PARLIAMENT OF NEW SOUTH WALES

Committee on the Health Care Complaints Commission

STUDY OF COMPLAINTS HANDLING AND PRACTITIONER REGULATION IN OTHER JURISDICTIONS

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Functions of the Committee

The Joint Committee on the Health Care Complaints Commission was appointed in 1993. Its functions under Section 65 of the Health Care Complaints Act 1993 are:

a. to monitor and to review the exercise by the Commission of the Commission's functions under this or any other Act;

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.

The Joint Committee is not authorised:

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.

Chairman's Foreword

Several Australian jurisdictions are doing some extremely innovative work on the issue of unregistered health practice and the internal handling of low-level complaints in private health facilities, in particular Victoria and South Australia.

The Committee was especially pleased to meet with the Central Highlands Division of General Practice and the other organisations involved in the Conflict and Litigation Minimisation CALM Pilot in Victoria. The project is seen as evidence of the results that can be achieved through partnership and innovation.

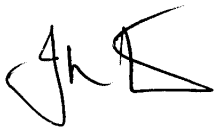
The importance of addressing complaints early on and equipping all staff to respond effectively to complaints is highlighted in this trial and is no doubt a major factor in the success of the pilot to date.

Building on the study tour the Committee were able to convene a round table with representatives from Victoria and New South Wales on the CALM pilot. The roundtable was well received by the delegates from New South Wales and should go some way to contributing to the handling of complaints in private practice in New South Wales.

Being the only Australian jurisdiction with a negative licensing system in place the Committee felt it was important to visit South Australia. Negative licensing is an important component of the recent legislative reforms for unregistered health practitioners introduced in New South Wales.

While there, the delegation was also pleased to meet with Professor MacLennan. Professor MacLennan offered valuable insight into the areas of western medicine and complementary medicine. As an expert in the field, Professor MacLennan helped to inform the Committee of developments which impact on the role of regulation on patient safety and on the important consideration of efficacy of treatments.

I would like to thank those who met with the delegation of the Committee for their time and for the lessons that they shared with us. Their contributions proved invaluable to the Committee in the drafting of its report into Internal Complaints Handling in Private Practices and its review of the 1998 Report into Unregistered Health Practitioners: The Adequacy and Appropriateness of Current Mechanisms for Resolving Complaints.



Jeff Hunter MP
Chairman

Chapter One - Melbourne

CENTRAL HIGHLANDS DIVISION OF GENERAL PRACTICE

Present	Teleconference
Ms Lynda Vamvoukis	Ms Therese Carroll
Ms Pam Trethowen	Ms Kate Bray
	Dr Chris Atkins
	Dr Richard Bills

Profile of the Organisation

1.1 The Central Highlands Division of General Practice is one of 123 such Divisions around Australia. It is primarily funded by the Commonwealth Department of Health and Aged Care to link General Practitioners with each other and to link GPs with their communities to improve health outcomes. The Division's operations are managed by a Board of Directors made up of six elected GPs.

1.2 The Division stretches from Melton, Bacchus Marsh and Sunbury up to Kyneton and Castlemaine and Daylesford and across to Kilmore, Seymour, and Wallan. It includes the towns of Gisborne and Lancefield, Romsey, Woodend and Riddells Creek.

1.3 There are 150 GPs practising in this Division, about thirty of whom are part time.

Background

1.4 The Medical Defense Association of Victoria has funded a 3-year Conflict and Litigation Minimisation (CALM) project, which intends to implement best practice complaints handling in all general practices within the participating divisions.

1.5 The initiative will be a partnership between Victoria's Office of the Health Services Commissioner, the MDAV and the Divisions of General Practice, and provides a process of informal mediation for complaints

1.6 The Pilot involves the set up of complaints coding systems that will be consistent across all practices, as well as training for all GPs and clinic staff

1.7 The Pilot was developed and funded in response to an increased demand from GPs over two years ago, who were concerned about increasing litigation.

1.8 The Conflict and Litigation Management pilot (CALM) stemmed from two main things:

- Medical litigation: There was alarm amongst GPs about increasing medical litigation, and they wanted to be proactive.
- The Divisions of General Practice putting an emphasis on quality improvement in General Practice.

1.9 GPs wanted to get the number of complaints down.

1.10 The decision to pilot the program came about as a result of concerns raised by GPs at an annual general meeting. Consequently, the Division met with the Medical Defense Association of Victoria and the Victorian Health Services Commissioner.

1.11 The Medical Defense Association covers 80% of the GP market. It agreed to fund the three-year trial (which has since been extended to five years). A consistent system of complaints recording between practices was desired.

1.12 The Pilot was to consist of:

- The development of a training program
- Upskilling practice managers, GPs and mediators
- Introducing a best practice complaints management policy

1.13 There are five stages to the Pilot:

- Stage One: Developing training modules for GPs
- Stage Two: Working on protocols with health services
- Stage Three: Developing a database for complaints recording
- Stage Four: Developing a coding system for complaints (being developed by MDAV), to enable complaints data to be compared between practices and services
- Stage Five: Piloting the system with GPs

1.14 The Division is developing the systems and providing training.

1.15 GPs needed to learn to think differently about complaints, particularly with regards to the issue of saying sorry without admitting guilt.

1.16 Skills in communication and complaints management vary between practices. Younger GPs are generally better skilled in this area.

1.17 No GPs or staff involved in the pilot previously had training in mediation.

1.18 Currently, in the mediation process made available by the pilot, patients are able to bring an advocate to the initial meeting with the GP. The goal of the meetings is to find an acceptable resolution that does not involve compensation. If a resolution is made, it is binding.

1.19 Indicators of success will not be available until the 3½ year mark. The pilot started 2 years ago, and has been refined, resulting in a new time frame of five years being proposed.

1.20 MDAV has been working on the development of the coding system, and intends to introduce it in November 2006.

1.21 45 practices are involved in the Central Highlands division. All up, around 200 practices are involved. Involvement is not compulsory, although it is mandatory to have some complaints handling process in place.

1.22 Interested GPs are being trained as mediators for the scheme, alongside other interested parties. Some GP mediators are needed, because of the clinical issues often involved.

1.23 There are three modules in the training program, based on the alternative dispute resolution concept. Training includes information on process, as well as providing hypothetical examples for participants to work through. The training takes into consideration OH&S legislation as well as mandatory accreditation requirements. The focus is on communication skills and the need to assess situations objectively.

1.24 Once systems are in place there will be agreed protocols for responding to complaints that are supported across the industry. If there is common agreement on the protocols, it is the people skills that need to develop- the systems then take care of themselves.

1.25 Also, once systems are in place, there will be a requirement to adhere to them. It will no longer matter whether some practitioners want to do it their own way- they will be required to comply.

1.26 There has to be as much training of staff as there is of GPs. Someone needs to be trained in each participating practice.

1.27 The Health Services Commission is the impartial fourth-tier of complaints handling. If it receives a low-level complaint against a GP, the first step taken by the Commission is to ask the complainant whether or not they have discussed the issue with their GP, and encourages the complainant to endeavour to do that first. The Commission is not involved in mediation.

1.28 A system like the one being piloted can be transferred to other professions. It is an excellent way to enable complaints data to be tracked.

Teleconference

1.29 The pilot was delayed due to the wait for a standardised code to be developed. This coding system has now been developed, and has been agreed on by other MDAs across Australia. Consequently, claims data Australia-wide can be compared.

1.30 The Victorian Department of Human Services are looking at reviewing claims coding (including the system developed for this pilot).

1.31 Historically, it has been hard to extract high quality information from claims data.

1.32 The current pilot will aim to:

- Prevent problems arising
- Deal with problems quickly when they do arise

1.33 The system involves the patient in the process. Most consumers are said to understand that medicine is not an exact science, and will be satisfied if they feel that they are being listened to and their concern is being managed.

1.34 Effective complaints management hinges on understanding dynamics and communication.

1.35 As soon as a practitioner graduates from Registrar, it is presumed that he or she is now an 'expert', and the level of supports decreases.

1.36 An example was given of a particularly good practice involved in the pilot. This practice comprised 13 GPs, and had proven extremely effective at responding to complaints. The Practice Manager made herself available to hear complaints.

1.37 MDAV ran forums at the beginning of the pilot to introduce their risk programs to GPs. The emphasis was that premiums can be contained if claims are reduced.

1.38 Preliminary analyses of claims data for those involved in the pilot are being conducted by an epidemiologist.

1.39 Another advantage of involvement in the program is more pleasant interactions with clients. Having formal communications training assists with interactions with colleagues too.

1.40 Feedback received from GPs and staff to date recognises the value in the training. The main problem raised was the time it takes to implement the techniques taught during training.

1.41 The amount of time required for managing a complaint decreases for long-term patients, as trust has already been established and the practitioner has a history of open communication.

1.42 Good communication can mean the difference between a resolved complaint and litigation. In 50-60% of cases received by the MDAV lawyer, the complainant has said that if the doctor had just told him/her what was going on, they wouldn't be suing.

1.43 A good attitude by GPs to complaints resolution usually flows through to staff. Staff know that they are backed up by the practice manager, and good communication between staff is also promoted.

1.44 Agreement between staff, the practice manager and GPs gives a consistent message to patients (who often receive conflicting information, which can lead to litigation because the client thinks they have been lied to by one party and that they are actually being poorly serviced).

1.45 More open discussion with patients increases patient accountability for their own health.

1.46 A similar risk management strategy has been in place in the legal profession for years (see the Law Institute of Victoria's risk management strategy).

1.47 Communication and complaints management should form part of GP training.

1.48 Consumers also should be made aware of the complaints resolution process.

1.49 The time it takes to become involved is the biggest problem for practitioners. Universities need to be encouraged to commence this training earlier on. Complaints resolution needs to be engendered in medical students from the beginning.

1.50 Practitioners and staff need a process they can feel comfortable with and secure in.

1.51 There has been a real cultural change in the attitudes of the community. Previously, there was a public perception that doctors knew everything. Nowadays, doctors are extremely fearful of litigation.

1.52 We need to ensure that systems are sustainable in the long term.

1.53 The Division now has a pool of mediators. Consumers are usually asked what sort of background they would prefer the mediator to have (i.e. do they want a GP, a lawyer etc). The practice manager can be a mediator in their own right.

1.54 NGO's are also training staff to be mediators for this pool, however complex complaints need medico-legal experts.

Evaluation

1.55 The pilot is being evaluated in steps.

1.56 The initial training program was evaluated, and it was decided it was too long and time consuming.

1.57 The focus groups were also evaluated and revised as a result.

1.58 In rural areas, mediation should occur outside the practice, and the mediator should not be from the area.

1.59 The option is there to draw from a pool of existing mediators in the area, rather than training new ones.

VICTORIAN DEPARTMENT OF HUMAN SERVICES

Present:
Ms Anne-Louise Carlton

Profile of the Organisation

1.60 The Department of Human Services is Victoria's largest state government department, encompassing health, housing, aged care, children and disability services.

1.61 *Health*

- Health care services through the public hospital system, community health services and ambulance services
- Health promotion and protection through emergency management, public health and related preventative services, education and regulation
- A range of alcohol and drug prevention and treatment services

1.62 *Housing*

- A range of accommodation and support services aimed at enhancing the quality of life of people with disabilities
- Accommodation and assistance support for people experiencing homelessness
- Secure, affordable and appropriate housing and support to low income Victorians

1.63 *Aged Care*

- Residential and rehabilitation care for older people, along with support and assistance to enable them to remain independently in their own homes

1.64 *Children*

- A wide range of community services for children and their families, such as kindergartens, early intervention and family support services
- Victoria's statutory responsibilities such as child protection and juvenile justice

1.65 *Disability*

- Services that provide support for Victorians with intellectual, physical, sensory and dual disabilities, neurological impairments and acquired brain injury

Background

1.66 Victoria is leading the way with regards to health practitioner research and regulatory policy, being the first Australian jurisdiction to register practitioners of Traditional Chinese Medicine and progressing investigations into potential regulatory models for other currently unregistered professions.

1.67 Recently, the Department of Human Services commissioned research into a number of areas relevant to the Committee's current inquiries, including best practice self-regulatory models for unregistered professions, Recovered Memory Therapy and risks and regulatory options for practitioners of naturopathy and Western Herbal Medicine.

1.68 The *Health Professions Registration Act* has been passed. This only impacts on unregistered health practitioners at the point where the Victorian Civil and Administrative Tribunal (VCAT) are deregistering someone. VCAT can now stipulate whether or not the practitioner can work in a related field (Section 77 (6)).

1.69 Negative licensing as a regulatory mechanism has merit, however some professions present such a risk to consumers that negative licensing is not sufficient. Generally, these professions are those whose members prescribe scheduled drugs and poisons (captured by the scheduling arrangements).

1.70 There must be a mechanism by which people can be authorised to legally prescribe and dispense restricted drugs (so this is controlled).

1.71 DHS is set to release a research report on the risks, benefits and regulatory requirements for the professions of Naturopathy and Western Herbal Medicine, with public consultation and national consideration through AHMAC.

1.72 On 14 July 2006, COAG announced a national registration scheme for already registered health professions. This will include a system of national accreditation, starting with the nine professions that are currently registered in all states and territories. Those professions that are registered in only some jurisdictions will be assessed against AHMAC criteria.

1.73 DHS has extended an invitation to all heads of state/territory health departments to attend a forum to discuss what could be done to advance Traditional Chinese Medicine (TCM) registration nationally and avoid duplication.

1.74 COAG has proposed that a national registration scheme be in place by July 2008, but has ruled out referral of power to the Commonwealth as the means through which this shall be done. Consequently, the remaining options are either adoption by reference or mirror legislation.

1.75 The complaints and disciplinary functions may remain state-based.

1.76 To date, only the AMA has expressed public opposition to the COAG reforms.

Recovered Memory Therapy

1.77 DHS commissioned research from the Health Services Commissioner into Recovered Memory Therapy. A report was issued last year.

1.78 Ms Carlton provided the Committee with the following summary of the findings:

1.79 The report acknowledges the reality of Child Sexual Abuse (CSA) in our community and the serious damage it causes to those affected. It also acknowledges the pain that family members experience when allegations of CSA are made. The impact of this suffering cannot be underestimated.

1.80 The report accepts that all memory, including continuous and forgotten memories, has the potential for inaccuracy. The available evidence, although indirect, suggests a reasonable foundation for the existence of both phenomena of recovered memories and false memories, with various theoretical explanations for traumatic memories that may be blocked and recovered.

1.81 Recovered memory critics believe there is a variety of memory recovery techniques, for example, hypnosis and dream interpretation, that place patients at an increased risk of suggestibility, and are implicated in the recovery of false memories. The literature review found little research on the incidence of use of such techniques to recover memories.

1.82 There is no agreement on the definition of RMT within the professional community, and no reliable evidence that RMT is being practised in Victoria. The report concluded that the existence of the practice of RMT is largely based on speculation. This is because:

- Submissions from therapists and professional bodies reported there is no recognised psychological therapy known as RMT.
- No practitioners came forward to the Inquiry claiming to practise RMT.
- Most accusers do not disclose how they come to recover memories of CSA. Therefore, those who are accused may assume RMT has taken place, but do not necessarily have evidence that the memories have been forgotten, when they were recovered (ie within or outside of therapy), and if any techniques have been used to assist with the recovery process.
- Some media reports inaccurately report legal cases as involving RMT when a closer reading of the transcripts does not bear this out.
- Some practitioners suggested that the types of therapy of concern, such as the use of suggestion or leading questioning, while a problem 10 years ago, were no longer in common practice.

1.83 There was no consensus amongst therapists about whether traumatic events can be blocked and recovered, whether recovered memories are a literal or symbolic interpretation of past events, the accuracy of recovered memories, the importance of accuracy in therapy, the cognitive process through which memories may be forgotten and whether events before the age of two can be remembered.

1.84 However, it appears that:

- Traumatic experiences can be partially or completely blocked for a period of time, and subsequently recovered.

- It is possible for therapists to create pseudo-memories through inappropriate use of certain techniques. This may be more likely to occur with practitioners who are unregulated, who work in isolation, who lack peer review and professional development and who use inappropriate techniques.

1.85 It was not possible for the HSC to make judgements in individual cases as to whether they involved the practice of RMT, and whether the allegations of CSA arose from genuine or false memories.

1.86 Some therapists submitted that the Inquiry questions the very essence of psychological practice, since many types of therapy involve revisiting childhood experiences and exploration of unconscious thoughts and feelings that may influence behaviour.

1.87 There were concerns expressed in evidence received that poorly trained practitioners may either intentionally or inadvertently be encouraging in patients/clients the generation of false memories of CSA. At issue was not whether a particular therapeutic technique is used, but whether it is used in an ethical and professional manner.

1.88 Respondents to the Inquiry were in broad agreement about what constitutes professional practice. Professional bodies submitted that all persons working with allegations of CSA need to be mindful of the impact of suggestion, their position of authority and their own beliefs on patients. Some professional bodies have developed guidelines that address the issues raised by recovered memory therapy.

1.89 There is little case law in Australia or New Zealand about the admissibility of expert evidence about memory of traumatic events of any kind, and controversy about the dangers of relying on evidence that is therapeutically recovered.

1.90 In relation to third party complaints, practitioners are bound by patient confidentiality and there are only limited circumstances in which they can discuss confidential patient details without the consent of the patient. Therefore, although existing complaints bodies such as the Health Services Commissioner (HSC) and registration boards can accept third party complaints, investigation and evidence gathering is difficult.

1.91 The Health Services Commissioner then made the following recommendations:

- Collaboration between universities, professional bodies and accredited teaching organisations to review the adequacy of training regarding trauma, with a view to ensuring practitioners are being adequately trained.
- Professional bodies (including those for registered and unregistered practitioners) and registration boards which have not established best practice guidelines related to recovered memories do so.
- All unregistered providers of trauma counselling, psychotherapy and hypnotherapy services become members of a suitable professional organisation within their profession.
- The Department of Human Services take a leadership role with professional bodies, registration boards and advocacy groups to conduct a community education campaign aimed at ensuring members of the public have the information needed to choose appropriately qualified practitioners.

- The Office of the Health Services Commissioner continue to monitor concerns expressed by all interested parties about RMT.

Practitioner Code of Conduct

1.92 Essential elements of a generic code of conduct include:

- Sexual misconduct
- Privacy
- Informed consent
- Record-keeping
- Financial exploitation
- Provision of sufficient information to the consumer
- Cooling-off period

1.93 A code of conduct needs to avoid the debate over scientific evidence- focusing instead on the consumer side (the safety of the therapy)

1.94 Consumers and their families need to be taught how to identify a professional taking a 'hard-sell' approach.

1.95 DHS is exploring options to prepare some consumer info for distribution in the context of cancer treatments.

List of Publications

1.96 The delegation received the following materials for reference:

- Communiqué- COAG Meeting, 14 July 2006

VICTORIAN HEALTH SERVICES COMMISSIONER

Present

Ms Beth Wilson, Commissioner
Ms Lynn Buchanan
Mr Michael McDonald

Profile of the Organisation

1.97 The Victorian Health Services Commission is the equivalent of the NSW HCCC, however the Victorian Commission does not investigate nor prosecute complaints, focusing instead on conciliation and assisted resolution.

1.98 The functions of the Commission, under the *Health Services (Conciliation and Review) (Amendment) Act 2001* are as follows:

(a) to investigate complaints relating to health services;

(b) to review and to identify the causes of complaints, and to suggest ways of removing and minimizing those causes;

(c) to investigate any matter referred to the Commissioner by either House of Parliament or by any Committee of either House or both Houses;

(d) to conciliate between users and providers where a complaint has been made;

(e) to consider ways of improving health complaints systems;

(f) to provide advice to the Health Services Review Council;

(fa) to refer issues to the Council for advice;

(g) to take steps to bring to the notice of users and providers details of complaints procedures under this Act;

(h) to develop programmes for the training of health complaints officers and others in the handling of complaints;

(i) to record all complaints received by the Commissioner and to maintain a central register of such complaints and all complaints shown on returns supplied by providers;

Background

1.99 The Victorian Health Services Commission has been involved in a number of initiatives that relate to the Committee's current inquiries.

1.100 The Health Services Review Committee, located within the Commission, was recently responsible for developing a *Guide to Better Complaints Handling*, focusing on best practice complaints handling for health service providers, which included training component.

1.101 The Commission also contributed to the development of the database for recording consumer complaints that formed part of the CALM project.

1.102 Regulation of health professionals is not simple, largely due to National Competition Policy and problems with definition of a health service.

1.103 GP's often have patients not disclosing other medication being taken (i.e. alternative medicine).

1.104 Bigger practices are more effective at complaints resolution. Older staff are also less likely to encourage complaints.

Guide to Better Complaints Handling

1.105 The core group targeted by the Guide was public hospitals, however private hospitals and practices would also benefit from consultation with the Guide.

1.106 Victoria has approximately 150 patient representatives in public hospitals.

1.107 Research in the UK National Health Service (NHS) showed the need for impartiality in complaints handling within health services.

1.108 It is good to have a tracking system to identify trends and large numbers of complaints against individual practitioners.

1.109 Three hospitals (2 metro and 1 country) were involved in the pilot of the Guide.

1.110 A training kit (which is different to the training originally piloted) has now been developed.

1.111 In terms of evaluation, it is difficult to evaluate a sustained quality change (i.e. measuring lasting impacts of training and other interventions).

1.112 The Victorian Health Services Commission is hosting a complaints handling conference on the 15th, 16th and 17th of November 2006.

List of Publications

1.113 The delegation received the following materials for reference:

- Annual Report- Office of the Health Service Commissioner (2005)
- Guide to Complaint Handling in Health Care Services (2005)
- Australian Council for Safety and Quality in Health Care- Better Practice Guidelines on Complaints Management for Health Care Services (July 2004)
- Australian Council for Safety and Quality in Health Care- Complaints Management Handbook for HealthCare Services (July 2005)

PSYCHOTHERAPY AND COUNSELLING ASSOCIATION OF AUSTRALIA

Present:
Mr Milan Poropat, Director

Profile of the Organisation

1.114 The Psychotherapy & Counselling Federation of Australia (PACFA) is an umbrella association comprising affiliated professional associations representing various modalities within the disciplines of Psychotherapy and Counselling in the Australian community.

1.115 PACFA has three main objectives:

- Objective One: To establish recognised standards of training;
- Objective Two: To develop professional accountability and public protection;
- Objective Three: To regulate therapeutic practice.

1.116 Individuals cannot join PACFA - it is an "association of associations". Individuals need to join a PACFA Member Association in order to demonstrate that they meet the professional standards required in the field. Background

1.117 As the peak umbrella association for the professional associations of many unregistered professions in the field of psychotherapy and counselling, the Committee sought the view of PACFA regarding potential changes to the regulation of these practitioners.

1.118 PACFA has also been commissioned by the Victorian Department of Human Services to investigate and report on best practice self-regulatory models for the unregistered health professions.

Notes of Meeting

1.119 PACFA has brought numerous associations together and provided guidelines for governance. Once a member of PACFA, they are bound by the constitution of PACFA.

1.120 There are currently 42 associations under PACFA.

1.121 PACFA was created in an attempt to have some uniformity between associations.

1.122 At present, there are around 3000 members of PACFA who meet the minimum standard for training or experience. Of these about 350 are on the National Register (which requires a higher standard).

1.123 PACFA is working towards having all members achieve the higher standard from 2009, with a revised ethical practice code and good governance code.

1.124 Generic registration would be difficult if they were at all specific. For example, in some therapies, touch is an extremely appropriate method of delivery. This is obviously not the case for most therapies.

1.125 Any generic registration would need to accommodate specific methods and content.

1.126 Outside registration, you rely on the goodwill of the practitioner to behave ethically. The vast majority of practitioners are good people. It is a very small minority that give others a bad name.

1.127 Belonging to an association shows that they want some form of accountability.

1.128 Consumers themselves need to be well educated and informed.

1.129 Information on complaints processes needs to be provided routinely by practitioners.

1.130 In general, associations are supportive of negative licensing.

1.131 If Governments are disinclined to register these professions, they need to strengthen self-regulation.

1.132 Associations have very little authority to prevent someone practicing in a field they are not trained in. This would only come to PACFA's attention if there were a complaint.

1.133 PACFA's approach is usually to tackle the issue from a positive angle, appealing to the practitioner's own ethical standards. PACFA can than emphasise the need for professional supervision.

1.134 There is no routine monitoring of practitioners.

1.135 Since 2003 PACFA has received only 8 complaints.

1.136 People are becoming more aware that complaints can be made, however this needs improvement. More education of consumers is needed.

1.137 Often, it is difficult for practitioners to tell upfront what skills will be needed for a particular client, so they need to know when to refer a client on.

1.138 There is no formal requirement for a practitioner to display qualifications or provide information on experience.

Negative Licensing

1.139 There are no disadvantages at all with negative licensing.

1.140 A list of those who have been reprimanded under the system would be needed to enable associations to check for disciplinary action.

1.141 Professional associations can be assets to the Government- helping to enforce negative licensing. Practitioners generally know others within their field, so they would know if somebody is practicing unlawfully.

1.142 It would be helpful if, once a year or so a larger meeting was held between professional associations and the health care complaint handling bodies in each state and territory.

Differences Between Therapies

1.143 For the average consumer, it is difficult to differentiate between therapies.

1.144 Often, they have received a referral from a GP. A lot of well-educated GPs recognise that other problems often underlie medical conditions- and that without treating those problems medication will either not work or will have limited effect.

1.145 Different modalities tend to be relatively equally effective. The nature of the relationship between practitioner and client is the key to success.

1.146 PACFA receives approximately 4-5 inquiries a week asking for a referral.

Registration

1.147 Government intervention is required when risks are involved. Government involvement is reassuring to the consumer.

1.148 Consumers like to know that someone independent can come in to assist if something is wrong.

Chapter Two - Adelaide

SOUTH AUSTRALIAN HEALTH AND COMMUNITY SERVICES COMMISSION

Present
Ms Leena Sudano, Commissioner

Profile of the Organisation

2.1 The office of the Health and Community Services Complaints Commissioner

- Was established by the *Health and Community Services Complaints Act 2004* proclaimed on 3 October 2005;
- Helps people resolve complaints about health and community services, including child protection services, when a direct approach to the service provider is either unreasonable, or has not succeeded;
- Covers health and community services across the public, private and non-government sectors;
- Handles complaints confidentially and impartially;
- Monitors and reports complaint trends;
- Makes recommendations to improve safety and quality;
- Is an independent statutory office.

Background

2.2 The first SA Health and Community Services Commissioner was appointed in 2005.

2.3 The Committee was interested in taking the opportunity to meet the new Commissioner, and to learn about the directions the new Commissioner intended to take with the Commission.

Notes of Meeting

2.4 South Australia's enabling legislation for the Health and Community Services Commission purports that three main avenues are available to consumers looking to make a complaint about a health service:

- Steps taken with the provider
- Health and Community Services Commission
- Ombudsman

2.5 The Commissioner is meeting with the Cancer Council to discuss what can be done with regards to the exploitation of terminally ill persons by rogue health practitioners.

2.6 There is currently an Australian best practice guide to complaints handling (Turning Wrongs into Rights), which has recently been superseded by an international standard.

2.7 Some of the main problems with the adoption of these standards have been:

- No executive engagement with the policy and procedure

- Almost no training of frontline staff

2.8 Effective complaints monitoring enables the identification of what the 'frequent flyer' issues are (the trends in complaints).

2.9 Around 75-80% of the work of the SA Commission is with regards to low-level complaints.

2.10 The Commission currently aims to:

- Acknowledge a complaint within 2 days
- Identify the providers in 10 days
- Resolve the complaint within 6 weeks (including conciliation)

2.11 The Commission has started to cut back on the types of complaints that are accepted, as it has employed numerous measures to help health facilities resolve their own low-level complaints. Consequently, at the end of this year the Commission is going to begin refusing some lower-level complaints that do not meet the required level of complexity to be handled by the Commission.

2.12 In Queensland, the Director of Nursing of one health facility surveyed all staff about their knowledge of and attitudes towards complaints handling:

- 90% of those surveyed said complaints handling was important
- Only 40% had had any sort of training in complaints handling
- Consequently, training was developed based on the Commonwealth best practice guidelines (Turning Wrongs into Rights).

2.13 It has been found that tracking complaints is extremely important for a number of reasons. For example, whilst the number of consumer complaints against one practitioner may be minimal, if these are compared with staff complaints against that same individual, a larger picture of bullying and/or harassment can be established. Alone, neither of these issues would have been considered significant, but together a significant problem emerges.

List of Publications

2.14 The delegation received the following material for reference:

- Health and Community Services Complaints Commissioner- Responding to Complaints About Health or Community Services: A Guide for Providers
- Health and Community Services Commissioner- Making a complaint about a Health or Community Service Provider: A Guide for Consumers

PROFESSOR ALASTAIR MACLENNAN, UNIVERSITY OF ADELAIDE

Present:
Professor Alastair MacLennan

Background

2.15 Professor Alastair MacLennan is a professor of obstetrics and gynaecology at the University of Adelaide. He has a special interest in complementary medicine epidemiology and the safety of complementary medicines

2.16 Professor MacLennan was a member of the Australian Government's Expert Committee on Complementary Medicines in the Australian Health System.

2.17 As a basis, Professor MacLennan believes that that the following should not be treated by unregistered health practitioners:

- Life-threatening diseases
- Pregnant women
- Children
- People who are unable to give informed consent

2.18 Unregistered health practitioners should also not be permitted to:

- Perform invasive treatment (anything surgical)
- Pass themselves as a qualified medical practitioner

2.19 When offering treatment, practitioners should explain efficacy, risks or side effects and costs.

2.20 Unregistered practitioners should also be insured, particularly if they are not going to inform someone of risks.

2.21 Only around 1 in 100 members of the general public understand the difference between registration and listing with the Therapeutic Goods Administration.

2.22 The priority for registration should be anything that requires medicine or manipulation.

2.23 Another danger of unregistered health practitioners is that the information that they can give to consumers may be misleading or incorrect.

2.24 Complementary and alternative medicines costs around $2 billion a year.

2.25 Queensland has recently conducted a telephone survey that has estimated the cost of complementary and alternative medicine at $4 billion per year. Two thirds was medicinal costs, one third was practitioner costs.

2.26 There is very week evidence for the traditional use of complementary and alternative therapies. There is a very high rate of adulteration of the products.

2.27 An increasing number of GPs are involved in the provision of complementary and alternative medicines and therapies.

2.28 Sometimes, GPs are not sufficiently trained in the alternative therapy they are providing. In this instance, accessing such therapies through this registered professional is more risky.

2.29 However, on the other hand, alternative practitioners may be treating things they shouldn't be treating, and GPs would be better placed than many alternative practitioners to identify these situations.

2.30 The issue needs to be considered that some medications that may not have established efficacy but are not harmful, they may offer the same benefit to consumers as a placebo (e.g. hope and temporary comfort).

2.31 The public needs to be informed about complementary and alternative products. The public want to have information to enable them to make informed choices about their own health care.

2.32 On the whole, consumers are currently very naïve about the degree of testing undertaken on health products. Consumers are also bad at telling doctors about their alternative medicine use.

2.33 Unregulated advertising is also a major problem, as consumers are often given access to advertising before they have access to information.

List of Publications

2.34 The Committee received the following publications for reference:

- MacLennan, A. H., Wilson, D. H., and Taylor, A. W. (1996). *Prevalence and cost of alternative medicine in Australia*. Lancet, 347, 569-73.
- MacLennan, A. H., Wilson, D. H., and Taylor, A. W. (2002). *The escalating cost and prevalence of alternative medicine*. Preventive Medicine, 35, 166-173.
- MacLennan, A. H., Myers, S. P., and Taylor, A. W. (2004). *The continuing use of complementary and alternative medicine in South Australia: costs and beliefs in 2004*. MJA, 184 (1), 27-31.
- MacLennan, A. H., and Sturdee, D. W. (2006). *The 'bioidentical/bioequivalent' hormone scam*. Climacteric, 9, 1-3.

Appendix – Itinerary

Tuesday 8 August

Meeting with the Central Highlands Division of General Practice
Level 1, 33 Brantome St, Gisborne

Wednesday 9 August

Meeting with the Victorian Department of Human Services
Level 20, 50 Lonsdale St, Melbourne

Meeting with the Victorian Health Services Commissioner
30th Floor, 570 Bourke Street, Melbourne

Meeting with the Psychotherapy and Counselling Federation of Australia
290 Park St, North Fitzroy

Thursday 10 August

Meeting with the Health and Community Services Complaints Commissioner
Level 4 East, 50 Grenfell St, Adelaide

Meeting with Professor Alastair MacLennan, Department of Obstetrics and Gynaecology, University of Adelaide
Level 1, Queen Victoria Building, Women's and Children's Hospital
72 King William Road, North Adelaide

Friday 11 August

Meeting with Katherine O'Neill, Deputy Commissioner, Legal and Policy Division, SA Office of Consumer and Business Affairs
Board Room, Level 2, 91-97 Grenfell St, Chesser House, Adelaide