



PARLIAMENT OF NEW SOUTH WALES

Report of the
**COMMITTEE ON THE HEALTH CARE
COMPLAINTS COMMISSION**

*Seeking Closure: improving conciliation of
health care complaints in New South Wales*

April, 2002

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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

COMMITTEE MEMBERSHIP

Legislative Assembly

Mr Jeff Hunter MP - Chairman
Ms Marie Andrews MP – Vice-Chairman
Mr Wayne D Smith MP
Mr Peter W Webb MP

Legislative Council

The Hon Dr Brian Pezzutti, RFD, MLC
The Hon Henry Tsang OAM, MLC
The Hon Dr Peter Wong AM, MLC

Secretariat

Ms Catherine Watson – Committee Manager
Ms. Jackie Ohlin – Project Officer
Mr Keith Ferguson – Committee Officer
Ms Glendora Magno – Asst. Committee Officer

Terms of Reference of the Inquiry

To inquire into and report back to Parliament on:

- (a) the effectiveness and efficiency of the Health Care Complaints Commission and the Health Conciliation Registry within the current legislative and administrative regime governing conciliation;
- (b) the effectiveness and efficiency of conciliation done at the local level by health providers;
- (c) the effectiveness of the Patient Support Office in assisting the local conciliation process;
- (d) client satisfaction with the current conciliation process;
- (e) conciliation schemes in similar agencies and comparative jurisdictions;
- (f) any other related issues.

CHAIRMAN'S FOREWORD

In New South Wales, health care complaints deemed suitable for conciliation by the Health Care Complaints Commission are referred to the Health Conciliation Registry. The Health Conciliation Registry is a statutory body within the NSW Department of Health, which, on receipt of the complaint for conciliation from the Health Care Complaints Commission deals directly with the parties concerned.

Conciliation of health care complaints in New South Wales has been predominantly a formally structured process led by an independent person, to allow two parties the opportunity to identify and discuss issues between them, with the aim of resolution. The model used by the Health Conciliation Registry is effectively a mediation model, widely practiced in this and other jurisdictions.

Alternative dispute resolution in the form of conciliation and mediation attempts to bring closure to patients by providing a forum where complainants and the respondents (the person who is the subject of the complaint) can be brought face to face to discuss key issues and hopefully achieve some sort of resolution.

Rising levels of medical negligence litigation in New South Wales, and the associated costs have been a concern for providers, practitioners and their insurers for some time. A recent Supreme Court award of over \$14m to a woman brain damaged during her delivery 24 years ago highlighted this issue. Last year the New South Wales Minister for Health introduced a medical negligence tort reform package to attempt to reduce the escalation of costs in this area. Towards the end of 2001 the Minister also announced that the State would cover insurance for Visiting Medical Officers (VMO's) in public hospitals.

The Committee believes that the Health Conciliation Registry could play an important role in helping to rein in the increase of medical negligence litigation and therefore the associated costs for providers, practitioners and taxpayers.

While it has to be acknowledged that there are many medical negligence matters which will ultimately always end up in the legal system, studies have shown that there are also many people who use litigation as a last resort. This is after they have felt frustrated seeking explanations, apologies and assurances that the mistake will not be repeated by the practitioner and agencies involved.

This indicates that conciliation can play an important part in stemming some of the flow of statements of claim currently being filed in our court system. Conciliation and mediation offer an important forum in which to bring parties together to address complainants' concerns by clarifying key issues in a way that the court system cannot.

As the report discusses, most other states of Australia have used their health complaints agencies as a vehicle for settling medical negligence matters. These sometimes involve large compensation payments.

While with the establishment of the Health Care Complaints Commission in 1994 we have a different framework of complaint handling in New South Wales the Committee sees no impediment to the New South Wales Conciliation Registry attempting similar types of settlements as undertaken in other States. This the Committee believe could be done on a case by case basis in conjunction with United Medical Protection or the Treasury Managed Fund. The Committee discussed the matter with United Medical Protection during the course of its inquiry and received assurances that the organisation was more than willing to participate in any trial programs. Recommendation 16 of this report specifically addresses this issue.

In the course of this Inquiry, the Committee has surveyed parties to recent conciliation registry processes, to seek their views on the value, to them, of these processes. The Committee has also received submissions from agencies and individuals involved in conciliation. Based on this information it would be fair to say that the Conciliation Registry has not reached its full potential to date.

The results of the Committee's survey of respondents and complainants strongly shows that a large percentage of complainants, in particular, have been unhappy with the process. The Committee was not ultimately of the view that a major framework overhaul was needed but rather that the existing system just required some internal and external modification to make it more effective.

What the system has most lacked since its inception has been accountability and transparency. The Registry has been somewhat isolated due to its position within the Department of Health structure and the fact that it sits outside the Health Care Complaints Commission. Without proper external scrutiny and feedback the Registry has found it difficult to significantly improve its operations because it has been unable to ascertain where its strengths and weaknesses lie. The Committee has made a number a key recommendations to improve both external reporting and gathering of client feedback.

The Committee understands that the vast majority of health care complaints are resolved at the local level by hospitals and area health services. The Committee would like to see the Registry playing a stronger educative role at this level, assisting with training programs in the same way the Health Care Complaints Commission provides training in investigations at the local level.

While the Committee did initially include conciliation done at the local level within the terms of reference of its inquiry, the topic is really large enough to be the subject of a future inquiry on its own. The focus of this inquiry has therefore been on the Conciliation Registry where it increasingly became clear that there were significant improvements to be gained. The Committee has the intention to revisit the area of localised complaint handling at a future date.

The Committee is conscious that there are many legislative and procedural factors that constrain the current conciliation process. Further, conciliation is no Magic Pill for the resolution of difficult and outstanding issues between parties in the area of health care complaints. The Committee recognises the multiple motivations, emotions and responsibilities involved in bringing and responding to a complaint. The conciliation process, itself, is but one method of alternative dispute resolution which could have effect for respective parties. The Committee wishes to ensure a system that is flexible and responsive to the needs of parties in resolving a complaint, but at the same time ensuring a public system that is robust and accountable.

I would like to thank all those individuals and agencies who submitted to this Inquiry. In particular I wish to acknowledge the time given to the committee by the former Health Conciliation Registrar Ms Albertje Gurley. The invaluable evidence provided by Ms Gurley assisted the Committee in better understanding the history of the Registry, its functions and the legislative constraints that have hindered its operations. The Committee wishes Ms Gurley, who left the Registry towards the end of the inquiry, all the best in her future endeavours.

In addition my thanks go to the newly appointed Conciliation Registrar Sharlene Wiebenga for her assistance. The Committee members look forward to liaising with her during the implementation of recommendations of this report. Also the contribution to the inquiry by the Health Care Complaints Commissioner Amanda Adrian and her staff is greatly appreciated by the Committee.

In conclusion I would also like to thank my fellow Committee Members and the Committee Secretariat for their hard work during the course of the inquiry and the preparation of the report.

Jeff Hunter MP
Chairman

Summary of Key Issues

This report addresses issues arising from the processes used for the conciliation of complaints received by the New South Wales Health Care Complaints Commission.

The report examines the basis of the mediation model used by the NSW Health Conciliation Registry. It refers to models used in other States and Territories, and it describes how the current New South Wales conciliation process works.

The report provides details of a survey conducted by the Committee of over 300 complainants/patients and respondents (ie *respondents* to a complaint) who had participated in the Health Conciliation Registry during the past three years. It identified that key issues for respondents were:

- general satisfaction with information provided prior to the conciliation conference
- general satisfaction with the fairness of the process
- dissatisfaction with the knowledge the conciliator had of the health system, health issues and their particular matters
- dissatisfaction with the conciliated outcome, with the particular concern expressed by some that complainants were only concerned with a cash settlement.

Key issues for complainants included:

- general satisfaction with the information provided prior to the conciliation conference
- general satisfaction with the conciliator's handling of the process
- some dissatisfaction with the process of referral for conciliation, with some complainants feeling under duress to comply
- dissatisfaction with the fairness of the conciliation process, with feelings of intimidation, partiality and confusion commonly mentioned
- dissatisfaction with the final outcome, including a feeling for some complainants that they were pressured into an outcome and/or that the written outcomes of the conciliation did not reflect the discussion.

The lack of satisfaction among complainants, the perception of a power imbalance and the degree of unhappiness with agreed outcomes are highlighted as issues of concern, particularly when the survey results are contrasted with the high percentage of respondents who considered the process fair and the outcome satisfactory.

The Committee recommended the need for the Health Conciliation Registry to remain separate from the Health Care Complaints Commission, in order to establish the perception and the fact of independence. The Committee recommends amending the *Health Care Complaints Act* (1993) to nominate the Registry, and not the Commission, as the body which seeks the consent of parties to a conciliation would help to reinforce understanding of the Registry's role, and its independence.

The Committee recommends that the Health Conciliation Registry play a greater educative role in health care complaint alternative dispute resolution at the local area health service level.

In relation to transparency and accountability, the Committee recommended that the Registry should prepare an annual report. It further identified the need, when seeking quality assurance feedback from clients, for this to be undertaken by an external agency, in order for objectivity to be maintained, and proposed that this information be included in the annual report.

Similarly, this quality assurance, and other analytical information should be provided to the Health Care Complaints Commission and to the relevant Registration Boards, to enable them to use the information to bring about further improvements to practice.

The Committee found that conciliation, and not the mediation processes which have to date been employed by the Registry, should be the primary method of resolving complaints. It found that there is merit in working with other bodies to trial dispute resolution settlements that involve financial settlements and independent medical expert review/advice. These processes would alleviate the hopelessness felt by some parties that the particular brand of mediation they were offered was a dead-end option.

The Committee has proposed recommendations to address the selection process and professional development of both the Registrar and conciliators, to ensure broadening of skills and experience. The Committee was persuaded that it was important to identify the need for conciliator recruitment to be extended to include regional areas of the State. This would help to pave the way for future conciliation conferences to be conducted in regional areas.

The Committee recommends a change to the *Health Care Complaints Act* (1993) to define the categories of people who would qualify as a 'support person' and the extent of their involvement in the conciliation process. This was considered important for those complainants affected by the genuine power imbalance and trepidation upon entering into conciliation. It was also seen as important to cement ongoing satisfaction with any agreement reached.

The Committee understands that the Patient Support Officers could perform a valuable role as advocates for patients at the local level. Evidence received suggested that the officers need a more clearly defined role with closer supervision by the Commission. The Committee recommends that enhanced statement of roles and responsibilities be developed for the Patient Support Officer and the performance review process be enhanced, including improved consultation with Area Health Services.

Summary of Recommendations

The Report includes the following recommendations:

Recommendation 1:

That Section 24 of the Health Care Complaints Act (1993) be amended to nominate the Registry, not the Commission, as the body which seeks parties' consents to conciliation.

Recommendation 2:

That the Health Conciliation Registry provide to parties, prior to the conciliation conference, information outlining the process; the qualifications and background of the conciliator; and, an explanation of the reason for referral of the case to conciliation.

Recommendation 3:

That the Health Conciliation Registry play a greater educational role in health care complaint alternative dispute resolution at the local area health service level.

Recommendation 4:

That the Registry actively promote itself to health practitioners and providers as a complaint resolution tool.

Recommendation 5:

That the HCCC create a more streamlined path for health providers to refer matters from the local level to the Registry through the HCCC.

Recommendation 6:

That the Registry be legislatively required to report separately within the NSW Department of Health Annual Report. This should include financial statements and performance information.

Recommendation 7:

That the Registry employ the services of an appropriate external agency to collect feedback from clients on a regular basis for quality assurance purposes and that this be included in the Registry's annual report.

Recommendation 8:

That Sections 53 (2) and 55 (1) of the Health Care Complaints Act be amended to require the Health Conciliation Registry, on a confidential basis, to provide the HCCC and relevant Registration Boards with more detailed information concerning outcomes of conciliation and issues covered.

Recommendation 9:

That the Registry and the Commission meet at least on a fortnightly basis for consultation purposes to discuss cases which have been identified as suitable for referral to the Registry.

Recommendation 10:

That Section 24 of the Health Care Complaints Act be either amended or deleted to allow the Commission to refer complaints, or parts of complaints, to conciliation at any stage during its handling of the complaint and that the Health Care Complaints Act be amended to provide for the splitting of a complaint enabling conciliation and investigations to continue concurrently.

Recommendation 11:

That an enhanced statement of roles and responsibilities be developed for Patient Support Officer, including a code of conduct.

Recommendation 12:

That the performance review process for Patient Support Officers be enhanced, and include improved consultation with Area Health Services regarding the performance of Patient Support Officers.

Recommendation 13:

That the capacity for direct feedback from the Commission to Area Health Services be further developed, to expedite and enhance complaint handling procedures.

Recommendation 14:

That conciliation, not mediation, should be the primary method of resolving complaints employed by the Health Conciliation Registry.

Recommendation 15:

That recommendation 14 not however preclude the Health Conciliation Registry employing a wide range of dispute resolution processes on a case by case basis.

Recommendation 16:

That the Health Conciliation Registry consult with United Medical Protection Society with a view to trialing dispute resolution conferences which may involve financial settlements and independent medical expert review or advice.

Recommendation 17:

That new selection criteria and a position description be developed for the Health Conciliation Registrar, addressing the need for medico-legal training, alongside other required qualities and duties as identified in this report.

Recommendation 18:

That the selection process for the Health Conciliation Registrar be formalised, to include a panel comprising at least the Health Care Complaints Commissioner and a relevant officer from the Department of Health.

Recommendation 19:

That the Health Conciliation Registrar develop both formal and informal linkages with similar authorities in other States/Territories and with other bodies coordinating public alternate dispute resolution processes within New South Wales, in order to address professional development and issues of common concern.

Recommendation 20:

That an effective and ongoing training program be developed for conciliators, and that this should include components of specialised training, in order to allow conciliators to gain advanced skills.

Recommendation 21:

That the recruitment of conciliators be publicly canvassed, including through advertisement and through the networks of relevant community-based organisations.

Recommendation 22:

That a selection panel for conciliators for the Health Conciliation Registry comprise the Registrar, a representative of the Health Care Complaints Commission, a health services provider representative, and a representative(s) of relevant community organisations.

Recommendation 23:

That the flexible approach of engaging conciliators on an hourly basis be maintained, and that a process for including increased rates for conciliators with advanced skills be examined.

Recommendation 24:

That conciliators be subject to regular performance review which is conditional on their reappointment.

Recommendation 25:

That either the Registrar or the relevant individual conciliator have at least one separate face to face meeting with respective parties prior to the conciliation conference to discuss key issues and outline the process.

Recommendation 26:

That the Health Conciliation Registry brief the relevant conciliator on the particulars of each case, prior to the conciliation meeting.

Recommendation 27:

That the Health Care Complaints Act be amended to define categories of people who qualify as a “support person” and the extent of their involvement in the conciliation process.

Recommendation 28:

That complainants be allowed to be accompanied to conciliation by a person or persons who fall within the legislative definition of “support person” as a matter of right.

Recommendation 29:

That respondents be allowed to be accompanied to conciliation conferences by a support person with the agreement of the Registrar and the complainant.

Recommendation 30:

That conciliator recruitment be extended to include regional areas of the State, both through canvassing suitable candidates living in regional areas and through those individuals prepared to travel to regional areas to undertake conciliation meetings.

Chapter 1: The Current Conciliation Process

Introduction

The *Health Care Complaints Act 1993* provides the framework within which conciliation of complaints received by the Health Care Complaints Commission can occur. Effectively, the model which applies is a classic mediation model, where a neutral third party establishes the ‘ground rules of engagement’ which enable two parties to discuss their differences, and the terms (if any) of agreement in relation to resolution of a complaint. There are, however, limitations to the process. The roles of the registrar and conciliators are outlined in the Act, and these roles have been strictly interpreted. Conciliation, as it is defined in the Act, is currently the only method of dispute resolution officially sanctioned in the health care complaints process, for complaints received by the HCCC. While parties might benefit from alternative approaches, the conciliation process may be seen by them as the ‘end of the line’ for their complaint. In turn, this can result in resentment or powerlessness, and an unsatisfactory process.

What is Alternative Dispute Resolution?

Alternative Dispute Resolution encompasses a range of approaches, including mediation, conciliation and arbitration – all processes designed to seek less formal means of resolution of disputes, and to attempt to contain the costs of matters proceeding through the formal court system. Alternative dispute resolution services are used extensively at local, State and national levels, in various jurisdictions, to help resolve matters for example, from neighbourhood disputes, to victim-offender discussions, to industrial disputes. The National Alternative Dispute Resolution Advisory Council, established in 1995, has developed definitions of the different types of Alternative Dispute Resolution, to try and bring consistency of understanding to the terminology used.

Definitions relevant to the Health Care conciliation process include:

Mediation is a process in which the parties to a dispute, with the assistance of a neutral third party (the mediator), identify the disputed issues, develop options, consider alternatives and endeavour to reach an agreement. The mediator has no advisory or determinative role in regard to the content of the dispute or the outcome of its resolution, but may advise on or determine the process of mediation whereby resolution is attempted.

Conciliation is a process in which the parties to a dispute, with the assistance of a neutral third party (the conciliator), identify the disputed issues, develop options, consider alternatives and endeavour to reach an agreement. The conciliator may have an advisory role on the content of the dispute or the outcome of its resolution, but not a determinative role. The conciliator may advise on or determine the process of conciliation whereby

resolution is attempted, and may make suggestions for terms of settlement, give expert advice on likely settlement terms, and may actively encourage the participants to reach an agreement.

(National Alternative Dispute Resolution Advisory Council, *Alternative Dispute Resolution Definitions*, Canberra, March 1997, pps 6,7).

As defined, the alternative dispute resolution process used by the New South Wales Health Conciliation Registry is most accurately described as ‘mediation’.

Why Have Alternative Dispute Resolution?

As indicated by the National Alternative Dispute Resolution Advisory Council, there is a twofold interest in seeking a less formal means of dispute resolution and in containing the costs of the formal court system.

In the context of Health Care complaints in New South Wales, it should be noted that somewhere in the order of 80% of complaints received by the HCCC involve communications issues. Given this, there are strong grounds, at an individual level, to seek to employ alternative dispute resolution models – that is, these processes which employ communications methodologies, can help to facilitate understanding of the disputed issues, and bring closure to the matter for respective parties. There are clear advantages to the parties in terms of cost and personal stress if dispute resolution can be achieved less formally.

Government and insurers alike are concerned about the impact on the increase in litigation arising from complaints. In meetings with the Committee, Richard Tjong, previous CEO of United Medical Protection warned about the rise in medical litigation. He noted that in the current year (1999), his organisation had logged 2000 incident reports, with civil claims in the order of 400 to 500.

The NSW Minister for Health, too, has indicated concern about the increasing size of claims. This led to the introduction of the *Health Care Liability Act* (2001). In his Second Reading speech on the Bill, the Minister noted the need for a legislative reform package for compensable personal injuries claims arising from the provision of hospital and medical care. He attributed the need to “escalating medical premiums”.

This has been caused by a number of factors: the increasing size of medical negligence claims, particularly the larger claims; the need for some medical indemnity organisations to build reserves to meet unfunded liabilities incurred in past years but not yet reported as claims; and the development of the practice within the medical indemnity industry of risk rating by specialty groups and consequently the setting of differential premiums based upon those ratings.

Conciliation Processes in Other States/Territories

Jurisdictions in other States/Territories of Australia have established agencies to specifically undertake conciliations rather than investigations and prosecutions as is done in New South Wales.

Thus, in all States and Territories, provision is made for conciliation of disputes between consumers and providers of health care services. The conciliation function is performed by a person authorised, and their role is independent of other functions under the respective Acts. In South Australia, the Ombudsman's office convenes and chairs the conciliation process.

The function of conciliators in all jurisdictions is to arrange for informal discussions between the consumer and provider, assist in the conduct of those discussions, and, if possible, assist parties to reach an agreement.

In Queensland, the Northern Territory and Tasmania, provision is made for recognising public interest matters that have been referred for conciliation. As a result, before the conciliation, the Commissioner needs to inform the conciliator of any issue raised by the complaint that the Commissioner believes might involve a matter of public interest. The conciliator must, in turn, draw this to the attention of parties at the commencement of the conciliation process, and at other times as required. Further, if the Commissioner has not already identified such issues, the conciliator must draw such public interest matters to the attention of the Commissioner.

In all jurisdictions, except Victoria, Queensland and South Australia, provision is made for addressing whether representation at conciliation is permitted. (Note, the New South Wales Act states explicitly that no party is entitled to be *legally* represented). Queensland and Victoria specifically allow the involvement of support persons (as distinct from 'representatives'). In the Northern Territory, Australian Capital Territory, Tasmania and Western Australia, representatives may only be appointed with the permission of the Commissioner, and then only if a party can demonstrate that their presence and knowledge will facilitate the conciliation process. Further, in the Northern Territory and Tasmania, the party seeking representation must give the other party at least 48 hours notice of their intention to have representation at conciliation.

In all jurisdictions, what is said in conciliation is confidential and cannot be used by the Commissioner to take further action under the Act or before any court, tribunal or body. (The New South Wales Act goes further, to state that any document prepared for the purpose of, or during the course of conciliation is not admissible in a court, tribunal or body, unless the parties consent). The Queensland Act states that such information cannot be used to enforce an agreement reached by the parties at conciliation.

Although information obtained from conciliation in the Northern Territory is not admissible in any court, body or tribunal, prosecution of a person for offences under that Act may still occur. The Act also provides for penalties for the disclosure of information obtained during the conciliation process, by a conciliator, mentor or any other person..

This provision also features in the Australian Capital Territory, while Tasmania specifies that only conciliators are not permitted to disclose such information at any further conciliation, to any person appointed, engaged or employed under that Act. The Victorian Act specifies that a person who hold a position for the

purposes of the Act must not disclose any confidential information obtained, on pain of penalty. A further provision along similar lines is included for conciliators.

All Acts make reference to agreements reached during conciliation, although South Australia is not specific in this regard. The variation between jurisdictions arises mainly in relation to the level of formality or particulars required for an agreement. For example, Victoria and Western Australia do not specify any content in this regard (New South Wales is similar). The Queensland Act states that parties can enter into a contract of settlement. The Northern Territory, Australian Capital Territory and Tasmania note that any agreement reached must be in a form that is binding upon parties.

Conciliators in all jurisdictions are required to prepare a report upon completion of the conciliation process. In Queensland, the Northern Territory, Australian Capital Territory and Tasmania, reference is made to professional mentors who have expertise in dispute resolution, who can advise conciliators.

The time taken to complete a conciliation can also vary markedly. In contrast with New South Wales, where conciliations are usually completed at one meeting, conciliation in Queensland may take between two months and two years, depending on the complexity of the situation, and the need for meetings with respective parties, coordinated by the conciliator.

Some jurisdictions (for example, Victoria) require two conciliators to attend sessions. Co-conciliation (ie having two complaints handlers present) is often considered to be an important part of establishing impartiality.

Statistically, Victoria and New South Wales complete similar numbers of conciliation cases as a component of all complaints closed, while Queensland perform a much high number of conciliations.

*Conciliation completed
1999/2000*

	No (% of all complts. closed)	Staff		Total Budget of Organisations .
		Total	Conciliation staff only	
Victoria <i>Health Services Commission</i>	67 (3%)	17	3	0.9 million
Queensland <i>Human Rights Commission</i>	163 (9.5%)	26	4	1.3
NSW – 2 bodies <i>Health Care Complaints Commission (HCCC) & Health Conciliation Registry (HCR)</i>	82 (3%) (HCCC only)	64 (HCCC)	(Health Con. Registry separate body has 1 Register plus p.t. secretary & panel of conciliators)	3.9 million (HCCC only – figures for HCR not available)

**figures obtained from relevant annual reports.

Details of the cost to each jurisdiction involved in the delivery of conciliation are difficult to determine. NSW's Health Conciliation Registry is a statutory body administered and funded by the Health Department and a separate costing for the Registry is not readily available, while in Victoria and Queensland the conciliation process is very much an integral part of the entire health complaint systems processes. Nevertheless the conciliation process within New South Wales appears to be relatively cost effective employing a full-time Registrar and using a panel of conciliators on a needs bases. However, the Conciliation Registry's systems and operations need improvement as outlined in this report.

(Note: This section was informed by the *Review of the Health Services (Conciliation and Review) Act 1987: Discussion Paper*, Aged, Community and Mental Health Division, Victorian Government Department of Human Services, September 2000).

How the Current Conciliation Process Works

The current New South Wales conciliation process is formal and highly structured. A complaint is referred for conciliation either during or following assessment once it is decided by the HCCC that the complaint does not warrant investigation. The consent of respective parties is required before conciliation can proceed. The matter is referred to the Health Conciliation Registry, a statutory body within the NSW Department of Health, whereupon the Registrar contacts and deals with the parties.

Conciliators employed by the Registry are constrained in their powers, in that they remain neutral, promote discussion, negotiation and guide terms of settlement. As is appropriate to their defined role, they do not act as an advocate for either party, cannot give advice, suggest alternative remedial action and cannot investigate matters.

The Health Care Complaints Commission seeks the consent of parties for the complaint to be referred to the Health Conciliation Registry. Conciliation is a voluntary process.

The Health Conciliation Registry advises parties of arrangements for the conciliation, explains the conciliation process and establishes the timeframe. Parties are advised to set aside a half-day. It should be noted that there is usually only one meeting, or conference.

Parties are not allowed to be legally represented. The Act is silent on the notion of support people.

The conciliation conference is usually held at the premises of the Health Conciliation Registry – an inner city location. Some conciliators are located in other parts of New South Wales, and conciliations have occurred in non-metropolitan locations, although experience suggests that parties are encouraged to participate either at the Registry or via telephone conference.

In preparation, parties are briefed on the proposed process, and are asked, individually, to note their objectives for the conciliation.

Conciliation Outcomes

Matters discussed during conciliation remain confidential and cannot be used later in proceedings before a Court, Tribunal or any other body.

Conciliation ends when parties reach an agreement; if the conciliator terminates the process; or, if either party decides to end the process. A report is prepared by the conciliator outlining the terms of the agreement (if any) which respective parties may sign prior to leaving the conciliation. Parties have been asked to complete an exit survey addressing their satisfaction with the process.

A conciliator may terminate the process if they judge it is unlikely that agreement will be reached, or if significant issues requiring investigation by the Commission have been raised during the meeting.

A complaint may be referred back to the Commission if new material or information becomes available, warranting investigation.

Local Conciliation Processes

The Committee believes that conciliations facilitated by local health providers are, in the main, effective and efficient. These conciliations generally relate to less serious complaints, where resolution as close as possible to the point of service proves to be advantageous. The advantages, for complainants and health service providers alike, were documented in the Committee's *Report on Localised Health Complaint Resolution Procedures*, August 1997.

The Committee notes for consideration the recommendations in that report. While some steps have been taken to implement particular recommendations (for example, establishment of the Statewide Data Collection Project, to collect and evaluate locally handled complaints data), other recommendations remain outstanding.

In the course of this Inquiry, the Committee accepted that local conciliation undertaken *before* a formal complaint is generated is more likely to be successful. Most Area Health Services believed that they were able to satisfactorily resolve the majority of complaints raised locally, where complainants have the opportunity to speak at 'first hand' with health providers. Some provided details of benchmarks for the management of complaints (for example, Northern Rivers Area Health Service indicated a three-month period, in which 70% of complaints were completed within 35 days).

Where Patient Representatives/Liaison Officers are locally available, the view of those providing submissions to the Inquiry was that local conciliations were handled expeditiously and positively. There are indications that with a

demonstrable increase in the number of local conciliations being undertaken by them, it is becoming necessary to increase the staffing capacity related to this role. Liverpool Health Service, for example (a unit of South Western Sydney Area Health Service), commented that a further 0.6 Full Time Equivalent has been allocated to assist its Patient Liaison Unit. The suggestion was made by Northern Rivers Area Health Service that having Patient Support Officers more readily available (ie based in the area) would be a very positive step.

However, in its submission, the Health Care Complaints Commission indicated that the effectiveness of local level resolution of health complaints is variable, and that strategies for improving performance include contracting with all Area Health Services to provide relevant staff with training in the investigation of complaints. The Commission is also proposing that it provides additional training in resolving disputes and handling difficult complaints.

Patient Support Officers

The provision of Patient Support Officers by the Health Care Complaints Commission was documented in the Committee's *Report on Localised Health Complaint Resolution Procedures*, August 1997. At the time of that report the Patient Support Office had recently been established and consisted of seven Patient Support Officers, with an officer located at each of the six Sydney metropolitan Area Health Services.

The Committee then concluded that there was a demand at the local level for independent patient advocates and recommended that:

the Minister for Health review the current resourcing of the Patient Support Office after December 1997 with a view to expanding the numbers of Patient Support Officers and, in particular, placing one into each Area Health Service in New South Wales.

The Committee received few submissions in respect to the effectiveness of the Patient Support Office from health consumers during the course of this inquiry. However, some Area Health Services themselves raised concerns about the performance of their individual PSOs and the way that the Commission dealt with these. Area Health Service concerns are discussed at page 38 (Chapter Three) of the report. Despite this, the Health Care Complaints Commissioner informed the Committee that the PSO scheme had been working successfully, and further funding had recently been approved to provide more officers. It is anticipated that eventually one officer will be positioned in each of the Area Health Services in New South Wales.

The Committee considers that Patient Support Officer Scheme offers an independent alternative to consumers who feel powerless or are confused about the health system and supports the provision of adequate resourcing to enable the expansion of the scheme. However, the Committee believes that individual PSOs need to be more accountable for their performance and has accordingly recommended tighter performance review and other accountability mechanisms.

Chapter 2: Results of a Survey of Conciliation Participants

Introduction

In June 2000 the Committee wrote to over 300 complainants/patients and respondents (ie *respondents* to a complaint) who had participated in the Conciliation Registry process during the previous three year period. A survey was enclosed for completion. Well over fifty per cent of both complainants and respondents completed the questionnaire and returned it to the Committee.

The trends illustrated in these surveys as well as the general themes they canvass, coupled with the individual comments made by participants, provided the Committee with a fairly comprehensive picture of the strengths and weaknesses of the current conciliation process being performed by the Health Conciliation Registry. A summary of survey responses is attached as an Appendix to this Report.

Satisfaction with Conciliation Process

Overall, respondents (health professionals and providers who were the subject of a complaint) were satisfied with the conciliation process. However, complainants (parties who lodged the initial complaint with the Health Care Complaints Commission) showed a high level of dissatisfaction with the process.

Areas of most satisfaction

In general, respondents were most satisfied with the information provided prior to the conciliation meeting, with the exception of the Health Care Complaints Commission's explanation for its assessment decision to refer the matter for conciliation. The other area of most satisfaction for respondents was the fairness of the process.

Similarly, complainants were most satisfied with the information provided prior to the conciliation meeting, with the exception of the Health Care Complaints Commission's explanation for its assessment decision to refer the matter for conciliation. The other area of most satisfaction for complainants was the conciliator's handling of the conciliation process.

Areas of least satisfaction

Respondents were least satisfied that the conciliator had sufficient knowledge of the health system, health issues and their particular matters (56% satisfied) and least satisfied with the conciliated outcome (51% satisfied).

A common theme in comments from respondents was that conciliators lacked medical knowledge and therefore were not able to understand the issues in depth or guide the process to an adequate resolution. Complainants made similar comments and many complainants would have liked independent medical advice about the particulars of their case.

Only 33 per cent of respondents believed that the other party was genuinely seeking a resolution and some commented that the other party seemed only to really be interested in obtaining financial compensation.

Complainants were least satisfied with the fairness of the conciliation process (only 35% believed it was fair) and with the final conciliated outcome (only 13% were satisfied with this).

Many complainants stated that they believed that the process clearly favoured respondents, especially doctors and that the conciliator was sometimes described as patronising or allowed the doctor to behave badly towards the complainant. Some complainants argued that the timing and format of the meetings was set to suit the doctors rather than being a mutually convenient time. Many complainants also felt disadvantaged by their own and the conciliator's lack of medical knowledge and regretted that independent medical knowledge about the adverse event was not available to them.

In terms of complainants' dissatisfaction with final outcomes, most complainants did not believe that the respondent involved was genuinely interested in achieving a resolution. Some thought doctors were arrogant and dismissive or only participated in conciliation to try and avoid legal action. Some complainants also commented that they felt that they had been pressured into attending conciliation by being informed that it was the only option still open to them.

Some complainants further stated that they considered that they had been pressured into an outcome by the conciliator, that this outcome was biased toward the health professional and that the final "agreement" reached was not monitored for compliance by the Registry and ultimately not adhered to by the health professional.

Survey of Respondents

Respondents who participate in the conciliation process are invariably health practitioners or providers, usually doctors and or hospital administrators. The survey revealed that overall, respondents were far more satisfied with the conciliation process than patients.

Provision of information about the nature of the complaint

Seventy seven per cent of respondents were satisfied with the explanation given to them by the Health Care Complaints Commission about the nature and details of

the complaint against them. However, a number felt that the information provided was too brief:

No explanation of the complaint was given, it was just referred to in general terms as being "deemed suitable for conciliation", with no reasons or basis given. At the conciliation session the complaint was laid out in detail by the complainant, but this was too late to optimise the process.

Another comment:

A telephone call was not sufficient provision of information.

Provision of information about why a case is referred to conciliation and general willingness to consent to conciliation

Sixty eight per cent of respondents were satisfied with the HCCC's explanation for its assessment decision to refer the matter to conciliation. The twenty nine per cent of respondents who were not satisfied, generally stated that either they were given insufficient detail of the decision or they felt the complaint was insubstantial and did not deserve the time spent on the conciliation process.

Typical comments were:

There was in fact no significant substance to the patient's complaint and the patient was not genuinely seeking conciliation.....there should be more strict criteria before allowing whingers to have similar access to conciliation as genuine complainants.

Another comment:

HCCC refers insubstantial complaints to conciliation to appease patients.

And another:

The HCCC should have the balls to deal with insubstantial claims at the outset and not flick them to conciliation.

Over eighty two per cent of respondents said that they were initially happy to attempt to conciliate the complaint.

Performance of Conciliator

Fifty six per cent of respondents believed that the conciliator had sufficient knowledge of the health system and health issues and an understanding of their particular case. Seventy per cent were satisfied with the conciliator's handling of the conciliation process.

Typical comments from dissatisfied respondents:

The conciliator wanted a result no matter what.

and:

In all fairness, it would be difficult for a non-medical professional to understand the issues adequately.

and:

Conciliator did not understand the particulars of the case or seem to comprehend the difficulties associated with health care complaints.

and:

The only way to overcome the complainant's dissatisfaction with the process would have been to have an appropriately qualified health professional be present at the conciliation meeting as her advocate and then explore in greater depth issues which were passed over in the spirit of "reaching an agreement".

Fairness of the Process

Overall, seventy eight per cent of respondents believed the conciliation process treated them fairly. Those that expressed problems with the process tended to concentrate their comments on questions about the legality and potentially prejudicial nature of information that could be divulged.

I felt I could not produce evidence against a patient because I would then not be able to use it in court later.

and:

I was concerned that issues discussed in conciliation will be used in a later court case even though I had initially thought the information was privileged.

Only thirty three per cent of respondents believed that the other party was genuinely seeking an outcome.

Satisfaction with the Conciliated Outcome

Fifty one per cent of respondents were satisfied with the conciliated outcome. Thirty five per cent were definitely not.

Comments from those who were happy with the outcome included:

It provides a valuable opportunity to clarify and ventilate issues of great concern and hopefully defuses a misunderstanding or even explain the reasons behind a "mistake".

and:

Conciliation cleared up a breakdown in communication, resolved the issue and gave the patient an opportunity to ventilate their anger – excellent system.

and:

It helped being given the opportunity to express the trauma of receiving a complaint.

A number of respondents mentioned that they believed that the complainant was ultimately only after some sort of financial settlement or misunderstood that that this could result from the conciliation process:

The complainant was really only seeking a cash settlement so I offered him a small sum just to get rid of him.

Another:

The Victorian model in which compensation can be negotiated may be more useful.

And another:

The patient used the process to determine whether litigation was likely to be successful.

Survey of Complainants

Use of Other Complaint Resolution Processes Before Approaching the HCCC

Thirty nine per cent of complainants said that they had tried other avenues of complaint resolution prior to approaching the HCCC. These complainants had predominantly gone through the relevant hospital, Area Health Service or approached the practitioner concerned directly. These complainants had approached the HCCC because they were unhappy with the outcomes of pursuing these paths.

Comments included:

The hospital staff and Area Health Service Chief Executive Officer were patronising to me and made excuses for the doctor.

another:

I received an inadequate response from the Director of the Area Health Service.

and another:

I was not satisfied with the investigation of the complaint as not all of the medical staff present at the incident were questioned.

Referral to Conciliation

Fifty seven per cent of complainants were happy with the explanation given by the HCCC as to why their matter was being referred to conciliation. Of the thirty five per cent that were not, nineteen per cent requested a review of the decision.

A common theme was that some complainants felt under pressure to comply with the process, particularly as conciliation was the only option left open to them.

I felt under duress to comply. The letter stated "your complaint has been assessed and it is the Commission's view endorsed by the Podiatrist's Registration Board that your complaint may be amenable to resolution by conciliation.". I was told if I did not agree "the Commission may decline to deal further with the complaint".

another:

I was told it was my only option, if I did not agree to conciliation no further action would be taken.

and:

I didn't agree with the idea of conciliation but I just wanted the trauma to be over.

Complainants who were unhappy with the amount of information provided predominantly wanted more information about: the process; the qualifications and background of the conciliator; and the amount of information the conciliator had been provided with about the case.

Performance of Conciliator and Fairness of the Process

Only forty six per cent of complainants believed that the conciliator had sufficient knowledge of the health system, health issues and other general issues surrounding their complaint. Thirty nine per cent did not.

Forty nine per cent of complainants were satisfied with the conciliator's handling of the conciliation process. Thirty seven per cent were not.

Even more concerning was the fact that almost fifty six per of complainants did not feel the conciliation process was fair. This may be related to the fact that forty six per cent did not believe that they were in a position to adequately explain and defend their position during the conciliation process.

The conciliator sided with the doctor at one stage, there was professional bias, the doctor intimidated and belittled me and my sister and the conciliator did not intervene.

another:

I do not believe that the conciliator remained impartial once the doctor was in the room.

another:

The doctor was sarcastic and belittling and the conciliator did not prevent this and was dismissive when I pointed out his behaviour.

another:

The conciliator allowed the doctor to shout at me and obfuscate and did not direct or control the proceedings.

another:

Conciliator was a nice lady but really only a spectator in the process.

another:

The conciliator sympathised with me but I felt that she was very confused.

another:

The conciliator allowed the doctor to talk at length on irrelevant issues. She also did not turn the discussion back to the major issues. The conciliator allowed the doctor to belittle me on several occasions. I expected her to stop this.

Overwhelmingly the majority of complainants who did not consider that the conciliation process was fair believed that there was a complete power imbalance between themselves and the respondent. Complainants were often denied support people they felt were also involved in the complaint despite the fact that they sometimes faced more than one respondent.

One comment:

I was disadvantaged at the outset. Two professionals were ranged against me sitting at a table. I was not allowed a support person even though the information in one of the brochures stated that an aged person (I was then 70) could have one. When the Registrar would not allow even my daughter or my husband to support me - they had to sit in another room for four hours – I should have refused to proceed. The Registrar's attitude was patronising, all powerful and dismissive, despite the conciliator and my two opponents saying that they would not object to a support person. The Registrar informed me that "You will feel so much better if you do it on your own". I was made a victim by the so-called conciliation process.

another:

The respondent was a doctor so of course their level of knowledge made it easier for him to express himself.

and:

I was confronted by four parties opposing me.

another:

After attempting to make some notes I was told I was not permitted to.

and:

We were not in a position to adequately defend our position during conciliation because of confusion presented by incorrect information and refusal for our daughter to be present during the conciliation process as she was the main witness at the hospital during admission and hospitalisation.

similarly:

My husband was excluded even though he had been present at the birth where the adverse event happened and had been involved in the complaint process with the hospital.....my husband's needs were therefore basically ignored for the simple reason that due to an oversight, he had not signed the initial complaint letter.

Many complainants felt that they would have liked the presence of an independent medical expert.

One typical comment:

I wanted an independent review of my father's care by a medical practitioner, conciliation with no medical expertise was useless.

and:

By the conciliator's own admission she told me that she had no knowledge of medical procedures, let alone the correct procedures in my case, although she was sympathetic and understanding. But what good was that, it was no help to me whatsoever.....she talked to us each in turn and then it was our turn to reply and that was that.

another:

There is an intrinsic problem with conciliation where the central issue relates to the justification of the relevant surgical procedure. An unqualified complainant is pitted against the doctor where the latter can use technical jargon not comprehensible to the complainant.

Conciliation Timing and Format

A number of complainants were unhappy with either the timing of the conciliation conference or the fact that it was done by teleconference, not face to face. They believed that the respondent's needs were given priority over their own.

One comment:

The Registrar agreed to a teleconference to accommodate the doctor, I was not consulted despite the fact that I wanted a face to face meeting.

another comment:

The doctor was allowed to take his holidays but when I said the date set for the conciliation fell during my holidays I was told that if I did not accept the date I would have to withdraw the complaint.

and another:

A teleconference rather than a face to face meeting meant that the doctor could not see the physical problem he had caused.

Satisfaction With the Conciliated Outcome

Over seventy two per cent of complainants were not satisfied with the conciliated outcome. Only thirteen per cent reported that they were satisfied.

A common theme amongst complainants who were unhappy with the conciliation process was that they felt pressured to come to an agreement.

One comment:

I was bullied and persuaded by the conciliator to get an outcome.

and another:

I was told that some sort of agreement had to be reached prior to leaving, to conclude the process. As far as I was concerned the agreement was reached under duress.

A significant amount of complainants believed that the respondent was genuinely not seeking conciliation:

To be honest, I felt that the other party considered the whole process an inconvenient waste of his time. He spent most of the time while I was talking shuffling through his briefcase. Then he proceeded to put the blame on my husband and myself and finished the whole process off with "If I did something wrong I apologise".This whole business has left both my husband and I with a lot of anger.

Disappointment was also expressed that agreements between the parties were not monitored or adhered to.

One comment:

The agreement was not binding and the treatment I complained about continued when I was admitted to the hospital the next time.

and:

The doctor agreed to a financial settlement but I was left to bargain with the medical insurer. The HCCC could have overseen this process without much difficulty.

Many complainants mentioned that they felt the ultimate report of the conciliation conference did not accurately reflect what had actually taken place.

One comment:

On almost every issue the parties did not reach agreement. The conciliator's report stated that "the conciliation was terminated after the parties reached agreement on the matters in dispute". This is misleading and incorrect!

another:

I was threatened with legal action when I complained to the Registrar that the conciliator's report was inaccurate.

and:

Registry staff changed the agreement statements without my permission.

Further avenues

Forty per cent of complaints said that they had made further attempts to resolve the complaint following unsuccessful conciliation. However, in response to a question as to whether they were made aware of alternate avenues of appeal by the Health Conciliation Registry, over sixty one per cent of complainants said they were not. Of the seventeen per cent who were made aware, sixty seven per cent said they took advantage of them.

Conclusion

The results of the survey indicated that there was significant room for improvement in the current conciliation process. While respondents were on the whole more satisfied with the process than complainants, they raised most concern about the types of matters which were ending up in conciliation and the lack of medical knowledge on the part of the conciliator. It should also be noted that thirty five per cent were not satisfied with the final outcome.

The lack of satisfaction amongst complainants is extremely concerning. The major issue here appears to surround the perception of a power imbalance between themselves and the respondent which does not appear to have been adequately counterbalanced by the conciliator/mediator. There is also a significant degree of unhappiness with agreed outcomes.

It is hard to argue that the Registry has adequately neutralised the balance of power between respondent and complainant when fifty six per cent of complainants did not believe the process was fair and an astounding seventy two per cent were unhappy with the final outcome. This is sharply in contrast with seventy nine per cent of respondents considering the process was fair towards them and only thirty five per cent being unhappy with the final outcome.

The Registry has been conducting “exit questionnaires” following conciliations. The results of the Registry’s exit polls have varied markedly to the results found by the Committee’s survey.

The procedures undertaken by the Registry and the results are further discussed on page 43.

Chapter 3: External Factors Affecting the Operation of the Current Conciliation Process

Introduction

The results of the Committee's survey serve to illustrate a number of key issues surrounding the current model and its procedures which have emerged over time since the Registry's inception. As has been discussed in Chapter One, the New South Wales health care complaint handling model is unique amongst the States and its framework set up by the *Health Care Complaints Act (1993)* was a creature of innovation and compromise.

It is to be expected that an analysis of the practical operation of the Act some nine years on would reveal some areas in need of updating and refinement. It was clear that significant issues were already emerging as early as the review of the *Health Care Complaints Act (1993)* which was conducted in 1997.

Separation of the Registry from the Commission

At the time of the drafting and passage of the legislation it was clear that both the Health Care Complaints Commission and the Registry should remain independent of each other.

The logic behind the decision appears to have been to inspire the trust of respondents in the independence and confidentiality of the process and to allow the Commission to focus on its primary tasks of investigation and prosecution.

Throughout the life of both the Commission and this Committee the HCCC has advocated strongly for the Health Conciliation Registry to be brought into its framework. The Commission argued, for example, in its submission to the Committee's 1997 inquiry into Localised Complaint Handling that the separation of the Health Conciliation Registry from the Commission interfered with the provision of a flexible, efficient, streamlined approach to complaint handling.

In its submission to the current inquiry, the Commission put forward the hypothesis that fewer complainants requested a review of the Commission's decision to assist the complainant resolve the complaint through the Patient Support Office than requested reviews of the decision to refer complaints to the Health Conciliation Registry*because complainants want the Commission itself to be involved in resolving issues due to the Commission's independence, authority and expert knowledge of the health system.*

The Commission also argued in its submission that its processes were more flexible and accessible to the parties due to the fact that*there is little administration between the making of a complaint and the provision of a service by the Patient Support Office.*

The review of the *Health Care Complaints Act* (1993) in 1997, after wide consultation, recommended against the amalgamation of the Registry and the Commission:

....provider groups expressed strong concern that any organisational amalgamation of the two bodies may lead to perceptions that information disclosed during conciliation is being used in investigations or disciplinary proceedings. They indicated that practitioners would be discouraged from participation in the conciliation process if it was not seen to be entirely independent of the HCCC.

The New South Wales Department of Health supported this view in its submission to this inquiry:

Any move to amalgamate the existing Registry would raise problems not only in relation to the actual independence of the process, but also in relation to the perception of independence. This is particularly problematic given the strong views expressed by health professional groups during the Review of the Act, that the conciliation process should remain separate to the Commission.

The basis of this concern was the potential for the confidentiality of conciliation to be lost when the organisation administering the process is also in effect the "disciplinary policeman" responsible for prosecuting individual practitioners.

In its submission to the inquiry, the New South Wales Medical Board had similarly strong views:

The issue of the independence of the HCR from the HCCC has been seen by the medical profession as one of fundamental importance. The Board has confidence in the integrity of staff of the HCCC, but recognises the need for the perception of separation between the conciliation and investigation function that is represented by current arrangements.

The Committee accepts that complainants may become disappointed or confused when their complaint gets referred from one body to another and this may take more administrative time. However, it considered that the Commission's argument to place the Registry within the Commission based on examples using the Patient Support Office was somewhat erroneous on two main grounds.

Firstly, both complainants and respondents must feel comfortable with the agency conducting the conciliation and no direct evidence was produced by the Commission to indicate that respondents were happier with officers of the HCCC dealing with the resolution of their complaint.

Secondly, it is difficult to draw an analogy between the Registry and the Patient Support Office. Patient Support Officers are not conciliators. They are employed by the HCCC to follow up on complaints received by the HCCC and have some role to work as an advocate for complainants.

Overall, although there would arguably be some relatively minor administrative streamlining and financial benefits obtained by amalgamating the Commission and the Registry the Committee could not see that there were any truly compelling

arguments why the current separation should not remain, particularly as so many stakeholders were clearly opposed to an amalgamation.

Patient Support Office

In fact, while Area Health Services who submitted to the Committee all supported the idea of the Conciliation Registry, their comments regarding the Patient Support Office ranged from very qualified to distinctly unsatisfied:

In written submissions, the Committee heard from two Area Health Services who raised grave concerns about the conduct of their Patient Support Officers.

Both Area Health Services the Committee heard from cited examples of their PSOs stepping well outside their jurisdictions and interrogating staff about incidents and, in some cases, seeking peer reviews. The situation had so deteriorated in one instance that an entire hospital refused to deal with a PSO on the basis of PSO's past behaviour.

In both cases the Area Health Services were disappointed with the Commission's response to their complaints. There was no follow up or feedback as to how the matter had been dealt with, if at all. Further, the Commission merely asks Area Health Services to fill out a questionnaire concerning their PSOs performance on an annual basis, rather than seeking more personal and informal feedback.

The Committee felt that, given the impact of PSOs on Area Health Services and the fact that they are rather isolated from the Commission given their location in their individual Area Health Services, there should be a better performance review system in place, a code of conduct and more stringent follow up between the Commission and the Area Health Services concerning problems with individual PSOs.

Consents

The consent of both parties is required under Section 48 of the Health Care Complaints Act (1993) before a conciliation conference can be held. Conciliation is generally a voluntary process in which parties reach agreement of their own choice.

Currently, consent is only being given by both parties in around twenty five per cent of all cases which are assessed suitable for conciliation.

The 1997 Review of the Health Care Complaints Act (1993) recommended that it be made mandatory that respondents attend conciliation.

The New South Wales Department of Health, in its submission to this inquiry described this recommendation as one of the more controversial conclusions in the Review.

The Committee is concerned with the suggestion that voluntariness be taken out of the process for respondents. Forcing doctors and providers to turn up to conciliation conferences to which they are hostile may often turn out to be a waste of everyone's time and totally uncondusive to arriving at a resolution.

However, the low level of consents being obtained was of great concern to the Committee. It was considered that the recommendation of the 1997 Review Committee that the Health Care Complaints Act (1993) be amended to make the Registry the body which seeks consents rather than the Commission was a sound one.

This will help get around the confusion that the Commission indicates many complainants feel about being handed from one agency to another. Clearly, the Registry is the body with the most interest in persuading parties to attend conciliation and best placed to explain the procedures and benefits of the process to parties unsure of whether to consent. Further, the Committee considers that the Registry is sufficiently well enough resourced to undertake the process and conversely, much needed Commission resources will be freed up.

As the New South Wales Department of Health argued in its submission to this inquiry:

The Act requires that the Commission must obtain the consent of both parties to the dispute. This process does not sit well with the design of the Act, whereby it is intended that once the Commission had determined the matter was appropriate for conciliation, the Registry would take over. There is clearly a tension between the options of conciliation and investigation and parties' perceptions of the disposition of the complaint, suggesting it would be easier for Registry staff to explain the conciliation process. For this reason the Review recognised that there would be gains in efficiency if the Registry were to be responsible for obtaining consents to conciliation. To ensure that the Registry could properly address any concerns raised by parties as to the reasons a matter has been referred to conciliation, the Review Committee also suggested background material on the complaint (which would include the reasons for referral) should also be supplied to the Registry.

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The Committee fully supports the amendment of Section 24 of the Health Care Complaints Act (1993) to allow for the Registry, not the Commission, to be the appropriate body to obtain consents to conciliation.

Recommendation 1:

That Section 24 of the Health Care Complaints Act (1993) be amended to nominate the Registry, not the Commission, as the body which seeks parties' consents to conciliation.

Recommendation 2:

That the Health Conciliation Registry provide to parties, prior to the conciliation conference, information outlining the process; the qualifications and background of the conciliator; and, an explanation of the reason for referral of the case to conciliation.

Expansion of the Registry's Role

In its 1997 report into localised complaint handling procedures, the Committee discussed the fact that it considered that the Registry was being underutilised. On the basis of the evidence that the Committee received during that inquiry, it concluded that there appeared to be a demand at the local level of complaint handling for a professional and independent mediation service both to provide training and to deal with difficult conciliations.

Accordingly, the Committee made the following recommendations:

Recommendation 4

The Committee recommends that the Minister for Health, as part of the current review of the Health Care Complaints Act 1993, consider expanding the role and powers of the Health Conciliation Registry by amending Part 6 and Section 57 of the Act in order to provide direct access to the Health Conciliation Registry, in prescribed circumstances, by bodies other than the Commission in order to facilitate the better handling of complaints at the local level.

Recommendation 5

The Committee recommends that the Minister for Health, as part of the current review of the Health Care Complaints Act 1993, consider expanding the role and powers of the Health Conciliation Registry by amending Part 6 and Section 57 of the Act in order that the Registry may perform a more educative role to facilitate the better handling of complaints at the local level.

The 1997 review of the Health Care Complaints Act similarly took the view that the Registry should expand its educative role.

Recommendation 47 of the Final Report said:

That the HCR develop and run the following educational programs:

Education programs targeted at respondent groups;
Education programs targeted at consumer groups;
Specific education programs for individual complainants and respondents whose complaint has actually been assessed as suitable for conciliation;

Initial and ongoing training programs for case managers and conciliators, coupled with regular debriefings, evaluation and group discussions.

However, the Final Report of the 1997 Review of the Act Committee did not support the Parliamentary Committee's belief that local providers should have direct access to the Registry, arguing that the Commission should maintain a "gatekeeper" role over such complaints.

It is the Committee's view, as it was at the time of making the recommendation in the *Report on Localised Health Complaint Resolution Procedures*, that any "gatekeeper" role the Commission has in these instances is somewhat illusory given that the overwhelming majority of complaints are dealt with at the local level and never seen by the Commission to begin with.

However, there is a real danger of the Registry becoming swamped with complaints from the local level, particularly the types of complaints that are extremely hard to resolve. At the moment the Registry does not have either the expertise or the resources to be able to effectively assess their own ability to deal with such cases.

The Committee therefore believes that it is probably most appropriate for the Commission to remain the channel by which these cases proceed to the Registry. However, the Committee thinks that it would be appropriate for the processes for referral to be streamlined by the Commission. It does not believe that the Commission should be hindering the rapid transferral of cases from the local level unless there is good reason and should definitely not be reassessing them as a matter of course. The Committee intends to monitor closely the flow and the number of cases being referred by the HCCC to the Registry. Further, both the Commission and the Registry should be providing feedback to the local level as to why matters referred did not go onto conciliation.

Northern Sydney Health, in its submission to the inquiry, argued precisely on this point:

A further problem is that, in those cases where the Hospital believes that an external mediator would be helpful in resolving a complaint, we are unable to refer the matter to the Registry. At present, when local conciliation fails, the complainant is advised to contact the Commission for further assistance. In our experience this has generally not lead to conciliation by the Registry, although we do not know the basis for this failure to proceed.

In our view conciliation would be ideally suited to cases where the barriers to communication between patient and doctor are so significant that skilled independent mediation is required to overcome them. We believe many of these cases at present end up in the formal legal system, which is ill-equipped to address these issues.

Recommendation 3:

That the Health Conciliation Registry play a greater educational role in health care complaint alternative dispute resolution at the local area health service level.

Recommendation 4:

That the Registry actively promotes itself to health practitioners and providers as a complaint resolution tool.

Recommendation 5:

That the HCCC create a more streamlined path for health providers to refer matters from the local level to the Registry through the HCCC.

Greater Transparency and Accountability

The current structure of the Registry is not conducive to publicly acceptable levels of transparency or accountability.

While the Health Conciliation Registry is established as a statutory body under Section 86 of the Health Care Complaints Act (1993) it is administered and funded through the Department of Health. Under Sections 86 and 88 of the Health Care Complaints Act the Health Administration Corporation employs the Registrar and other staff of the Registry. The Health Administration Corporation is the Director General of the Department of Health, established as a statutory body under Section 9 of the Health Administration Act. On this basis, the Department of Health funds the Registry and annual reporting requirements such as they apply to the Registry are addressed in the Department of Health's annual report.

The Registry does not therefore report directly to the Minister for Health, unlike the Health Care Complaints Commission. Further, the Registry's statutory obligations are conducted at arms length from the Department of Health, to assist its integrity and independence in the complaints management process.

Public Accountability

The current structure casts the Registry rather adrift in terms of a clear reporting framework. The Committee believes strongly that the current system needs to be opened up to allow for greater external scrutiny. Therefore the Registry should be legislatively required to prepare an annual report which will be tabled by the Minister for Health in the Parliament each year. It would not be necessary for the Registry to meet the fairly stringent requirements of the Annual Reporting legislation but any annual report the Registry prepares should detail its financial expenditure, staffing structure, major activities, key performance indicators and

related performance information and so on. A number of similar bodies such as the Victims Compensation Tribunal are required to report in this way.

Gathering Objective Data

The Committee also believes that the Registry should employ an external agency to follow up with parties to conciliation on a regular basis. Up until now the Registry has been conducting “exit questionnaires” following conciliations. The divergences in the data collected by the Registry in these surveys and that collected by the Committee in its survey is extremely marked. The Registry method seemed to capture very little of the complainant unhappiness with the process that was evidenced by the Committee’s survey.

While the Committee believes that the Registry conducted its surveys in good faith, two major factors are highlighted here. Firstly, useful feedback should be sought by an independent neutral party. For instance, if the parties personally liked the conciliator or were being polite, they may be unwilling to be truthful if they were unsatisfied with the process. Secondly, some time must be allowed to elapse before the parties’ views are sought. Parties need time to consider the process in retrospect and live with the consequences of any agreement reached. Conciliation is about seeking a type of closure and it is impossible to judge the extent of this immediately after a long and emotional conciliation process.

The Committee therefore believes that an appropriate external agency should be contracted to undertake regular follow ups with parties to conciliation on a regular basis. The results of these should be published in the Registry’s annual report.

Useful Feedback to the HCCC and Registration Boards

The 1997 Review of the Health Care Complaints Act noted that while Section 55 of the Act required the Registry to provide a six monthly report to each registration authority in relation to conciliated complaints involving practitioners, the information that was being provided had not proved sufficient to allow registration authorities to deduce meaningful information about the conciliation process.

From the information the Committee received during the course of this inquiry the provision was still not fulfilling its intended function of providing analytical data of a sufficient quality to provide registration boards with feedback as to issues relevant to professional or educational standards. Further, Registration Boards are having a hard time deducing from the information why it might be that conciliation failed.

This issue was raised by the NSW Medical Board in its submission to this inquiry:

In overview the NSW Medical Board is concerned at the apparent failure of the conciliation mechanism to achieve its full potential. While the limitation on disclosure of information has meant that the Medical Board has not been able to examine in detail where conciliation has and has not worked, there is an overall impression that the strictures placed upon the mechanism by the Health Care Complaints Act have limited its scope, and have not made it an attractive option

for rapid and inexpensive resolutionThe Medical Board would support the relaxation of the confidentiality provisions to enable more useful reporting of outcomes of conciliation.

The Act does not require periodic reporting from the Registry to the Commission. Further, Section 53 of the Health Care Complaints Act is very specific in terms of what can be reported back to the Commission and other agencies:

In particular, Section 53 (2) provides:

*The report may state only:
whether the conciliation process was terminated after reaching agreement or without reaching agreement; and
whether or not a recommendation is made that the Commission investigate the complaint.*

The issue of the amount of conciliation information fed back to other relevant authorities is a vexed one as it must always be balanced with confidentiality considerations. However, it is clear that the current provisions are both too narrow in themselves and have been interpreted even more narrowly by the Registry in the past.

It is critical that information provided back to the HCCC and the Registration Boards be useful for quality improvement purposes. Information which has been fed back until this point has been virtually useless. It is also clear from the information that the Committee received via the surveys that in many instances Section 53 (2) is also too narrow to properly reflect the complainants' and respondents' understanding of the conciliation outcome.

If the conciliation process is to be properly monitored and improved, the terms of Section 53 (2) must be expanded to allow much more information about key issues of agreement and disagreement to flow back to the relevant Boards and the HCCC. As the Commission and the relevant Board are already aware of the detail and circumstances of the complaint in each instance there would appear to be little problem with them being supplied with information which will indicate any outstanding issues in relation to the conciliation as well as degrees of agreement and disagreement. This will also provide the Commission and the Boards with the opportunity to attempt to address outstanding problems in another way.

Recommendation 6:

That the Registry be legislatively required to report separately within the Department of Health annual report. This should include financial statements and performance information.

Recommendation 7:

That the Registry employ the services of an appropriate external agency to collect feedback from clients on a regular basis for quality assurance purposes and that this be included in the Registry's annual report.

Recommendation 8:

That Sections 53 (2) and 55 (1) of the Health Care Complaints Act be amended to require the Health Conciliation Registry, on a confidential basis, to provide the HCCC and relevant Registration Boards with more detailed information concerning outcomes of conciliation and issues covered.

Relations between the HCCC and the Registry

It has been the Committee's observation over the years and during the course of this inquiry that relations between the Registry and the Commission have traditionally been strained.

The Committee notes that one of Commissioner Amanda Adrian's first initiatives was to invite the Registrar to attend, and participate in, assessment meetings. The Committee does not necessarily see that there is a need for the Registry to be involved in discussing the wide ambit of complaints which are assessed by the Commission, and confidentiality problems may arise as a result of this.

However, the Committee would like to see regular meetings take place between the Commission and the Registry for the purposes of consultation and quality improvement. This may have to be provided for in the legislation based on past failure to do so.

An amendment to the Act requiring the two bodies to consult had been a recommendation of the 1997 Review of the Act Committee. The Committee intends to closely monitor the ongoing relationship between the HCCC and the Registry.

Recommendation 9:

That the Registry and the Commission meet at least on a fortnightly basis for consultation purposes to discuss cases which have been identified as suitable for referral to the Registry.

Referral to Conciliation at any Time in the Process

Section 24 of the Health Care Complaints Act limits the Health Care Complaints Commission to referring complaints to the Registry only during the initial assessment period and within 60 days of receipt.

It had been the view of the 1997 Review of the Act Committee that this provision unduly restricted matters going to conciliation. It had accordingly recommended that the Commission be free to refer matters at any time either during or after an investigation process as it sees fit.

The Committee would agree with this view.

Splitting Complaints

Referral of matters to conciliation at any time during the investigation process should not cause the investigation to cease. A number of Australia States have found that many of their complainants were primarily interested in seeking an apology, and in jurisdictions that permit it, a compensation settlement. Delays while the public interest component of the complaint is investigated before possible conciliation can take place can cause dissatisfaction.

The ACT Community and Health Services Commission Act provides for a procedure enabling splitting of complaints. In a limited number of matters the Commissioner may split the complaint enabling for conciliation of questions of apology and compensation while the Commission continues with the investigations into possible professional misconduct.

The ACT Act provides for:

Section 25 – Splitting of Complaints.

deals with more than 1 subject matter;

deals with more than 1 set of circumstances;

makes allegations against more than 1 provider;

makes more than 1 allegation against a provider; or

for any reason is susceptible to being dealt with in separate parts;

the Commissioner –

may if it is administratively convenient to do so; and

shall if it is in their interest of the user that the Commissioner do so;

determine that any subject matter, set of circumstances, allegation or part (as the case requires) be granted as a separate complaint.

(2) The Commissioner shall not make a determination under subsection (1) unless he or she is satisfied that any attempt at conciliation is not likely to be prejudiced by the making of the determination.

The Committee considers that this is a useful approach providing for a means to quickly resolve the complainants issues and enabling the Commission to continue with the investigation of the substantive issue of the public interest issues. The Committee considers that a similar scheme should be introduced into New South Wales.

Recommendation 10:

That Section 24 of the Health Care Complaints Act be either amended or deleted to allow the Commission to refer complaints, or parts of complaints, to conciliation at any stage during its handling of the complaint.

That the Health Care Complaints Act be amended to provide for the splitting of a complaint enabling conciliation and investigations to continue concurrently.

Patient Support Officers

During the course of the inquiry the Committee heard evidence from two Area Health Services who were unhappy with the performance of their Patient Support Officers. It became clear that there is a distinct variance between the personalities and roles performed by individual officers.

Both Area Health Services considered that their Patient Support Officers frequently overstepped their roles, interrogating doctors and other hospital staff, including, on occasion, ringing them up at home. One Area Health Service had an entire major hospital under its jurisdiction that refused to deal with their PSO due to past behaviour. It was felt that Area Health Service and hospital staff are bound by Codes of Conduct and therefore so should Patient Support Officers.

Both Area Health Services were also unhappy with the way that their complaints about their Patient Support Officers were handled by the Health Care Complaints Commission. One of the largest Area Health Service said that they had not heard back from the Commission concerning the outcome of the complaints about their PSO. Further, rather than contacting senior staff directly on a regular basis concerning PSO performance, the Commission merely sends out a questionnaire for the Area Health service to fill out.

The Committee had grave concerns about this situation. The role of the Health Care Complaints Commission should be an independent one. While it believes that Patient Support Officers perform a valuable role as advocates for patients at the local level, the Commission should be very careful that the work that they perform does not compromise its independence.

The original role of the Patient Support Officers was to support patients with complaints to write letters, to refer them to the right people and accompany them to meeting if needed etc. It was not to act as de facto investigators for the Commission.

It is clear that PSOs need much more clearly defined roles and closer supervision by the Commission. Further, the Commission should be more actively seeking performance appraisals from the Area Health Services regarding their PSOs and enhancing their complaint handling procedures in this area.

Recommendation 11:

That an enhanced statement of roles and responsibilities be developed for Patient Support Officer, including a code of conduct.

Recommendation 12:

That the performance review process for Patient Support Officers be enhanced, and include improved consultation with Area Health Services regarding the performance of Patient Support Officers.

Recommendation 13:

That the capacity for direct feedback from the Commission to Area Health Services be further developed, to expedite and enhance complaint handling procedures.

Chapter 4: Internal Factors Affecting the Operation of the Current Conciliation Process

Flexibility of Dispute Resolution Mechanisms

As previously outlined, in contradiction to its title, the Health Conciliation Registry has in fact been practising mediation in relation to all its complaints. The Committee was of the view that the “content free” nature of mediation was probably not the most appropriate method to use in many circumstances. The Committee would like to see the Registry actually focussing on providing conciliation, not mediation, where appropriate.

Overall, it would like a much more flexible range of dispute resolution tools used to try to individualise the way each complaint is handled. The results of the Committee’s survey indicate that many parties have found this inflexible approach of “mediation or nothing” unhelpful in the past.

During the course of the inquiry the Committee spoke to Mr Michael McLeod, Chief Executive Officer of United Medical Protection about the Fund’s willingness to work with the Registry in widening scope of how matters are dealt with by the Registry. Given the great concern that has been raised about levels of medical litigation the Committee was keen to float the idea of a trial project of conciliations which might involve financial settlements as is done in the other State. Mr McLeod agreed with the suggestion that United Medical Protection could work with the Registry in identifying a number of cases that may be suitable for a trial conciliation process which may involve the presence of legal advisors and lead to the option of financial settlements.

The Committee would also like to see the views of both respondents and complainants to the survey that independent expert medical advice may have assisted in some way be taken on board and that this option be made available where appropriate. This is often done in other States as part of their conciliation process.

Recommendation 14:

That conciliation, not mediation, should be the primary method of resolving complaints employed by the Health Conciliation Registry.

Recommendation 15:

That Recommendation 14 should not however preclude the Health Conciliation Registry employing a wide range of dispute resolution processes on a case by case basis.

Recommendation 16:

That the Health Conciliation Registry consult with United Medical Protection Society with a view to trialing dispute resolution conferences which may involve financial settlements and independent medical expert review or advice.

Human Resources

In considering evidence to the Inquiry, the Committee formed the view that it was critical to both reform and support human resources available to the Conciliation Registry. The aim of reform would be to enable the Registry to function more consistently, to genuinely focus on conciliation as a dispute resolution mechanism, and to promote a regime of effective professional development.

The Committee believes that the current conciliator/mediators need to be supported to ensure integrity of the process, including effective outcomes for involved parties.

The Registrar

Legal Knowledge

The Committee notes that all registrars in other areas such as the medical Board generally hold legal qualifications. A legal understanding is considered important to the role, given the expectation upon the Registrar to have the ability to provide advice regarding the legality of agreements; key evidentiary issues; and matters requiring referral of cases back to the Health Care Complaints Commission. The Committee believes that the Registrar needs also to be in a position to both brief conciliator/mediators about legal constraints and obligations, and to monitor and respond to cases in which complex legal questions are likely to arise.

As the previous Registrar was not involved in actual conciliation conferences, it would be desirable to ensure that the position is one of coordination, oversight and advice for conciliator/mediators within the program.

Recruitment

The Committee is aware that the Health Conciliation Registry has recently recruited a new Registrar. Accordingly, the Committee believes it is an ideal time to adopt particular reforms relating to the position description and to the recruitment and selection process. It recommends that new selection criteria and a position description should be prepared, addressing the need for and scope of medico-legal training, alongside other required qualities and duties. Further, the Committee believes that the selection process for the Registrar should be expanded. A panel comprising at least the Health Care Complaints Commissioner and a relevant officer from the Department of Health is proposed, to provide a

greater breadth of scope with regard to expectations of the position and the individual selected to fill the position.

Professional Development

The Committee recognises the problems of isolation inherent in a 'sole operator' position, and notes the comments of the Health Care Complaints Commission in their submission on this point. The Commission expressed concerns about the unclear reporting relationship for the Registry, and the lack of professional supervision of the Registrar to assist the development of the conciliation program (page 9 of HCCC submission). The Commission also noted that other jurisdictions offer coordinated training for conciliators and that these may provide continuous improvement opportunities for the Registrar and conciliators.

The Committee supports the view that the Registrar should be encouraged to develop strong and effective linkages with similar authorities in other States and Territories, and with other bodies coordinating public 'alternative dispute resolution' processes, such as the New South Wales' Anti-Discrimination Board and the Human Rights Commission. An explicit purpose of such linkages should be to ensure ongoing professional development, a purpose that may be supported via regular Email and Telephone Conferencing; identification and sharing of professional development opportunities such as conferences and workshops; and, annual, scheduled, face-to-face peer group meetings to address an agenda of issues of common concern.

Such an approach is commonly used as a professional development and problem-solving tool among 'sole operator' individuals (for example, health practitioners in remote areas). A regime of ongoing professional development will ensure that the Registrar has access to good practice information, training and problem-solving opportunities, thereby assisting improved practice and improved input to policy development.

Recommendation 17:

That new selection criteria and a position description be developed for the Health Conciliation Registrar, addressing the need for medico-legal training, alongside other required qualities and duties as identified in this report.

Recommendation 18:

That the selection process for the Health Conciliation Registrar be formalised, to include a panel comprising of at least the Health Care Complaints Commissioner and a relevant officer from the Department of Health.

Recommendation 19:

That the Health Conciliation Registrar develop both formal and informal linkages with similar authorities in other States/Territories and with other bodies coordinating public alternate dispute resolution processes within New South Wales, in order to address professional development and issues of common concern.

Conciliator/Mediators

Professional Development

As discussed in Chapter Two, the Committee noted concerns raised by both complainants and respondents about the professionalism and/or capacity of conciliator/mediators to undertake their role. These concerns included an apparent incapacity by the conciliator/mediator to control dominating behaviour, on occasion, for example:

The doctor was sarcastic and belittling. The conciliator did not prevent this and was dismissive when [the complainant] pointed out the behaviour.

and:

The doctor sniggered and made derogatory comments.

and:

The conciliator allowed the doctor to shout [at the complainant].

Other concerns relate to occasional unprofessional personal interventions by the conciliator/mediator. Several complainants cited examples of being 'patronised' by the conciliator. Others indicated instances of partiality being shown towards the respondent to the complaint, for example:

I don't believe she remained impartial once the medical professional was in the room.

and:

The conciliator sided with the doctor.

Similar concerns about partiality were raised by respondents to complaints, for example:

"I was persecuted for being a white, Anglo-Saxon male ...the undertones of racial and sexual discrimination exhibited by the female officers towards me was inexcusable".

In evidence, the Committee also heard examples of personal judgments being cast by conciliators/mediators during conciliation meetings. Conciliators themselves expressed the view to the Committee that patients were “dummies” or vexatious complainants who wasted doctors’ valuable time.

The survey also revealed some suggestions that conciliators/mediators may have been ineffectual, for example:

She was a nice lady, but only a spectator”.

She sympathised, but I felt she was very confused”.

The Committee believes that there is a clear need for better screening of suitable conciliators and effective and ongoing training, and that components of this training should be specialised, in order to assist conciliators to gain advanced skills.

A Broader Mix

In particular, the Committee noted the need for conciliators to be drawn from broad backgrounds, including different cultural backgrounds, and to receive cultural awareness training, to enable them to deal more effectively with complainants and respondents from diverse backgrounds. This includes, for example, the need for awareness that health professionals are used to having to be forceful as part of their day-to-day work. This presents a special challenge to conciliators in setting the tone for conciliation conferences.

While the Committee believes that it is not critical, in every case, for the conciliator/mediator to have medical and/or legal knowledge, the inclusion of individuals with such a background in the register of conciliators is recommended. Their services will be required for dealing with complex cases, and to provide additional assistance on an at-call basis.

Reaching Agreement

An apparent propensity for conciliators/mediators to force an agreement between parties is a concern expressed by both complainants and respondents to complaints:

The conciliator said there was an agreement, I didn’t think there was.

and:

....agreement was reached ‘under duress’.

and:

The conciliator had not researched the case. I felt bullied and persuaded to get an outcome.

and:

I was concerned that contractors have a self-interest in getting a result at any cost.

Parties had also reported that details of the agreement document were inaccurate or distorted:

The document ... had many mistakes and statements which were not agreed upon and had the potential of being used adversely if the complainant wished to proceed with litigation.

and:

The conciliator misrepresented the discussion during the hearing and I had to make changes to the Report.

and:

The final report supplied by the Commission (sic) to me was unsatisfactory in its lack of specifics. I believe a summary of the outcomes of the case with some details would be more satisfactory than a perfunctory acknowledgment.

Parties also commented that Registry staff made changes to the agreement statements without their permission, and one commented that staff had 'threatened' the party with legal action and was abusive, when the party complained the conciliator's report was inaccurate.

The Committee believes these instances of miscommunication can be addressed through improved training and appropriate application of performance measures.

Recruitment

The Committee recommends that recruitment of conciliators, specifying requisite skills and background, should be more publicly canvassed, including through advertisement, but also through relevant community-based organisations, and alternative dispute resolution networks. A selection panel to oversight the process should comprise: the Health Conciliation Registrar, a representative of the Health Care Complaints Commission, a health services provider and relevant community organisations.

The flexible approach of paying conciliators at an hourly rate should be maintained, although the panel might wish to recommend increased rates for conciliators with advanced skills. It is proposed that conciliators should be subject to performance-based annual contracts, with a review undertaken either by the Registrar, or through the reconvened 'selection panel'. As indicated above, there is a need to develop more appropriate indicators of outcomes, reflective of the qualitative aspects of the process for the parties involved.

The Committee also recommends that the recruitment process is extended to include regional areas of the State, both through canvassing suitable candidates living in regional areas, and through those individuals prepared to travel to regional areas to undertake conciliation meetings.

Recommendation 20:

That an effective and ongoing training program be developed for conciliators, and that this should include components of specialised training, in order to allow conciliators to gain advanced skills.

Recommendation 21:

That the recruitment of conciliators be publicly canvassed, including through advertisement and through the networks of relevant community-based organisations.

Recommendation 22:

That a selection panel for conciliators for the Health Conciliation Registry comprise the Registrar, a representative of the Health Care Complaints Commission, a health services provider representative, and a representative(s) of relevant community organisations.

Recommendation 23:

That the flexible approach of engaging conciliators on an hourly basis be maintained, and that a process for including increased rates for conciliators with advanced skills be examined.

Recommendation 24:

That conciliators be subject to regular performance review which is conditional on their reappointment.

Preconferencing Procedures

As previously mentioned, up until this point the Registry has been performing mediation, not conciliation. This notion by which conciliators attend a conference “content free” does not appear to be suitable to a lot of parties.

Both complainants and respondents expressed concern through survey responses and evidence before the Committee that the conciliator/mediator lacked information about the case, was apparently not briefed about the particulars of the case, or had no medical knowledge. The Committee believes that it is important

that conciliators are briefed on the particulars of the case prior to the conciliation meeting. While conciliators/mediators may invite re-statement of issues as a technique for ‘drawing out’ participants, this should not occur merely to apprise the conciliator/mediator of the facts of the case.

Conciliators/mediators should be fully aware of all issues and able to anticipate the introduction of new matters which may have a bearing on the outcome of the conciliation. It is also incumbent upon the conciliator/mediator to ensure that the act of re-statement of the issues does not cause undue distress to the party concerned. Many complainants explained how emotional it was for them to go through the entire history of a complaint all over again in the conciliation conference and felt they were placed at a disadvantage by it.

There also appeared to have been minimal contact between the Registrar or relevant conciliator and the parties prior to the conciliation and this contact was generally by way of a phone call. The handing over of the authority to seek consent from the Commission to the Registry may serve to alleviate this situation. However, the Committee firmly believes that there should be more pre conference contact and preparation between the Registry and the parties. Ideally, it would like this to be by way of face to face contact.

Recommendation 25:

That either the Registrar or the relevant individual conciliator have at least one separate face to face meeting with respective parties prior to the conciliation conference to discuss key issues and outline the process.

Recommendation 26:

That the Health Conciliation Registry brief the relevant conciliator on the particulars of each case, prior to the conciliation meeting.

Time Allotted to a Conciliation

The scope of the timeframe available for conciliation raised some concerns among survey interviewees, and in evidence considered by the Committee. Some suggested that the time was set to suit the doctor or that the time was inflexible

“I was told that if I did not accept the date I would have to withdraw the complaint”.

Several interviewees spoke of being exhausted after the half-day session:

“a gruelling 4 hours”.

Still others indicated that having to fill out a lengthy questionnaire at the end of the process was draining, that the details of their responses were difficult to remember under the circumstances, or that they felt under pressure having to fill out the post-conference questionnaire “*while the other party watched*”. Interviewees and those making submissions also noted that in spite of requesting a blank copy of the questionnaire, and receiving assurance this would be provided, it never was.

The ‘voluntariness’ of conciliation again comes into question, as interviewees indicated a sense of compulsion to reach an agreement:

“I was told that some kind of agreement had to be reached prior to leaving, to conclude the process, the conciliator point-formed our meeting and we both signed it”.

Others spoke of being ‘bullied’ into an outcome, or the agreement being reached ‘under duress’.

In other jurisdictions, the process of the conciliation conference may take longer than the general half-day allotted in the New South Wales system. In Queensland, for example, the process might include separate meetings with respective parties, or a series of meetings with both parties until resolution is achieved. The Registry should ideally take a more flexible approach to conference length on a case by case basis. Recommendations made earlier in this Report regarding seeking of consents, and pre-conferencing, should also assist in addressing the issues identified.

Support People for Complainants

The whole issue of support people has been a vexed one throughout the course of this inquiry. It is clear that Section 50 of the Health Care Complaints Act (1993) should be amended to be more specific on this question. As it stands, the Act is silent on the subject of support people, referring only to “agents” representing the complainant who are allowed at the discretion of the Registrar.

The previous Registrar and many conciliators have up until now taken a hard line regarding complainants wishing to bring support people into conciliation arguing that support people disrupt the process by their “huffing and puffing” even when they are instructed not to say anything. This line was taken despite the fact that the term “agent” in the Act was clearly envisaged as a type of advisor, not just a close friend or family member whose mere presence could offer some emotional support to the complainant.

The Committee believes that the results of the survey bear out the fact that complainants feel a genuine power imbalance and trepidation in conciliation and in many cases being accompanied by a spouse, family member or close friend as a support person would serve to counter this feeling. It must also be recognised that, in the important and emotional area of a family member’s health, family and close friends are also affected by adverse events to loved ones. Further, including as

many key players as is reasonable in the conciliation process should help to better cement ongoing satisfaction with any agreement reached.

The issue was support people was also recognised in the 1997 review of the Health Care Complaints Act. The Final Report concluded that:

The Review Committee was generally of the view that support people should be more readily accepted at conciliation for complainants and respondents.

The Review Committee ultimately recommended:

That the Act be amended to clarify that support people, excluding legally qualified people, may attend conciliation to assist either the complainant or respondent.

Given the power imbalance that patients obviously perceive in conciliation, the Committee would be loathe to recommend that respondents make a practice of bringing support people to conferences. Obviously, there will be exceptional circumstances where this may be appropriate. However, trained professionals such as doctors and area health service officers should reasonably be expected to front a conciliation on their own in most circumstances.

However, complainants should have a support person as of right, subject to internal guidelines as to the extent of their participation, which should be clearly spelled out to them in advance. The Committee believes that it is reasonable to expect well trained counsellors to keep support people under control so that they do not interfere with the conciliation process.

Recommendation 27:

That the Health Care Complaints Act be amended to define categories of people who qualify as a “support person” and the extent of their involvement in the conciliation process.

Recommendation 28:

That complainants be allowed to be accompanied to conciliation by person or persons who fall within the legislative definition of “support person” as a matter of right.

Recommendation 29:

That respondents be allowed to be accompanied to conciliation conferences by a support person with the agreement of the Registrar and the complainant.

Regional Coverage

The Committee received several submissions indicating problems caused by the Registry's insistence on holding the conciliation conference at its city premises. The Rural Doctors' Association of NSW noted that failure to base conciliation in the local community caused significant disruption for doctors and for the delivery of health care services within local communities because of the extra time spent in travelling to participate in a conciliation conference.

Several individuals commented on the personal distress they had experienced in being offered only the options of a city-based conciliation conference, or a teleconference as an alternative. One complainant commented that there was little regard for their desire to have a face-to-face conference, although the reason they had agreed to conciliation was out of a desire to confront their doctor about the outcome of unsatisfactory facial cosmetic surgery. A complainant wanted to have a conciliation conference conducted in their regional area, a proposal resisted by the Health Conciliation Registry. In this instance, the Health Care Complaints Commission intervened, to arrange for the involvement of a locally-based conciliator.

The Committee has significant misgivings about the capacity of a one-off telephone conference as an effective means of bringing about resolution of a complaint. In general terms, teleconferences are effective when all of the parties have previously met face-to-face, have had experience of teleconferencing, and have had prior discussion together relating to the issues at hand. Clearly, few, if any, of these conditions would be operative under the current system. Some individuals raised concerns about privacy and the confidentiality of issues discussed in a teleconference, there being no effective way of knowing if other people were present in the room with the other party.

Recommendation 30:

That conciliator recruitment be extended to include regional areas of the State, both through canvassing suitable candidates living in regional areas and through those individuals prepared to travel to regional areas to undertake conciliation meetings.

LIST OF APENDIXES

Appendix 1: List of Submissions

Appendix 2(a): Survey response summary (complainants)

Appendix 2(b): Survey response summary (respondents)

Appendix 3: Minutes of Meetings