REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

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

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At Sydney on Wednesday 16 April 2014

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The Committee met at 10.30 a.m.

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PRESENT

Mrs L. G. Williams (Chair)

Legislative Council
The Hon. P. Green
The Hon. H. Westwood

Legislative Assembly
Dr A. D. McDonald

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

KIERAN PEHM, Commissioner, Health Care Complaints Commission, and

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

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

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

Mr PEHM: That is correct.

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

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

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

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

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

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

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

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

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

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

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

Mr PEHM: The ageing male practitioner is particularly prone.

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

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

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

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

Dr ANDREW McDONALD: It is not in your area?

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

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

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

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

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

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

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

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

CHAIR: Are the results of that research project public?

Mr PEHM: That is public and we can send you a copy[1].

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

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

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[1] http://www.parliament.nsw.gov.au/Prod/Parlment/committee.nsf/0/A3E4F4B45530BF7DCA257CE60021BD2B

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

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

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

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

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

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

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

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

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

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

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

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

CHAIR: Yes.

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

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

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

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

Dr ANDREW McDONALD: Yes, the HQCC.

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

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

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

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

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

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

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

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

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

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

Mr PEHM: They are discontinued.

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

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

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

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

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

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

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

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

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

The policy change was in 2007 to encourage open disclosure. The working group now is drafting more detailed guidelines about how to do it and what sort of support is available. There are a few missed steps along the way. They rolled out quite extensive training to practitioners with role playing. The trouble with training is if it is not used and it does not come up it lapses within the next six months or so and you forget all that. The

scheme now is to have an expert adviser available to clinicians in this situation so that a person can help organise a conference and give them advice about how to participate so that they do not feel exposed or vulnerable as well.

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

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

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

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

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

Dr ANDREW McDONALD: Or do not.

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

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

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

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

Mr PEHM: I do not know about that.

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

Mr PEHM: Part of it depends on the seriousness of the error as well. The more serious it is the more difficult it is and those more serious things tend to be in surgery and those with really catastrophic

consequences. Medication errors are a fairly significant cause of complaint and there can be quite harmful side effects from that with GPs prescribing. But I could not say any one type of practitioner is better or worse at it. I think it is almost a personality-type thing. I think there are clinicians that are good at communicating with patients generally in a good bedside manner and getting formal consent and are able to judge the level of the complainant's comprehension and respond to that. They are the sort of people who would be good at open disclosure, except they are the sort of ones that probably open disclosure does not become necessary because the lead-up is so good. It is a mistake to think that open disclosure is a discrete thing that happens when something goes wrong. It really should be part of the continuum of the practitioner communicating responsively with complainants all the way through their treatment journey.

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

Mr PEHM: Own motion.

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

Mr PEHM: Make our own complaints?

The Hon. PAUL GREEN: Yes.

Mr PEHM: Yes, we have had a few.

The Hon. PAUL GREEN: Can you update us?

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

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

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

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

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

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

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

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

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

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

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

Mr PEHM: Local resolution, that is right.

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

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

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

Mr PEHM: Yes. There is always variation. It varies at different LHDs over time as well; they might have a manager in complaints that is particularly passionate or dedicated. There is one LHD that was very good. If they got a complaint from us asking for a response they would get straight onto the complainant on the phone saying, "Can we sort this out? Can we have a meeting?" They would come back to us and say, "It has been resolved", which is fantastic. We have a resolved-during-assessment line on the graph; that is where either the practitioner or the health service comes back with an explanation of a complaint and says, "That's fine, I understand that. Good, that is resolved for me". If the health service comes back and says, "We have spoken to them and we have fixed it all up. They are happy", we will just confirm that with the complainant. This particular LHD, I think about 17 per cent of the complaints we sent to them they would deal with in that way, which was great, and we promoted that to the other LHDs.

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

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

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

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

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

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

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

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

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

Dr ANDREW McDONALD: Yes.

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

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

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

Dr ANDREW McDONALD: They were once clinicians.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We do not only go at the beginning; we go at the end as well. If there is an investigation where there is a practitioner and we are going to compile a brief of evidence to the director of proceedings we cannot disclose the investigation report for the practitioner, but if there is a facility investigation we can disclose that. We will send them the report and arrange a meeting so they have time to digest the report and then they can ask a number of questions. We go there at the end as well. We have been doing that for probably about three years.

But it was only as a result of the recommendations that the Committee made that we actually put it into our procedures manual and made it policy. We are recording it now as well. I call them category A investigations. We can record how many times we have done it. That is the process.

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

The Hon. PAUL GREEN: Well done.

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

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

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

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

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

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

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

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

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

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

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

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

Dr ANDREW McDONALD: The bottom of page 108.

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

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

than their dental practitioner could reasonably provide. We expect to see that number of complaints fall off against dentists with that scheme going out.

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

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

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

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

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

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

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

Mr PEHM: Yes.

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

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

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

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

Dr ANDREW McDONALD: They are relatively low numbers.

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

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

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

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

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

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

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

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

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

Mr PEHM: He did.

Dr ANDREW McDONALD: But he was not known.

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

Mr PEHM: Certainly.

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

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

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

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

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

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

Ms MOBBS: I think it is unclear.

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

The Hon. HELEN WESTWOOD: Do you mean permanently?

Dr ANDREW McDONALD: No.

The Hon. HELEN WESTWOOD: A shift.

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

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

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

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

Ms MOBBS: That is an issue we see in some of the prosecution cases and we rely on experts from the field to say what the applicable standard is across all the practitioners. Certainly the evidence I have heard and I have seen in statements is to the effect that it depends. You are allowed to drink. There is no absolute prohibition but really it is a matter of monitoring yourself. If you get called and you are not in a position to treat a patient, it is your responsibility to advise—

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

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

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

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

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

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

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

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

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

CHAIR: Than your generation.

Dr ANDREW McDONALD: Than my generation. As Mr Pehm said before, the problem with teaching stuff is you have to use it and the students do not communicate with people. Have you looked at communication training that will be eligible for maintenance of professional standards? Every medical or nursing practitioner has to do something. Have you looked at trying to get that put in rather than finding out about rare diseases? Perhaps we should use teaching communication skills because it is done very poorly. Senior clinicians are not taught how to communicate and it is assumed they can but, as you can see, they often cannot.

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

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

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

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

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

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

CHAIR: Are they randomly selected?

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

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

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

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

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

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

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

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

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

Dr ANDREW McDONALD: That is for most cancers?

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

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

CHAIR: Obviously good outcomes for the LHD.

Mr KOFKIN: Yes.

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

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

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

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

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

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

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

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

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

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

Dr ANDREW McDONALD: The doctors are insured.

Mr PEHM: Yes.

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

Mr PEHM: Yes, that would be fine.

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

(The witnesses withdrew)

(The Committee adjourned at 11.55 a.m.)