income, it is their self-esteem and it is their profession. Those sorts of things are already deeply ingrained. We are aware of all that but we still have the job to do of getting responses and dealing with them.

**Dr ANDREW McDONALD:** Do you do many grand rounds? There was a time when the HCCC would go out and do medical grand rounds.

**Mr PEHM:** We have done a few. We have done some at Royal Prince Alfred [RPA] hospital on the process. As part of this tour around the LHDs some of the local health committee [LHC] executive have asked us to address clinical staff as well. That issue of the senior clinical staff being very protective of their junior staff when they get notified of complaints is constantly raised with us, so we are very conscious of it.

**Dr ANDREW McDONALD:** The RPA is the last place that needs it, I would have thought.

**Mr PEHM:** They call it grand rounds. They are traditional—

**Dr ANDREW McDONALD:** Do you wait to be invited or do you offer it to them?

**Mr PEHM:** We do not specifically offer it to them; it is not a program of ours but we are available to do that. We meet with the executive and leave it to them to suggest it. We are happy to do it if it is asked for.

**The Hon. PAUL GREEN:** Is there any long-term follow-up after it has all been moved through just to check that they are going okay?

**Mr PEHM:** On the ones that are referred for local resolution?

**The Hon. PAUL GREEN:** The ones that we are talking about. You go through what you have to do but does anyone follow up 12 months on to make sure that the clinicians are able to find their mojo again?

**Mr PEHM:** We do not do that. No, I doubt there is. There are the professional associations like the nurses and the union. There are their insurers, and they have welfare programs as well. There is the Australian Medical Association [AMA] and that sort of thing. The employers would have a duty, but people move on as well.

**The Hon. PAUL GREEN:** Do you hold any sessions with the AMA, for example, at conferences, where you speak about things like that?

**Mr PEHM:** I have done in the past but not for quite a while. We meet with the AMA and raise those issues. Again, they are very conscious of the impact and they advise their members about getting in touch with professional indemnity.

**The Hon. PAUL GREEN:** It would be good to share that sort of information.

**Mr PEHM:** We do. We get around, and we are conscious of the issue. I think it is just such a deeply ingrained cultural issue that we are not in a position to provide any comprehensive redress for it. It is something that the profession needs to culturally change over time.

**The Hon. PAUL GREEN:** That was why I was suggesting that someone like you—

**Mr PEHM:** Dr McDonald is shaking his head saying it is never going to happen.

**Dr ANDREW McDONALD:** It is not going to happen. Perfectionism is just a part of the health profession, but some medical schools are now teaching students how to react to an adverse event. For example, if somebody has come in with a fever and the clinician has missed the white cell count showing leukaemia for four days how do you explain that. They are doing that at medical student level.

**Mr PEHM:** I think it is happening. There are more and more accountability mechanisms like root cause analysis [RCA], internal complaint reporting, mandatory reporting and all that sort of stuff. While the culture is quite rigid, in a way there are more and more influences that are requiring accountability, but it is a slow process of change.

**Dr ANDREW McDONALD:** Have you noticed that mandatory reporting has led to an increase in reports?

**Mr PEHM:** It has been in for a fairly short time, but yes. I have not got exact figures on it but I assess all the complaints, so I see them. Where there has been a particular increase, it has been with reports from employers. They have an obligation to report as well and, of course, the liability for employers is potentially more serious; medical practitioners not so much.

**Dr ANDREW McDONALD:** I understand that the AMA has expressed concerns.

**Mr PEHM:** There are sensitive situations where a psychiatrist might be consulting a medical practitioner and something will be disclosed that requires a mandatory report. They have raised a lot of ethical issues about confidentiality and so on. Those situations are very sensitive. It is another one of those situations where the culture will change over time but, no, there has not been a rush of individual clinicians making mandatory reports.

**The Hon. HELEN WESTWOOD:** In cases where there has been a serious complaint perhaps resulting in a traumatic outcome and/or death, does the Commission provide information regarding the complaint face-to-face with the parties involved?

**Mr PEHM:** We took on board some recommendations of the Committee arising out of its most recent inquiry and we have changed our assessment process to identify those sorts of issues. They are specifically identified now in the database and in the assessment plan that is given to the officers. They will talk to the parties in those cases. I might let Mr Kofkin speak to investigations. It has changed its procedure on that score as well.

**Mr KOFKIN:** For a number of years, about three years, when we get a complaint to the investigation division where there is an adverse outcome such as death or life-changing

injuries, et cetera, we have been visiting the complainant and the family members. It would be me as the director and the investigator. Wherever they are in the State we will go and visit. We will set aside as long as they need; a whole afternoon or a whole day if necessary. At that point it is not about going into detail about the investigation because it is quite early. It is about explaining the process, managing expectations, letting the parties know that we are independent, impartial, open and transparent and then formulating a contract in terms of how often we are going to update them, at what stages we are going to update them and making sure we get a single point of contact.

I have done this on probably five or six occasions over the last year and it would be the complainant and family members, et cetera, so we need to make sure that the channels of communication are effective so you have a single point of contact. We do that now for all investigations where there is an adverse outcome or we believe it warrants the visit. There is no hard-and-fast rule but it certainly happens if there is death or life-changing injuries. At times we will offer that to the family and they do not want it, so we have an audit trail there. But certainly from my experience, every time we go out and visit it really does allay a lot of their fears and the feedback we get is really good.

We do not only go at the beginning; we go at the end as well. If there is an investigation where there is a practitioner and we are going to compile a brief of evidence to the director of proceedings we cannot disclose the investigation report for the practitioner, but if there is a facility investigation we can disclose that. We will send them the report and arrange a meeting so they have time to digest the report and then they can ask a number of questions. We go there at the end as well. We have been doing that for probably about three years. But it was only as a result of the recommendations that the Committee made that we actually put it into our procedures manual and made it policy. We are recording it now as well. I call them category A investigations. We can record how many times we have done it. That is the process.

**The Hon. HELEN WESTWOOD:** The Committee is pleased to hear that because, as you would know, we came across a case that was very traumatic and there was a great sense that the family had not been communicated with adequately. Not only were they grieving the loss of their very young family member but they also felt that the process had let them down. That is very good to hear. We will make sure the other Committee members know of that.

**The Hon. PAUL GREEN:** Well done.

**The Hon. HELEN WESTWOOD:** Looking at the total picture of complaints against health practitioners and the categories, is there an opportunity to look at them as a proportion of the number of registered health practitioners? Maybe it is in there and I did not see it.

**Mr PEHM:** It is table 16.5 on page 108. They are the complaints about each practitioner group. Right down the bottom you have got the number of practitioners in New South Wales.

**The Hon. HELEN WESTWOOD:** I thought it would be good to see the proportion because often it can look like a huge number but when compared with the number of registered practitioners in a category it shows in fact that only a very small number are complained against.

**Mr PEHM:** Yes, we usually have something in the text as well to the effect that you cannot draw general conclusions out of complaint numbers given the small proportion.

**The Hon. HELEN WESTWOOD:** I understand that, but I think it would be good for the community and health consumers to see the proportion of the profession that are complained against.

**Mr PEHM:** It is a small number. When you think about the number of patient-clinician interactions on top of that it is even smaller.

**The Hon. HELEN WESTWOOD:** That is absolutely right. We need a thorough complaint process, which we have, but it is also important that we do not undermine confidence in the health system.

**Dr ANDREW McDONALD:** The 3,155 complaints on page 108 against medical practitioners is the number of complaints rather than the number of practitioners, is it not?

**Mr PEHM:** Yes. There might be multiple complaints against one practitioner. That is true.

**Dr ANDREW McDONALD:** It would be interesting to see the actual number of practitioners as well, if such a thing is possible in future reports.

**Mr PEHM:** We do have figures on that. But you are right. It is a fairly small number of practitioners that have multiple complaints compared to the general number, but we can certainly have a look at that.

**The Hon. PAUL GREEN:** Regarding dental practitioners, there cannot be that many dentists compared to doctors.

**Dr ANDREW McDONALD:** The bottom of page 108.

**The Hon. PAUL GREEN:** Why would there be that proportion of complaints against the Organisation Medical Officers? Is it more about self-image? It seems to be disproportionate.

**Mr PEHM:** Dentists have a relatively high number of complaints because of the \$4,000 worth of dental treatment paid by Medicare on referral from a general practitioner. If the general practitioner said you had a chronic health condition you would get \$4,000 worth of dental work paid for by Medicare. That scheme finished about November last year. It would take in this annual report and probably a fair bit of the aftermath. So you would have an increased volume of services and also people with chronic conditions; it may be more than their dental practitioner could reasonably provide. We expect to see that number of complaints fall off against dentists with that scheme going out.

**Dr ANDREW McDONALD:** Changing the subject to unregulated practitioners, my understanding is that it is only New South Wales and South Australia that can investigate them and you have only been able to do that since—

**Mr PEHM:** I think it was in 2008 that the code of conduct was introduced.

**Dr ANDREW McDONALD:** Has there been an increase in complaints? Where are they written down as being distinct from unregistered compared to unregulated?

**Mr PEHM:** There has been an increase. It is table 16.3.

**Dr ANDREW McDONALD:** On page 107. These are the unregistered ones?

**Mr PEHM:** Yes, at the bottom of the table on page 107, you can see they have gone from 41 in 2008-09 to 114 last year.

**Dr ANDREW McDONALD:** So 114 against various naturopaths, cosmetic therapists and dental technicians?

**Mr PEHM:** Yes.

**Dr ANDREW McDONALD:** Does that have all the unregulated people?

**Mr PEHM:** Any unregistered health service provider would be included in that table.

**Dr ANDREW McDONALD:** Is that an increase, a decrease or about the same?

**Mr PEHM:** It has gone up slowly over the past five years.

**Dr ANDREW McDONALD:** They are relatively low numbers.

**Mr PEHM:** Low numbers, yes. In explaining that, I do not think that the potential for harm is as great with unregistered providers because it is not readily heavily interventional like surgery. The complaints that we investigate and make prohibition orders for tend to be around boundary issues, such as massage therapists, for instance, making sexual advances on clients, those sorts of things—although I think there is potential for growth in the technician-type area such as perfusionists and anaesthetic technicians. One was published on our website about an anaesthetic technician becoming addicted to drugs and taking drugs from the workplace. We are currently talking to the Health Education and Training Institute [HETI] about getting a more comprehensive awareness program out amongst unregistered practitioners already employed in the health system about the application of the code of conduct.

**Dr ANDREW McDONALD:** There has been a move from social workers and speech pathologists to become registered practitioners. Has the Health Care Complaints Commission [HCCC] been involved in that?

**Mr PEHM:** I think the naturopaths would be keen to become registered as well. Generally the more responsible alternative health service providers, if you like, would prefer the discipline of a registration system because their qualifications would be recognised and their standards could be set in a more consistent and rigorous way by their fellows and by their peers. Recently Chinese traditional medicine became registered in New South Wales because it was done so in Victoria. There is a national registration scheme. Again, it is that cost benefit analysis. Registration is a much more expensive process than with the unregistered which, in effect, lets anyone practice. I guess that is a matter for government. There is currently a consultation process going because the Australian Health Ministers have agreed that all State

and Territory Ministers should consider the institution of a code of conduct along the New South Wales model.

**Dr ANDREW McDONALD:** So all unregistered practitioners are bound by the code of conduct?

**Mr PEHM:** If it goes through, that is what will happen. There will be mutual recognition. So an order in one State will be applicable through all the States and Territories that sign up.

**The Hon. HELEN WESTWOOD:** Can I pick up on the thread of that question and your answer? I have been thinking about where you get complaints and finding they are a consequence of drug addiction of a practitioner. In recent times we have seen a couple of horrendous consequences as a result of health practitioners with a drug addiction. There was that awful case in Victoria where many women contracted hepatitis C at a pregnancy termination clinic because the anaesthetist had an addiction to painkillers. We saw a terrible fire in a nursing home—again, a registered nurse had an addiction to painkillers. Is there any further action that is taken when we see complaints that should cause alarm and may lead to serious consequences?

**Mr PEHM:** Yes. All of the health professional councils in New South Wales, such as the Medical Council of New South Wales and the Nursing and Midwifery Council, have impairment programs. The impairment program will involve the practitioner having conditions placed on their registration. Those conditions might relate to access to drugs, having psychiatric examinations, doing random urine tests, and there is one they can do for alcohol now—carbohydrate deficient transferrin [CDT] tests—as well. Those programs are administered by the councils. I cannot say how common it is but there are complaints that raise those issues which are often picked up by colleagues who notice a clinician acting unusually at work. They will go into that health program.

If they have some insight and are compliant with the conditions and they are getting help and are dealing with their addiction, they can continue to practise. They will be monitored. The impairment committees will meet monthly and review their progress and might eventually lift conditions and broaden their practice. They are pretty effective, on the whole, in New South Wales. I cannot speak for others. They do require the practitioner to acknowledge that they have a problem and to be cooperative with the process. If they are not cooperative and they breach conditions, for instance, then the Council will refer them back to us for investigation and potentially prosecution in a tribunal and either deregister them or put conditions on their registration. That is how the scheme works. We have not had any terrible cases in New South Wales for a while in that impairment area.

**The Hon. HELEN WESTWOOD:** Except the nurse that set the nursing home alight. He was a registered nurse who had an addiction.

**Mr PEHM:** He did.

**Dr ANDREW McDONALD:** But he was not known.

**The Hon. HELEN WESTWOOD:** It brings up that issue of what can be put in place to ensure that we are alerted. Health practitioners with an addiction can have serious consequences.

**Mr PEHM:** Certainly.

**The Hon. HELEN WESTWOOD:** What are we doing to ensure we can identify it and then deal with it?

**Mr PEHM:** In this case the problem was the identification. He was never part of any of the programs.

**Dr ANDREW McDONALD:** These people deliberately marginalise themselves out of the public health system.

**Mr PEHM:** And drug abusers generally are fairly good at covering up their addictions. Well, not always, but there is a lot of deviousness there about not getting caught out.

**Dr ANDREW McDONALD:** In relation to alcohol and practitioners on call, does the Health Care Complaints Commission have any advice for practitioners about drinking alcohol at all? Is there any published advice?

**Mr PEHM:** I really do not know. I assumed you did not drink while you were on call.

**Ms MOBBS:** I think it is unclear.

**Dr ANDREW McDONALD:** It is usual for many people to have a single glass of wine when on call. It is not uncommon. You could be a theatre nurse on call. You could be a retained paramedic on call. You could be a doctor on call.

**The Hon. HELEN WESTWOOD:** Do you mean permanently?

**Dr ANDREW McDONALD:** No.

**The Hon. HELEN WESTWOOD:** A shift.

**Dr ANDREW McDONALD:** People can be on call every second night. Not on duty, on call.

**The Hon. HELEN WESTWOOD:** Yes, I understand what the difference is. I did not think you were allocated a time and that it was shared so that you were not on five nights out of ten.

**Dr ANDREW McDONALD:** A lot of people are on every second night.

**The Hon. PAUL GREEN:** For instance an obstetrician might plan to play golf the whole weekend but one phone call can wreck the whole weekend.

**Ms MOBBS:** That is an issue we see in some of the prosecution cases and we rely on experts from the field to say what the applicable standard is across all the practitioners.

Certainly the evidence I have heard and I have seen in statements is to the effect that it depends. You are allowed to drink. There is no absolute prohibition but really it is a matter of monitoring yourself. If you get called and you are not in a position to treat a patient, it is your responsibility to advise—

**Dr ANDREW McDONALD:** It is your responsibility to ensure patient safety.

**Ms MOBBS:** That is right. We rely on the experts and practitioners as to what the standards are and should be.

**Dr ANDREW McDONALD:** The reason I ask is because the Americans are moving towards prohibition; banning alcohol when a practitioner is on call. Most of the rest of the world still permits responsible consumption of alcohol when on call.

**Ms MOBBS:** It is the national boards and maybe the State councils that promulgate those standards and if there is to be a change that is where they would be initiated.

**The Hon. PAUL GREEN:** Do we have many complaints where alcohol is an issue?

**Mr PEHM:** No. It is pretty rare. It usually gets to the extent where the practitioner is severely lurching about and it is obvious to everyone that they have a serious problem. The odd glass of wine has not come up through complaints.

**CHAIR:** I am going to go back to the issue that often gets raised and that is communication. We continue to see a steady increase in complaints about communication regarding a whole range of medical practitioners. I wondered if you wanted to make a comment about that trend. What is it that we can do to address some of those issues about communications with health professionals?

**Mr PEHM:** That is a big question. It is a constant and continuing problem. We touched on it before about the open disclosure issue, communicating. The Commission is working with the Clinical Excellence Commission and Sydney University on a health literacy program, which we think is one of the keys to this. It is really about getting practitioners to talk at a level where patients understand what they are saying and to test back with them, to use aids, diagrams, that sort of thing. Again, it is one of these situations where people continue to practise as they have always practised. It can be taught in medical schools and we certainly have done training sessions on it, and webinars. Those that are interested in communicating well will be interested, those who are not, not so much. It is one of those difficult cultural problems. It needs to be attacked on a lot of different fronts.

**Dr ANDREW McDONALD:** They teach it in medical school and the students hate it, only because they are the wrong population. They are better at communicating than their previous medical students.

**CHAIR:** Than your generation.

**Dr ANDREW McDONALD:** Than my generation. As Mr Pehm said before, the problem with teaching stuff is you have to use it and the students do not communicate with people. Have you looked at communication training that will be eligible for maintenance of professional standards? Every medical or nursing practitioner has to do something. Have you



looked at trying to get that put in rather than finding out about rare diseases? Perhaps we should use teaching communication skills because it is done very poorly. Senior clinicians are not taught how to communicate and it is assumed they can but, as you can see, they often cannot.

**Mr PEHM:** We can look at the continuing professional development aspect of it as well.

**The Hon. PAUL GREEN:** In previous inquiries, we have asked about the resources needed to resource your manpower. How is it going and what is the outlook?

**Mr PEHM:** We received quite a substantial budget increase about two or three years ago from the incoming Government of that time. I think you can see the numbers are continuing to increase. We have been coping fairly well but I think it is starting to get a bit tight again and we might raise that this next round.

**CHAIR:** I note in the report—and bear in mind it is the 2012-13 report—that you were auditing public hospitals for the first time. Do you want to comment on that? It was about checking the compliance with recommendations and so on.

**Mr PEHM:** Yes, we decided to do two audits per year and these would involve investigations where we have made recommendations that education be provided to staff or they review a procedure. We have partnered with the Clinical Excellence Commission [CEC] and Tony's investigations division has staff trained in doing the audits. Perhaps Tony would like to speak to that.

**Mr KOFKIN:** We have completed four audits now, two at regional hospitals and two at metropolitan hospitals.

**CHAIR:** Are they randomly selected?

**Mr KOFKIN:** No, we have a look at the investigations or the recommendations we made previously. We then liaise with the CEC to make sure they have not audited the same things. Sometimes we look to make sure that as a result of our audit they can check off some of the other national quality standards as well. The feedback from the chief executives has been very good. The responsiveness from the local health district [LHD] has been very good. Certainly from our perspective, we use CEC auditors but it is a commission audit, we make that clear. It is not a Clinical Excellence Commission audit under the quality system assessment [QSA] system; it is a Health Care Complaints Commission audit focusing on recommendations we have made previously.

About three or four weeks ago we conducted an audit into a tragic matter of the death of a woman and a stillbirth, a horrendous incident. Certainly from conducting the audit with the chief executive there, the Director of Clinical Governance, the Director of Medical Services and the relevant clinicians, we found, firstly, the recommendations have been implemented beyond expectations. Certainly, from my perspective and that of my staff who attend, the impact it has on the LHD is massive and the impact it has on the chief executive, senior members of the executive and the clinicians is huge. We spoke about a letter from the Commission in terms of a complaint. These are real life-changing, career-defining matters. It is a really worthwhile process for us.

What we have found from the LHDs is that they value us coming along because it gives them the opportunity to reassess where they are and to see how they are travelling. It also gives them an opportunity to promote to us in terms of how that incident two or three years ago has not only led to a change in policy but sometimes cultural differences as well. And, understandably, it often leads to a diversion of resources to a particular area where there was previously a need but where resources had not been diverted. It is something we will continue to do. I think two a year is enough for us, in terms of capacity.

**Mr PEHM:** I think that was another thing this Committee kicked off. The Committee asked us how we knew that our recommendations were being actioned.

**CHAIR:** Considering the positive outcomes of your auditing of the recommendations, are they shared with other LHDs? You have done four but would not some of the recommendations be worthy of all LHDs checking off to see whether they already had policies like that in place?

**Mr KOFKIN:** All our recommendations and investigation reports, where we make a recommendation, go to the Clinical Excellence Commission. It is their role to disseminate—

**Mr PEHM:** And the Director General of the Health Department or the Health Ministry as well so that they can look at the potentially wider applicability. Some things are obvious and are picked up quickly, like a mistake made in dosage of an anti-cancer drug.

**Dr ANDREW McDONALD:** Weekly compared to daily, yes? Methotrexate.

**Mr PEHM:** They have changed that process state-wide almost.

**Dr ANDREW McDONALD:** That is for most cancers?

**Mr PEHM:** Yes. Other things, a bit more local.

**Mr KOFKIN:** For the record, the Clinical Excellence Commission [CEC] has been fantastic in the support we have had from them in terms of getting the framework together and the ministry as well, providing doctors and nurses free of charge so that it is cost neutral for us. The support we have had from the Clinical Excellence Commission and the Ministry has been good.

**CHAIR:** Obviously good outcomes for the LHD.

**Mr KOFKIN:** Yes.

**Dr ANDREW McDONALD:** That has brought me to on-call. Do you get many complaints about failure to attend on-call? The reason I ask is there is no apparent guideline to anybody as to call to bedside time.

**Mr PEHM:** It is an area that generates complaints and it is not just failure to attend when called in. The more probable common issue seems to be communication between the Registrar onsite and the consultant.

**The Hon. PAUL GREEN:** I said yes, he said no.

**Mr PEHM:** Precisely. Exactly what was told and what advice was given is rarely documented. Then you will get a poor or catastrophic outcome sometimes and the issue will be: What advice was given? What care was taken? What observations were made? That is where the absent consultant becomes quite common in the complaint situation.

**Dr ANDREW McDONALD:** What about time from call to bedside? That can vary from ten minutes to two hours or never. The British have a requirement for some jobs that one is available within 20 minutes, one has to live within 20 minutes of the hospital.

**Mr PEHM:** I know some hospitals in Melbourne do that, where anaesthetists in the obstetrics area have to be within 20 minutes of the hospital. It is rare that it comes through complaints. I can think of one obstetric case where an emergency caesarean was delayed because the clinician took longer than the circumstances demanded. It does not come up often though.

**Ms MOBBS:** Generally it is associated with other issues. If there was an impairment issue or issues about performance it may be related, but it would not normally be the prime complaint, it would be associated with other issues.

**Dr ANDREW McDONALD:** For example, in a case of a patient with an acute surgical condition where the surgeon takes an hour to arrive because the surgeon on call is an hour from the hospital, is the surgeon responsible for that delay or is the hospital, which knew the surgeon was an hour away? Does it come up?

**Ms MOBBS:** It is not a complaint that is usually sustained through to the legal section, so it is not considered a serious matter generally.

**Mr PEHM:** There has never been disciplinary action taken against a practitioner that has involved that issue. I would think if the employee says, "I am an hour away", one takes that into account as to whether you have him on call or not. And if the employer does, I think that would be a question of medical negligence and a private action. You would always sue the employer anyway because they have more money generally.

**Dr ANDREW McDONALD:** The doctors are insured.

**Mr PEHM:** Yes.

**CHAIR:** Commissioner, if the Committee has additional questions, are you happy for us to forward them in writing and that the answers form part of your evidence today?

**Mr PEHM:** Yes, that would be fine.

**CHAIR:** On behalf of the Committee, I thank you and your staff for attending today. We appreciate your time and the answers to the questions that we received with regard to the report.

**(The witnesses withdrew)**

**(The Committee adjourned at 11.55 a.m.)**

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# Chapter Eight – Response to Question Taken on Notice at the Public Hearing

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## Identification of doctors at risk of recurrent complaints: a national study of healthcare complaints in Australia

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### ABSTRACT

**Objectives** (1) To determine the distribution of formal patient complaints across Australia's medical workforce and (2) to identify characteristics of doctors at high risk of incurring recurrent complaints.

**Methods** We assembled a national sample of all 18 907 formal patient complaints filed against doctors with health service ombudsmen ('Commissions') in Australia over an 11-year period. We analysed the distribution of complaints among practicing doctors. We then used recurrent-event survival analysis to identify characteristics of doctors at high risk of recurrent complaints, and to estimate each individual doctor's risk of incurring future complaints.

**Results** The distribution of complaints among doctors was highly skewed: 3% of Australia's medical workforce accounted for 49% of complaints and 1% accounted for a quarter of complaints. Short-term risks of recurrence varied significantly among doctors: there was a strong dose-response relationship with number of previous complaints and significant differences by doctor specialty and sex. At the practitioner level, risks varied widely, from doctors with <10% risk of further complaints within 2 years to doctors with >80% risk.

**Conclusions** A small group of doctors accounts for half of all patient complaints lodged with Australian Commissions. It is feasible to predict which doctors are at high risk of incurring more complaints in the near future. Widespread use of this approach to identify high-risk doctors and target quality improvement efforts coupled with effective interventions, could help reduce adverse events and patient dissatisfaction in health systems.

### INTRODUCTION

To many doctors who are sued or complained against, the event seems random. At the population level, however, there are patterns. Previous studies have

compared doctors who experienced multiple malpractice claims,<sup>1-5</sup> complaints,<sup>6 7</sup> and disciplinary actions<sup>8-10</sup> with doctors who experienced few or none, and identified differences in the sex, age and specialty profile of the two groups. Such research helps to explain medico-legal risk retrospectively, but does not provide practical guidance for identifying risks prospectively. Clinical leaders, risk managers, liability insurers and regulators all lack reliable methods for systematically determining which doctors should be targeted for assistance and preventive action *before* they acquire troubling track records. Consequently, the medico-legal enterprise remains reactive, dealing primarily with the aftermath of adverse events and behaviours that lead to costly disputes.

The conventional wisdom is that future medico-legal events cannot be predicted at the doctor level with acceptable levels of accuracy.<sup>11 12</sup> Numerous studies have tried,<sup>13-23</sup> most with limited success. This body of research has two important shortcomings. First, only a few studies<sup>15 17 21</sup> report a method for predicting medico-legal risk that is potentially replicable, and these methods are statistically complex. The practical consequence is that regulators and liability insurers today have no clear way of estimating risk at the practitioner level, and doing so is not a standard part of risk management practice.

Second, no study to date has found a way to deal well with temporal aspects of risk, such as the evolving nature of doctors' medico-legal event histories, which can be crucial information in assembling a risk profile. Previous claims and complaints have been identified as an important predictor of future events, but only in analyses that specify this variable crudely—usually by 'freezing' a doctor's

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track record at a specific point to estimate a 'one-time' effect.<sup>13 14 16 17 19 21 24 25</sup> This approach is out of step with how claims and complaints are managed. The frontline challenges are to determine

Outside of the clinic or hospital in which care is received, Commissions are the primary avenue of redress for patients dissatisfied with the quality of care they have received. Plaintiffs' lawyers in Australia will rarely take

how a practitioner's risk profile changes over time as new information (including new events) comes to hand; when support or intervention measures to prevent further events are warranted; and how strong those measures should be. A risk prediction method that helped to address these questions would have considerable potential for boosting the contribution of medico-legal institutions to quality improvement.

We assembled a national sample of nearly 19 000 formal healthcare complaints lodged against doctors in Australia between 2000 and 2011. We then used a time-to-event method of analysis to determine characteristics of doctors poised to incur recurrent complaints, and to estimate each practitioner's risk of recurrence at specific time points. The study had two main goals: to identify predictors of complaint-prone doctors in Australia, and to develop a robust and useful method for forecasting medico-legal risk.

METHODS

Setting

Health service commissions (Commissions) are statutory agencies established in each of Australia's six states and two territories. Commissions have responsibility for receiving and resolving patient complaints about the quality of healthcare services. Patients or their advocates must initiate complaints in writing, but the process is free and legal representation is optional.<sup>26</sup>

Table 1 compares the jurisdiction and functions of Commissions to those of the two other agencies that handle medico-legal matters in Australia—civil courts and the Medical Board of Australia.

on cases unless they have first proceeded through Commission processes (although the vast majority of complaints do not become negligence claims). At least 10 other Organisation for Economic Co-operation and Development (OECD) countries—including Austria, Finland, Israel, New Zealand and the UK—have similar bodies.<sup>27 28</sup> In the UK, the closest analogue is the Parliamentary and Health Service Ombudsman.

Commissions in all Australian states and territories except South Australia participated in the study. These seven jurisdictions have 21 million residents and 90% of the nation's 88 000 registered doctors. The study was approved by the ethics committee at the University of Melbourne.

Data

Between May 2011 and February 2012 we collected data on-site at Commission offices in each participating state and territory. Complaints against doctors were identified by querying the Commissions' administrative data systems. The filing period of interest spanned 12 years and differed slightly by jurisdiction: 2000–2011 for the Australian Capital Territory, the Northern Territory, Queensland, Tasmania and Victoria; 2000–2010 for Western Australia; and 2006–2011 for New South Wales.

All Commissions record the names of persons and institutions that are the subject of complaints, as well as the filing date, the nature of the complaint, the type of health professional named and their practice location. Although all Commissions recorded doctors' clinical specialty, the quality of this variable was mixed. Doctors' age and sex were not routinely

Table 1 Jurisdiction and functions of key agencies with responsibility for medico-legal matters in Australia

|                      | Civil courts                                                                                                                   | Health complaints commissions                                                                                                                                                                                | Medical Board of Australia                                                                                                                                           |
|----------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Cases handled        | ► Negligence claims                                                                                                            | ► Patient complaints                                                                                                                                                                                         | ► Conduct, competence, or health matters                                                                                                                             |
| Jurisdictional focus | ► Substandard care causing patient harm                                                                                        | ► Low-quality care<br>► Patient dissatisfaction with care                                                                                                                                                    | ► Professional misconduct<br>► Performance or competence falling below professional standards<br>► Ill-health, substance misuse, or impairment                       |
| Procedures used      | ► Out-of-court negotiation<br>► Alternative forms of dispute resolution (eg, mediation, arbitration)<br>► Trials before judges | ► Early resolution<br>► Conciliation<br>► Investigation                                                                                                                                                      | ► Review of doctor's competence or health status<br>► Investigation<br>► Disciplinary charges                                                                        |
| Remedies             | ► Monetary damages                                                                                                             | ► Communication (eg, facilitate apology or explanation)<br>► Restoration (eg, facilitate provision of further treatment, fee forgiveness, monetary settlement)<br>► Correction (eg, recommend system change) | ► Correction (eg, requirement that practitioner undergo education, rehabilitation, monitoring etc)<br>► Sanction (eg, suspension or revocation of practice licence*) |

\*Typically, such sanctions are imposed by external administrative tribunals in proceedings initiated by the Medical Board of Australia.

collected. We therefore supplemented the Commissions' administrative data with data from another source.

AMPCo Direct, a subsidiary of the Australian Medical Association, maintains a comprehensive list of doctors in Australia, including information on their sex, date of birth, specialty and subspecialty, and practice location. We purchased the AMPCo Direct database and matched doctors listed in it to doctors named in the complaints databases. The matching method is described in an online supplementary appendix.

#### Variables

We coded specialty into 13 categories, based on those promulgated by the Medical Board of Australia.<sup>29</sup> Doctors' principal practice address was classified as urban or rural, based on the location of its postcode within a standard geographic classification system.<sup>30</sup> The nature of concerns raised in complaints was sorted into 20 broad 'issue' categories. Commissions run dispute resolution processes; they generally do not rule on the merit of complaints, nor make findings for or against parties, so it was not possible to include a variable indicating how meritorious complaints were.

#### Statistical analysis

##### Distributional analysis

We plotted the cumulative distribution of complaints among two populations of doctors: (1) all unique doctors named in complaints and (2) all practicing doctors in the seven jurisdictions under study (ie, regardless of whether they had been named in complaints). The size of this second population was based on the number of doctors in employment in 2006,<sup>31</sup> the median study year. Because certain classes of complaints do not name doctors individually (eg, complaints arising in public hospitals in several of the study jurisdictions), we adjusted the proportions in the distributional calculations to ensure the numerators (number of complaints) matched the denominators (size of the 'exposed' segment of the medical workforce). Details are provided in the online supplementary appendix.

##### Multivariable survival analysis

We used multivariable survival analysis to identify predictors of doctors' risks of recurrent complaints. Specifically, we used an Anderson-Gill model<sup>32</sup> in which the time-scale ran from time from first event (ie, a doctor's earliest complaint) and allowed each doctor in the sample to accrue multiple complaints over the period of observation. The outcome variable was the occurrence of a complaint against a doctor, conditional on the doctor having been named in an earlier complaint. The covariates were the number of prior complaints a doctor had experienced,

jurisdiction, and the doctor's specialty, age, sex and principal practice location.

The number of prior complaints was specified as a time-varying covariate. Age was also time-varying in the sense that we allowed doctors to move into higher age categories, commensurate with their age at the time of the complaint. We fit cluster-adjusted robust SEs to account for doctors who experienced repeated complaints over time.

Details of model selection and specification are described in the online supplementary appendix. All statistical analyses were conducted using Stata 12.1.

##### Risk predictions

To estimate doctors' risks of experiencing complaints over time, we plotted adjusted failure curves.<sup>33 34</sup> Details of the statistical techniques used to create these curves are provided in the online supplementary appendix. We also plotted failure curves showing the predicted risk of recurrent complaints for several individual doctors. Values for all failure curves were computed using coefficients from the main multivariable model, and hence, derived from the survivor function,  $S(t)$ .

##### Sensitivity analysis

We tested the robustness of estimates from the main multivariable analysis by rerunning the analysis on a subsample of complaints ( $n=10\,010$ ) with issue codes suggestive of relatively serious concerns (namely, poor clinical care, breach of conditions, rough or painful treatment and sexual contact or relationship).

## RESULTS

### Characteristics of complained-against doctors and complaints

The study sample consisted of 18 907 complaints against 11 148 doctors. Sixty-one percent of the complaints addressed clinical aspects of care, most commonly concerns with treatment (41%), diagnosis (16%) and medications (8%) (table 2). Nearly one quarter of complaints addressed communication issues, including concerns with the attitude or manner of doctors (15%), and the quality or amount of information provided (6%).

Seventy-nine percent of the doctors named in complaints were male, 47% were general practitioners and 14% were surgeons (table 3). Examples of several complaints are included in the online supplementary appendix.

### Incidence and distribution of complaints

Doctors in the sample were complained against an average of 1.98 times (SD 2.31). The distribution was highly skewed, with a small subgroup of doctors accounting for a disproportionate share of complaints.

Figure 1 plots the cumulative distribution of complaints among doctors in six jurisdictions over a decade. (New South Wales data was not included in these plots because the complaints window there spanned only 5 years.) The curve on the left side of



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**Table 2** Issues in a national sample of 18 907 complaints filed by patients

|                                           | n     | %*  |
|-------------------------------------------|-------|-----|
| Clinical care                             | 11579 | 61  |
| Treatment                                 | 7746  | 41  |
| Diagnosis                                 | 3080  | 16  |
| Medication                                | 1572  | 8   |
| Hygiene/infection control                 | 190   | 1   |
| Discharge/transfer                        | 113   | 0.6 |
| Other clinical care                       | 127   | 0.7 |
| Communication                             | 4279  | 23  |
| Attitude or manner                        | 2823  | 15  |
| Information                               | 1132  | 6   |
| Consent                                   | 582   | 3   |
| Other communication                       | 32    | 0.2 |
| Costs or billing                          | 1309  | 7   |
| Medical records, certificates, or reports | 1304  | 7   |
| Access and timeliness                     | 1257  | 7   |
| Sexual contact or relationship            | 625   | 3   |
| Rough or painful treatment                | 477   | 3   |
| Confidentiality or information privacy    | 392   | 2   |
| Breach of conditions                      | 332   | 2   |
| Grievance handling                        | 213   | 1   |
| Discrimination                            | 103   | 0.5 |
| Other                                     | 126   | 0.7 |

\*Complaint issues sum to more than 100% because some complaints involved multiple issues.

the figure shows the distribution of complaints among doctors who experienced one or more complaints in the decade. Fifteen percent of doctors named in complaints accounted for 49% of all complaints, and 4% accounted for a quarter of all complaints. The curve on the right side of the figure shows the distribution of complaints across the full population of practicing doctors, not just those who experienced complaints. Three percent of all doctors accounted for 49% of all complaints, and 1% accounted for a quarter of all complaints.

#### Multivariable predictors of recurrent complaints

In multivariable analyses, the number of prior complaints doctors had experienced was a strong predictor of subsequent complaints, and a dose-response relationship was evident (table 4). Compared with doctors with one prior complaint, doctors with two complaints had nearly double the risk of recurrence (HR 1.93; 95% CI 1.79 to 2.09), and doctors with five prior complaints had six times the risk of recurrence (HR 6.16; 95% CI 5.09 to 7.46). Doctors with 10 or more prior complaints had 30 times the risk of recurrence (HR 29.56; 95% CI 19.24 to 45.41).

Risk of recurrence also varied significantly by specialty. Compared with general practitioners, plastic

**Table 3** Characteristics of 11 148 doctors named in complaints

|                            | n    | %  |
|----------------------------|------|----|
| Gender                     |      |    |
| Male                       | 8818 | 79 |
| Female                     | 2255 | 20 |
| Missing                    | 75   | 1  |
| Speciality                 |      |    |
| General practice           | 5289 | 47 |
| Surgery                    | 1540 | 14 |
| Orthopaedic                | 432  | 4  |
| General                    | 398  | 4  |
| Plastic                    | 177  | 2  |
| Other surgical             | 533  | 5  |
| Internal medicine          | 1243 | 11 |
| Obstetrics and gynaecology | 541  | 5  |
| Psychiatry                 | 672  | 6  |
| Anaesthesia                | 404  | 4  |
| Ophthalmology              | 243  | 2  |
| Dermatology                | 157  | 1  |
| Radiology                  | 200  | 2  |
| Other                      | 501  | 4  |
| Missing                    | 358  | 3  |
| Age                        |      |    |
| 22–35 years                | 757  | 7  |
| 36–45 years                | 2624 | 24 |
| 46–55 years                | 3354 | 30 |
| 56–65 years                | 2184 | 20 |
| 66+ years                  | 691  | 6  |
| Missing                    | 1583 | 14 |
| Practice location          |      |    |
| Urban                      | 8241 | 74 |
| Rural                      | 2775 | 25 |
| Missing                    | 132  | 1  |

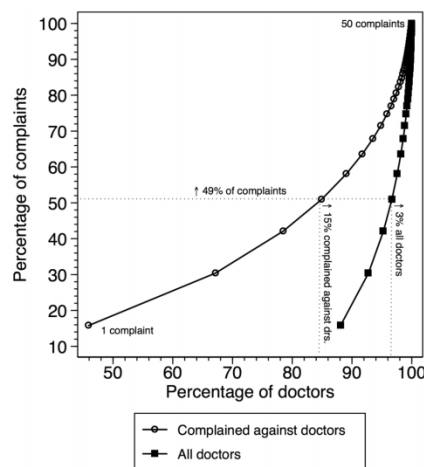
surgeons had twice the risk (HR 2.04; 95% CI 1.75 to 2.38), and risks were approximately 50% higher among dermatologists (HR 1.56; 95% CI 1.30 to 1.88) and obstetrician-gynaecologists (HR 1.50; 95% CI 1.29 to 1.76). Anaesthetists had significantly lower risks of recurrence (HR 0.65; 95% CI 0.54 to 0.79).

Male doctors had a 40% higher risk of recurrence than their female colleagues (HR 1.36; 95% CI 1.23 to 1.50). Location of practice (urban vs rural) was not significantly associated with recurrence. Compared with doctors 35 years of age or younger, older doctors had 30–40% higher risks of recurrence; this level of heightened risk was similar through the middle-aged and older-aged groups.

#### Risks of recurrence over time

Doctors named in a third complaint had a 38% chance of being the subject of a further complaint within a year, and a 57% probability of being complained against again within 2 years (figure 2A). Doctors named in a fifth complaint had a 59% 1-year





**Figure 1** Cumulative distribution of complaints and doctors named in complaints.

complaint probability and a 79% 2-year complaint probability. Recurrence was virtually certain for doctors who had experienced 10 or more complaints, with 97% incurring another complaint within a year. Regardless of the number of previous complaints, doctors' risks of further complaints increased sharply in the first 6 months following a complaint, and then declined steadily thereafter. This is evident from the steep rise and then plateauing of the curves in figure 2A (these curves plot cumulative risks over time).

The curves shown in figure 2A depict average population-level risks for selected predictors, controlling for other covariates. However, our modelling approach is fundamentally designed to predict risk at the practitioner level. Figure 2B illustrates this; it shows wide variation in risk profiles among a selection of seven doctors in the sample. Doctor A, for instance, is a 62-year-old male general practitioner who accumulated 10 complaints over 9.2 years of observation. He had a 39% risk of recurrence after his fourth complaint, a 61% risk after his fifth complaint and a 94% risk after his sixth complaint.

#### Sensitivity analysis

Re-estimating the main multivariable model using a subset of 'severe' complaints produced very similar results to the main model. Low-churn complaints are in appendix shows the full set of results.

#### DISCUSSION

This study of patient complaints made to the chief health-quality regulators in Australia found that the complaints clustered heavily among a small group of

**Table 4** Multivariable regression analysis estimating risk of recurrent complaints\*

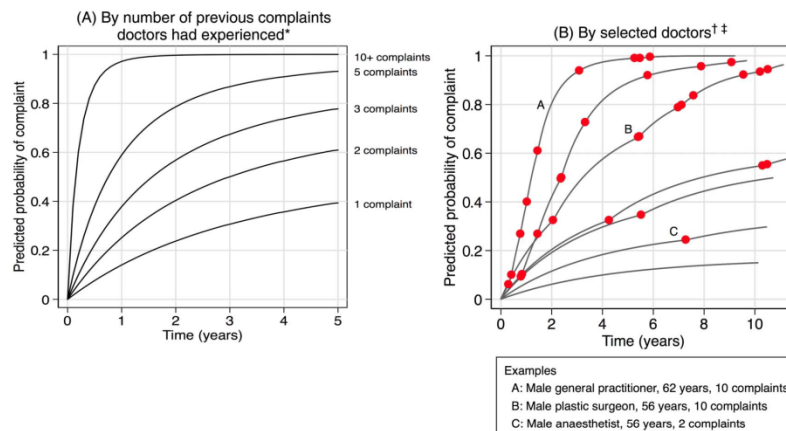
|                            | HR (95% CI)            | p Value |
|----------------------------|------------------------|---------|
| Number of prior complaints |                        | <0.001  |
| 1 (ref)                    | 1.00                   |         |
| 2                          | 1.93 (1.79 to 2.09)    |         |
| 3                          | 3.21 (2.87 to 3.59)    |         |
| 4                          | 4.54 (3.90 to 5.27)    |         |
| 5                          | 6.16 (5.09 to 7.46)    |         |
| 6                          | 8.83 (7.05 to 11.05)   |         |
| 7                          | 9.57 (7.40 to 12.37)   |         |
| 8                          | 9.49 (7.05 to 12.77)   |         |
| 9                          | 16.09 (11.72 to 22.10) |         |
| 10 or more                 | 29.56 (19.24 to 45.41) |         |
| States and territories     |                        | <0.001  |
| 1 (ref)                    | 1.00                   |         |
| 2                          | 2.23 (1.86 to 2.67)    |         |
| 3                          | 2.10 (1.75 to 2.53)    |         |
| 4                          | 1.91 (1.53 to 2.37)    |         |
| 5                          | 1.86 (1.52 to 2.29)    |         |
| 6                          | 1.73 (1.37 to 2.20)    |         |
| 7                          | 1.25 (1.02 to 1.53)    |         |
| Male doctor                | 1.36 (1.23 to 1.50)    | <0.001  |
| Urban practice location    | 0.98 (0.90 to 1.07)    | 0.65    |
| Specialty of doctor        |                        | <0.001  |
| Plastic surgery            | 2.04 (1.75 to 2.38)    |         |
| Dermatology                | 1.56 (1.30 to 1.88)    |         |
| Obstetrics and gynaecology | 1.50 (1.29 to 1.76)    |         |
| General surgery            | 1.45 (1.17 to 1.80)    |         |
| Orthopaedic surgery        | 1.32 (1.20 to 1.44)    |         |
| Other surgery              | 1.30 (1.19 to 1.43)    |         |
| Ophthalmology              | 1.19 (1.02 to 1.40)    |         |
| Psychiatry                 | 1.15 (1.02 to 1.29)    |         |
| General practice (ref)     | 1.00 (ref.)            |         |
| Internal medicine          | 0.93 (0.80 to 1.09)    |         |
| Radiology                  | 0.89 (0.34 to 2.37)    |         |
| Anaesthesia                | 0.65 (0.54 to 0.79)    |         |
| Other                      | 0.65 (0.51 to 0.82)    |         |
| Age of doctor              |                        | <0.001  |
| <35 years                  | 1.00 (ref.)            |         |
| 36-45 years                | 1.31 (1.13 to 1.51)    |         |
| 46-55 years                | 1.40 (1.22 to 1.62)    |         |
| 56-65 years                | 1.43 (1.23 to 1.67)    |         |
| Gamma                      | -0.21 (-0.23 to -0.19) |         |

\*Analysis based on 14 986 index complaints against 8749 doctors, and 6237 subsequent complaints.

doctors. Approximately 3% of practicing doctors accounted for half of all complaints. The number of prior complaints doctors had experienced was a particularly strong predictor of their short-term risk of further complaints. At the practitioner level, short-term risks of recurrence varied widely, from <10% risk among low-risk doctors to >80% risk among high-risk doctors. Overall, recurrent-event survival

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**Figure 2** Probability of recurrent complaints over time.

\*Curves adjusted for doctor age and sex, practice location, specialty, state and complaint year. †Dots on the curves indicate points in time when actual complaints occurred (ie, x-axis), but have no meaning in relation to predicted probability of complaints (ie, y-axis).

‡Ages reported refer to mid-points of the period over which the doctor was followed.

analysis showed considerable promise as a statistical approach for flagging complaint-prone doctors early in their complaints trajectory, using only a few simple descriptive characteristics.

Our study used a national sample to examine the distribution and predictors of medico-legal events. Patients treated in healthcare facilities throughout seven states and territories were eligible to file complaints with a Commission about the quality of the care they received. Previous studies of claims and complaints risk have tended to focus on pools of doctors covered by a single liability insurer or a few hospitals.

The extent to which complaints were concentrated in a small group of doctors was striking, consistent with other studies of complaints<sup>7 19 22</sup> and claims.<sup>18</sup> This highly skewed distribution of medico-legal events among doctors has several implications. The obvious one is that there is a pressing need for interventions that address the behaviour of doctors who are chronically complained or claimed against. Medical boards in Australia and elsewhere already address conduct, competence and health concerns with certain practitioners, but these efforts may fall short. Our study identifies a target population within which systematic deployment of interventions to improve performance<sup>35 36</sup> might be manageable: less than 500 doctors accounted for 25% of all complaints that named doctors in the decade under study. Immediate steps to improve, guide or constrain the care being provided by these 'high-risk' practitioners could be a very cost-effective way to advance quality and safety, and produce measurable benefits at the system level.

A more sobering implication of the clustering phenomenon is that remediation activities targeted at

doctors who have attracted many complaints, while critical, come too late. Complaints are best understood as sentinel events, and complainants as representatives of much larger groups of harmed or dissatisfied patients.<sup>37–39</sup> By the time multiple complaints have accrued, substantial damage to quality of care is likely to have occurred already. The clustering of medico-legal events highlights the huge gains that would be put in reach by a capability to identify early doctors who are on course to incur multiple complaints.

Our approach is ripe for replication, not only by hospitals and regulators that hold complaints data, but within liability insurers with malpractice claims data, large hospital systems with risk management data, and medical boards and other professional bodies with data on disciplinary matters. Several distinctive aspects of our approach, descriptions of which follow, pave the way for better prediction of medico-legal risk in these settings than has been achieved to date.

Previous efforts to predict malpractice risk in liability insurance pools have included doctors with and without claims in their analyses.<sup>11 14 15 17 19 21</sup> This approach suits a core goal in many of these studies: to explore the feasibility of 'experience rating' doctors' liability insurance premiums.<sup>24 40</sup> By contrast, our study sought to predict risk for purposes of targeting quality-improvement interventions. In this context, it is appropriate to focus on doctors who have been the subject of at least one complaint because this is the group with whom regulators have a natural point of contact and opportunities to intervene. An ancillary benefit of this 'conditional' approach to modelling medico-legal risk is that it enhances the ability to identify strong predictors of recurrent risk.

A key technical challenge encountered in previous studies has been how to deal with the recurrent nature of medico-legal events. The approach used by Rolph<sup>11 14 21</sup> and others who have emulated his method,<sup>15 17 24</sup> 'fixes' the effect of prior events in a single variable at the doctor level. The 'weighted sum algorithm' behind the PARS risk score, developed by Hickson and colleagues, comes from analyses regressing a sample of 'risk management events' on information obtained from unsolicited patient complaints.<sup>19 25</sup> A limitation of both approaches is their static consideration of doctors' event histories. In its application, however, the PARS algorithm adopts dynamic features (doctors risk scores can be recalculated as new complaints appear over time).

An advantage of recurrent-event survival analysis is that it permits dynamic consideration of the effect of time-varying factors in the predictive model itself. In other words, it is not necessary to rely on a snapshot taken of a doctor's situation at a particular point in time: as risk profiles evolve—and the coefficients on the previous complaints variable in our study illustrate how dramatically this may occur—survival analysis incorporates these changes into the estimation of future risk. A related advantage of survival analysis is that it permits estimation of doctors' risk levels at different points in time—a year after an index event, 2 years later and so on. Our analysis showed that for some predictors, particularly the number of previous complaints, doctors' risks of additional complaints were non-linear: the risk tends to rise quickly over the several months after a complaint and then level off by the time the doctor reaches a year without further incidents. For clinical leaders, regulators and liability insurers trying to determine when in a doctor's trajectory of events to intervene to prevent recurrence, and how aggressively, this kind of temporal information may be very informative.

Our study has several limitations. First, the generalisability of our findings and method—to other types of medico-legal events, to other types of health practitioners, and outside Australia—is unknown, and should be tested. In other medico-legal settings, it may not be possible for practitioners to accrue the large numbers of events that some doctors in our sample did. Lower ceilings on the number of prior events may reduce the predictive value of this variable. Nonetheless, our analyses showed high risks of recurrence within 2 years (>60%) among doctors with as few as four complaints.

Second, the predictors we examined were doctor-focused. Other variables—including, patient characteristics,<sup>41–44</sup> case-type and outcomes,<sup>39 45</sup> doctors' ethnicity and country of training,<sup>46 47</sup> the practice setting, and aspects of the patient-doctor relationship<sup>48</sup>—may also predict complaint risk. However, because these variables are usually more difficult to measure at the population level, their suitability for

large-scale predictive modelling is questionable. Moreover, given the high predictive values obtained with the simple doctor-level variables used in our analysis, the scope to boost predictive values with the addition of other variables is limited. Finally, we used head counts of practitioners, not more sophisticated measures of doctors' exposure to complaint risk, such as volume of patients treated or procedures conducted.

During the rise of the quality and safety movement over the last 15 years, medico-legal institutions have been largely on the sidelines. They remain essentially reactive enterprises, with workloads that focus on dealing with the fallout from care that has gone wrong. Patient safety experts regard the medico-legal system's fixation with posthoc assessments of individual behaviour, rather than prevention and systems, as anachronistic.<sup>49</sup> But as Rolph recognised 30 years ago,<sup>11</sup> methods for accurately and reliably forecasting the medico-legal risk of clinicians have transformative potential because they could focus and drive prevention. Identifying and intervening early with doctors at high risk of attracting recurrent medico-legal events has considerable potential to reduce adverse events and patient dissatisfaction system-wide; it may also help those doctors avoid the vicissitudes of medico-legal processes.

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**Contributors** MB, MS and DS developed the study idea, collected the data and conducted the analyses; MB and DS wrote the first draft of the manuscript; MW advised on design of the study, contributed expertise in interpretation and analysis of study data, and helped revise the draft manuscript; LG contributed to design and conduct of the statistical analysis and helped revise the draft manuscript; all authors reviewed and agreed on the submitted version of the manuscript. MB, MS and DS are guarantors for the study.

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**Competing interests** All authors have completed the Unified Competing Interest form and declare that: (1) MB, MS and DS have support from the Australian Research Council (Laureate Fellowship to DS); (2) none of the authors have had a financial

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relationships with any organisation that may have an interest in the submitted work in the previous 3 years; (3) none of the authors' spouses, partners or children have any financial relationships that may be relevant to the submitted work and (4) none of the authors have any non-financial interests that may be relevant to the submitted work.

**Ethics approval** The study was approved by the Human Research Ethics Committee at the University of Melbourne

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*BMJ Qual Saf* published online April 10, 2013  
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## Appendix One – List of Witnesses

Wednesday 16 April 2014 Waratah Room Parliament House

| Witness        | Organisation                                                    |
|----------------|-----------------------------------------------------------------|
| Mr Kieran Pehm | Commissioner<br>Health Care Complaints Commission               |
| Mr Tony Kofkin | Director of Investigations<br>Health Care Complaints Commission |
| Ms Karen Mobbs | Director of Proceedings<br>Health Care Complaints Commission    |



## Appendix Two – Extracts from Minutes

### MINUTES OF PROCEEDINGS OF THE COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION (NO. 22)

Wednesday, 16 April 2014

9:45am

Waratah Room, Parliament House

#### Members Present

Mrs Williams (Chair), Mr Green, Dr McDonald, Ms Helen Westwood

#### Staff Present:

Jason Ardit, Elaine Schofield, Vedrana Trisic, Jacqueline Isles, Millie Yeoh

The Chair commenced the meeting at 9:50 am.

#### 1. Apologies

Apologies were received from Ms Cusack, Ms Sage, and Mr Rohan.

#### 2. Confirmation of Minutes

Resolved, on the motion of Ms Westwood that the Minutes of meeting No. 21, held on 5 March 2014, be confirmed.

#### 3. Review of the 2012-2013 Annual Report of the Health Care Complaints Commissioner

Resolved, on the motion of Mr Green that the Committee authorise the publication of the responses to the Questions on Notice received from the Commissioner on 8 April 2014.

The Committee deliberated proposed questions, previously circulated, for the hearing with the Commissioner.

#### 4. Admission of media

Resolved, on the motion of Dr McDonald that the Committee authorise the audio-visual recording, photography and broadcasting of the public hearing on 16 April 2014 in accordance with the Legislative Assembly's guidelines for the coverage of proceedings for parliamentary committees.

#### 5. \*\*\*\*

The committee adjourned at 10:10 am until 10:33 am.

#### 6. Public Hearing

The Chair opened the public hearing at 10.30 pm.

The press and public were admitted.

The following witnesses were affirmed and examined:

- Mr Kieran Pehm, Commissioner, Health Care Complaints Commission
- Mr Tony Kofkin, Director of Investigations, Health Care Complaints Commission
- Ms Karen Mobbs, Director of Proceedings, Health Care Complaints Commission

Evidence concluded, the witnesses withdrew.

The Chair closed the hearing at 11.55 am.

Resolved on the motion of Ms Westwood, seconded by Dr McDonald that the corrected transcript of evidence given today [and any tendered documents, which are not confidential] be authorised for publication and uploaded on the Committee's website.

The Committee adjourned at 11:57am until 8:30am 7 May 2014.

### MINUTES OF PROCEEDINGS OF THE COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION (NO. 24)

Wednesday, 28 May 2014  
1:10 p.m.  
Room 1153, Parliament House

#### Members Present

Mrs Sage(Deputy Chair), Mr Green , Mrs Maclaren-Jones and Mr McDonald.

**Staff Present:**

Jason Arditi, Elaine Schofield, Vedrana Trisic and Jacqueline Isles

The Deputy Chair took the Chair and opened the meeting at 1.10 p.m.

1. Apologies

Apologies were received from Mr Page, Mr Rohan and Ms Westwood

2. Confirmation of Minutes

Resolved, on the motion of Mrs Maclaren-Jones: That the Minutes of meeting Number 23 held on 15 May 2014 be adopted

3. \*\*\*\*

4. Review of the 2012-2013 Annual Report of the Health Care  
Complaints Commissioner

Resolved, on the motion of Mr Green: That the Committee publish the response to the question on notice taken by the Commissioner on the Committee's webpage

5. Next Meeting

The Committee adjourned at 1:16 p.m. sine die.

MINUTES OF PROCEEDINGS OF THE COMMITTEE ON THE HEALTH  
CARE COMPLAINTS COMMISSION (NO. 25)

Wednesday, 18 June 2014

1:03 p.m.

Room 1136, Parliament House

**Members Present**

Mr Page, Chair; Mrs Sage, Deputy Chair; Mr Green; Ms MacLaren-Jones; Mr Rohan; and Ms Westwood.

**Staff Present:**

Carly Maxwell, Jason Arditi, Vedrana Trisic, Leon Last; and Jacqueline Isles.

1. Apologies

Dr Andrew McDonald

## 2. Confirmation of Minutes

Resolved, on the motion of Mrs Sage, seconded by Mr Rohan: That the Committee confirms the minutes of meeting No. 24 held on 28 May 2014.

## 3. Report on the Review of the 2012-2013 Annual Report of the Health Care Complaints Commission

The Chair spoke to the draft report previously circulated. The Chair invited Members to suggest amendments to any part of the report chapter by chapter. There being no suggested amendments, resolved on the motion of Ms Westwood, seconded by Mrs Sage:

1. That the draft report be the report of the Committee and that it be signed by the Chair and presented to the House.
2. That the Chair and Committee staff be permitted to correct stylistic, typographical and grammatical errors.
3. That, once tabled, the report be published on the Committee's website.

## 4. \*\*\*\*

## 5. Next Meeting

The Committee adjourned at 1:31 p.m. sine die.