Submission

No 31

INQUIRY INTO THE OPERATION OF THE HEALTH CARE COMPLAINTS ACT 1993

Organisation: The Royal Australasian College of Physicians

Name: Dr Jennifer Alexander

Position: Chief Executive Officer

Telephone: 02-9256 5444

Date Received: 23/10/2009

The Royal Australasian
College of Physicians

Monday, 19 October 2009

Hon Helen Westwood AM MLC
Committee on the Health Care Complaints Commission
Parliament of New South Wales
Macquarie Street
Sydney NSW 2000

Dear Hon Helen Westwood

Re: The Royal Australasian College of Physicians (RACP) response to the Discussion Paper from the Committee on the Health Care Complaints Commission (HCCC) in relation to the Operation of the Health Care Complaints Act 1993

The RACP welcomes the opportunity to present feedback from College members from the NSW Health Discussion Paper to the Committee on the Health Care Complaints Commission in relation to the Operation of the Health Care Complaints Act 1993.

The RACP supports the work of the HCCC and commends them in their attempt to maintain consistent standards and processes throughout NSW. In a previous submission on healthcare complaints to the Australian Health Ministers' Advisory Council consultation paper on the proposed arrangements for handling complaints, the RACP supported the principle of maintaining a transparent process for complaint handling. [1]

The College supports the principles that the system must balance the rights and interests of consumers with those of health practitioners and that the system must be a robust one that protects public safety yet deals effectively with complaints. The College would like to see a standardised approach across all jurisdictions for registration, as it simplifies the process of communication. Currently the practice of different approaches in each jurisdiction across Australia is not sustainable and is not in the best interests of patients or consumers. A model that works well is currently operating in New Zealand.

In relation to privacy there would need to be discretion to protect the reputation of the practitioners in their working environment where a complaint has been made against them. It would also be of benefit to know who is involved in the commission and whether they are representative of community or particular specialty of the medical profession or both. Additionally, in some cases, it may require independent medical assessment as to whether there is a medical reason behind the practitioners action involved in the complaint.

The document focuses predominantly on the "administration" of the processes involved with 'complaints' within the health care delivery system whether this be at an individual, local hospital or Area Health Service (AHS) level. It makes peripheral reference to the "communication" within

145 Macquarie Street, Sydney NSW 2000, Australia □ Tel: +61 2 9256 5444 □ Fax: +61 2 9252 3310
□ Email: racp@racp.edu.au □ Web: www.racp.edu.au

ACN 000 039 047 ABN 90 270 343 237

this system of health care information which in essence provides the cornerstone of care delivery. [Information is care. [1]

The College notes that the types of complaints which the HCCC will assess as suitable for conciliation are likely to meet at least one of the following criteria:

- Breakdown in communication between the parties[2]:
  With reference to the 'communication of care' this process will always remain impaired when it comes to the 'measurement' of care delivery because the current 'paper-based' system is unable to meet the needs of the modern health care system. [2]

- Insufficient information provided to the complainant:
  Information management issues come to the fore under the current system and were confirmed in the Harvard Study into Negligence in 1991. A significant conclusion of this study was that "Lawyers generally believe that investigation of substandard care only begins with the medical record; that in many instances the medical record even conceals substandard care; and that substandard care is not reflected in, or "discoverable" in the medical record." [3] These findings suggest that inherent in the Health Complaints debates and negotiations that the underlying premises for resolution are founded on inadequate and inaccessible information so all parties suffer and the process becomes very costly.

- Inadequate explanation was given for a poor outcome or adverse event:
  With the lack of reliable (or inaccurate) information this type of inadequacy will be perpetuated.

- Improvement in the quality of the particular health service for the complainant:
  To improve the quality of care it must be able to be measured [4] or the complainant is seeking a refund or financial compensation as an outcome.

In relation to the 'accessibility' of relevant information within the HCCC process the foundation of the mediation is with the content (information) within the medical record which remains the primary communication tool for health care delivery.[5] With the availability of a cumbersome, poorly accessed 'record' system these time delays are inevitable thus prolonging the arbitration process and adding significantly to the costs. [6]

In relation to procedural fairness the HCCC refers to complaints about individual practitioners for formal investigation where, if substantiated, the complaint would provide grounds for disciplinary action, or involves gross negligence on the part of a practitioner. The purpose of an investigation is to obtain information so that the Commission can determine the most appropriate action (if any) to take, and its focus is on the protection of public health and safety.

The College notes that the Health Care Complaints Act 1993 be amended to provide for a statutory internal review process for the HCCC, based on complaint handling best practice. Within the current care delivery system characterised by information overload and poor knowledge access the concept of best practice can be questioned. Over a 4 decade time span it has been demonstrated that of what we do in routine medical practice has a persistently low level of compliance (20-40%) with what has a been published in scientific research.[7-10]

The College notes that the NSW Medical Board raised the issue of peer review as part of the investigation process, and in particular the way in which the HCCC felt bound to follow the opinions expressed by the expert or peer in an investigation notwithstanding the sometimes

---

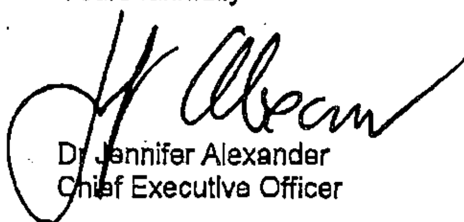
[1] There is no health without management, and there is no management without information. Gonzalo Vecina Neto, head of the Brazilian National Health Regulatory Agency

[2] Communication of health care -requires the availability of an adequate medical record and the current paper record is simply unable to meet the needs of modern health care systems. Medical practice is medical decision making

unanimous divergence from those views expressed by the medical members of the Board at the time of consultation. Whilst the Board acknowledges the difficulty of selecting peers to review a practitioner's work, it suggests that where its own Conduct Committee – which includes seven medical and two lay members - considers that the wrong expert/peer has been chosen, or that that person has applied the wrong standard, the Commission ought to be obliged "to at the very least seek a further view." The College would like to refer to this topic and the role of the 'expert'. We know there are major variations in how care is delivered regardless of the costing infrastructure of the health system. [11]. Also it has been demonstrated that 'experts' have significant variation in the management and decisions on outcomes sometimes with very little correlation to standard protocols.[12-13]

Thank you once again for the opportunity to contribute to the consultation. The College would be happy to provide an expert to appear before the Committee to discuss any of these matters further.

Yours faithfully



Dr Jennifer Alexander
Chief Executive Officer

References

1. The Royal Australasian College of Physicians (2009) *National Registration and Accreditation Scheme Consultation Paper.*
2. Shortliffe, E. and L. Perreault, eds. *Medical Informatics: Computer Applications in Health Care.* ed. G. Wiederhold and L.M. Fagan. 1990, Addison-Wesley: Reading, MA.
3. Brennan, T., et al., *Harvard Medical Practice Study I.* N Engl J Med, 1991. **324**(6): p. 370-6.
4. James, B., *Quality Improvement in the hospital: managing clinical processes.* Internist, 1993. **34**(3): p. 11-3.
5. Dick, R. and E. Steen, eds. *The Computer-Based Patient Record: An Essential Technology for Health Care.* ISBN 0309044952, ed. Committee on Improving the Patient Record. 1991, Institute of Medicine Washington DC
6. Studdert, D.M., et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation.* N Engl J Med, 2006. **354**(19): p. 2024-2033.
7. Williamson, J., *Medical Practice Information Demonstration Project: Final Report*, in *Contract #282-77-0068GS.*, Office of the Asst. Secretary of Health, Editor. 1979, Policy Research Inc: Baltimore MD.
8. Institute of Medicine (1985) *Assessing Medical Technologies.* **5**.
9. Ferguson, J., *Forward. Research on the delivery of medical care using hospital firms. Proceedings of a workshop.April 30 and May 1 1990 Bethesda Maryland.* Med Care, 1991. **29**(7 Suppl): p. JS1-2
10. Balas, E. and S. Krishna, *From SARS to systems: developing advanced knowledge management for public health.* Stud Health Technol Inform, 2004. **100**: p. 149-56.
11. Wennberg, J., *Practice variation: implications for our health care system.* Manag Care, 2004. **13**(9 Suppl): p. 3-7.
12. Eddy, A., *Manual for Assessing Health Practices & Designing Practice Policies: The Explicit Approach*, The American College of Physicians, Editor. 1992: Philadelphia PA. p. 14.
13. Eddy, A., *Variations in physician practice: the role of uncertainty.* Health Affairs, 1984. **3**: p. 74.