Submission No 12

REVIEW OF INQUIRY INTO COMPLAINTS HANDLING IN NSW HEALTH

Organisation: United Medical Protection

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Date Received: 28/07/2006

Subject:

Summary

UNITED
Medical Protection

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GPSC's

28 July 2006

Our Ref: HT:JMD
Your Ref:

Private and Confidential
Hon Patricia Forsythe MLC
Committee Chair
Legislative Council
Parliament House
Macquarie Street
SYDNEY NSW 2000

Facsimile: 9230 3416

Dear Ms Forsythe

Review of Inquiry Into Complaints Handling In NSW Health

Thank you for your letter dated 9 June 2006 giving UNITED Medical Protection an opportunity to provide a submission in relation to the "Review of Inquiry Into Complaints Handling in NSW Health".

Please find ***attached*** UNITED's submissions.

Yours sincerely

Helen Turnbull
Legal Manager (Disciplinary Services)

UNITED MEDICAL PROTECTION

SUBMISSION TO GENERAL PURPOSE STANDING COMMITTEE NO. 2 REVIEW OF INQUIRY INTO COMPLAINTS HANDLING IN NSW HEALTH

1. INTRODUCTION

In June 2004, the General Purpose Standing Committee No. 2 tabled its report "Complaints Handling within NSW Health". The report contained 19 substantive recommendations. The Committee also had a special interest in the outcome of the Special Commission of Inquiry into Campbelltown and Camden Hospitals. The General Purpose Standing Committee No. 2 has now reconvened to undertake a review of the implementation of its recommendations.

To assist with the review the Committee has sought a submission from UNITED Medical Protection.

UNITED Medical Protection is grateful for the opportunity to provide the following submission:

2. BACKGROUND

2.1 The Role of UNITED

UNITED Medical Protection is the largest medical defence organisation in Australia. Its insurance subsidiary (Australasian Medical Insurance Ltd) provides indemnity to medical practitioners for the legal costs of civil claims, complaints and coronial inquests. UNITED also provides legal advice and assistance to its members.

As a defence organisation with the largest membership of practising doctors in New South Wales UNITED has had a very close involvement in complaints handling in New South Wales. UNITED represented the majority of the doctors at Campbelltown and Camden Hospitals, which were referred by the Special Commission of Inquiry to the Health Care Complaints Commission for investigation.

3. GPSC NO. 2 RECOMMENDATIONS

3.1 Balance Between Professional Accountability and System Issues

In the Committee's report of June 2004, the issue of balance between system issues and individual accountability was discussed on the following terms:

"However what is less clear is how to strike a balance between an appreciation of the systemic nature of medical error with the need to ensure individuals are held accountable for their actions. It is fair to say that this has been one of the most vexed issues confronting [this Committee] and the Special Commission [of Inquiry] and one which will continue to be debated even after the finalisation of both inquiries."[1]

[1] Complaints Handling within NSW Health, p.4, para 1.15.

"Inadequate resources, especially clinical resources, are inextricably linked to patient safety and quality of care. If the level and quality of resources is poor, this is likely to lead to a greater number of adverse events."[2] The Barraclough review in October 2003, which was reflected to some extent by the HCCC investigation report into Campbelltown and Camden Hospitals in December 2003, recognised that *"The lack of adequate numbers of medical workforce with adequate skill and experience levels is perceived to be the greatest weakness in the delivery of care"* [3] in Campbelltown and Camden Hospitals.

This was never more so apparent than when dealing with the Campbelltown and Camden doctors who were subsequently investigated by the Health Care Complaints Commission. UNITED endorses the principle that doctors should be accountable for their actions. However, as quite clearly emphasised throughout the Standing Committee's report the marrying of professional accountability with the systemic nature of medical error is a difficult exercise.

3.2 The Importance of Adequate Protection for Individuals

Whatever pathway is taken, whether it is through a complaints body dealing with personal accountability or through system processes such as Root Cause Analysis (RCA) and Open Disclosure, it is fundamental that the individual practitioner be afforded protection. Our primary concern when encouraging a culture of learning and the willingness to share information about errors is that the individual involved is protected appropriately. Protection in this context does not imply protection from appropriate accountability. Rather it involves protection from:

- unfair process.
- denial of natural justice.
- premature personal consent and criticism.
- trial by media.
- scape-goating.

The protection can occur in different forms. The most definitive is legislative protection. Protection can also be provided through clearer guidelines and policies which govern processes such as Open Disclosure. Finally, but no less significantly, there is protection through education and training programs.

3.3 The Importance of Differentiating Investigation Pathways

The protection of the individual can only occur if there is a clear differentiation between the different pathways open to the Area Health Service. A single adverse medical incident may give rise to any combination of the following investigation pathways:

- Root Cause Analysis.
- Open Disclosure.
- Complaint against a clinician.
- HCCC inquiry.

[2] Ibid p. 68 para 5.0
[3] Ibid p.69, para 5.8

- Medical Board process.
- Coronial inquiry.
- Criminal investigation.
- Employment contract issue.

There is an inherent danger that the documents relating to that particular incident will cross over from one pathway to another. For example the clinicians report to the RCA team may be used by the Area Health Service as evidence against the clinician in their investigation into a complaint. If there is inadequate differentiation then medical practitioners will not be afforded the legal protection which they are due as of right i.e. procedural fairness. The documents which arise from these different pathways may well be similar in nature as there is only one incident. The medical practitioner has the right to know what pathway he is providing information for. He can then make an informed decision as to whether this information is privileged or not. If the pathways are properly delineated and the documents which emerge are properly identified then open and active discussion and improvement in clinical care is facilitated and encouraged.

3.4 Open Disclosure and Medical Defence

UNITED has had the opportunity of being closely involved in assisting in drafting the Open Disclosure Standard and its subsequent implementation at both national and state level.

UNITED is represented on the State Open Disclosure Steering Committee, which will oversee the implementation of the NSW Health Open Disclosure Policy.

In the formal procedure for adoption of the Standard, Medical Defence Organisations voted in favour of its introduction. In endorsing this Standard it is recognised that *"health care organisations need to foster an environment where people feel supported and are encouraged to identify and report adverse events so that opportunities for systems improvements can be identified and acted on."*[4]

UNITED has never endorsed the philosophy that the medical profession should stay silent and cover up their mistakes. The role of the Defence Organisations being closely involved in drafting and endorsing the Open Disclosure Standard may not be universally known to the individual medical practitioner. It is essential through education and training that doctors are aware not only of the endorsement by Defence Organisations of the Standard but also that the Defence Organisations will play a significant role in assisting members in implementing the Standard. The Standard specifically refers to Defence Organisations being notified at an early stage to provide medico-legal advice and assistance in the Open Disclose process.

3.5 Flexibility and Local "Ownership" of Open Disclosure

The Open Disclosure Standard must be flexible enough to work at any level. In that respect UNITED does recognise that there is a significant governance problem in implementing the Standard. It is just as important that the VMO GP who is running the small country hospital be at ease in applying the Standard as the CEO of a large teaching hospital. This is not to say that there needs to be more regulation. In

[4] Open Disclose Standard Background 1.1.

UNITED's view overregulation detracts from the simple philosophy behind the Standard being an open discussion of an incident that resulted in harm to a patient while receiving healthcare.

Moreover it is important to recognise that the Standard itself provides significant guidance as to application and process. For instance there are appendices' which provide guidance in relation to particular patients circumstances such as the death of a patient or a patient with mental health issues. There is also an example of a matrix for initial assessment of the level of response and an example of an incident grading matrix.

What is important is that practitioners have the opportunity to adapt the Open Disclosure Standard in their own environment to make it work. The local authority and local clinicians must have a sense of ownership of the Standard. In implementing the Standard there needs to be a strong emphasis on support in the local authority, the local hospital and the local application of the Standard.

In the small rural hospital the most senior health care professional responsible for the clinical care of the patient may also be the person best trained in the open disclosure processes and may also be the specific individual who caused the adverse event. Who will carry out the investigation? How can the individual professional escape the blame and shame scenario when it would be almost impossible to hide behind the lack of anonymity.

Issues requiring attention will include:

- who will carry out an investigation?
- how will issues around anonymity and personal blame be addressed?
- how will continuity of medical service be supported?

3.6 Root Cause Analysis

Privilege

In UNITED's view Root Cause Analysis (RCA) is an important tool in improving the standard of healthcare in New South Wales. It is submitted that RCA can work extremely successfully as long as the appropriate protections are in place. Currently there appears to be confusion as to what is or what is not protected. Whether the RCA team is carrying out an investigation into a "*reportable incident*" or some other incident, it is submitted that all documentation which has been prepared for the purposes of RCA must attract privilege. Documents, records of interview tables etc which have been formulated as part of RCA need to be clearly identified for example by use of approved heading or stamp such as:

"***Produced solely for the purpose of RCA. Not to be disclosed***".

There is an obvious distinction between, for example, a theatre list which is a pre-existing document which is not subject to privilege and a post incident flow chart describing the causes of the adverse event, which would be subject to privilege.

That allows the individual health practitioners who are requested to be involved in the RCA to speak freely knowing that all information is protected. Other avenues are available for investigating the individual practitioners over the same incident, if this becomes necessary.

3.7 Reporting possible professional misconduct

Another issue of particular concern to UNITED's members is the interpretation of **s.20 O(1) *Health Administration Act 1992 (NSW)*** which provides that a RCA team must notify the Health Services Organisation if it is of the view that the reportable incident "*raises matters that may involve professional misconduct and unsatisfactory professional conduct.*" The terms "*professional misconduct*" and "*unsatisfactory professional conduct*" are unhelpful in a practical sense as these are specific legal concepts which are referred to in the *Medical Practice Act 1992*. Our members who have had to consider this particular section are concerned that they do not have sufficient expertise to form an opinion whether an incident may amount to professional misconduct or unsatisfactory professional conduct. UNITED accepts that there does need to be a mechanism to report certain conduct however it is submitted that alternative wording be considered with clear guidance and training on how to apply this section.

3.8 Clinical Excellence Commission (CEC) Role

As previously raised there is a concern that different pathways arising from same incident should be more clearly and strictly delineated. This is particularly relevant when identical documents are used in different pathways. It is submitted that the CEC could play an important role in mapping out the clear pathways and the process of the documents through those pathways. The status of all documents, whether it be a statement, report or merely a notification, should be immediately identifiable. Again there should be an emphasis on training and local awareness of this issue.

3.9 Complaints Against Clinicians

UNITED was also grateful for the opportunity to contribute to the NSW Health Policy Directive "*Complaint or Concern about a Clinician – Management*".

Our concern primarily is the underlying knowledge and awareness on the part of the local administrator about proper investigation methodologies and principles.

Our observation is the apparent lack of awareness by the administrator as to precisely what ought to trigger an investigation process and what should not. It is submitted that there must be a sufficient level of training for the administrator to make a sound judgment as to the significance of the information provided for example distinguishing between malicious rumours and appropriate whistle blowing.

The policy directive alone will not answer each and every problem faced by the administrator when a complaint or concern is notified. Issues such as the lack of awareness of the importance of setting and agreeing timetables in order to provide the clinician reasonable time to respond to the concerns or complaint are examples of matters which require appropriate training and judgment.

Case Study: Dr B

Dr B an anaesthetist was notified that his privileges had been restricted due to concern by other staff members. The privileges were restricted without the doctor being provided with any details about the specific incidents or particular issues.

Dr B requested details concerning the particular incidents and/or issues however no details were forthcoming. The Dr was subsequently interviewed by an external reviewer who failed to describe the purpose of the interview or outline the specific allegations against the doctor. The reviewer also failed to explain that the interview was being recorded.

Dr B was not provided an opportunity of seeing the reviewer's report and providing a response to that report. A further interview was held to discuss "*the way forward*". An ultimatum was given that he either be suspended or take leave and be referred to a Medical Board program.

May 2005

3.10 Notification to the family of the referral to the Coroner (Recommendation 13)

"That NSW health takes steps to ensure senior health managers are aware of the existing protocols in relation to notifying family members about the referral of a death to the Coroner."

It is noted that the Open Disclosure process includes providing information to family members of a referral to the Coroner.

From UNITED's point of view it is important that senior health managers do notify family members promptly that there is a referral to the Coroner as that is often a source of complaint by the family. In many respects, it is simply an example of lack of communication from the health service to the patient or the patient's family.

3.11 Notification of outcome of RCA (Recommendation 14)

"That the NSW Health implement a State-wide protocol to ensure that the patient or next of kin of a patient whose treatment is the subject of a Root Cause Analysis is informed of the conduct and results of this analysis by a suitable clinician.

UNITED has had experience that if there is timely feedback on the conduct and results of Root Cause Analysis to patients/carers, the patients/carers make a more informed decision whether it is appropriate to make a complaint or not as to the management and treatment of the patient.

Case Study: Patient F

This was a case of wrong sided surgery. The family were interviewed as part of the Root Cause Analysis process and they were provided with the outcome. The family recognised that there were system issues as well as an individual error. The matter was referred by the Special Commission of Inquiry (SCI) for investigation by the HCCC. The family did not want to be involved in the HCCC investigation.

4. THE SPECIAL COMMISSION OF INQUIRY INTO CAMPBELLTOWN AND CAMDEN HOSPITALS FINAL REPORT, 30 JULY 2004 - RECOMMENDATIONS

4.1 Legislative Clarity

The Special Commissioner identified *"difficulties and obscurities in the present provisions of the law"*[5].

As the Joint Parliamentary Committee in 2003 stated *"this is much to do with the fact that the Health Care Complaints Act has not been reviewed or amended at all since its introduction in 1993. The Committee considers that it is imperative that all relative legislation be reviewed to ensure clarity and consistency"*[6]

It is submitted that though a number of the legislative recommendations made by the SCI in its final report of 30 July 2004 have clarified the two main acts, Health Care Complaints Act 1993 and the Medical Practice Act 1992, difficulties and obscurities still remain.

As it is a co-regulatory system where two bodies, the Health Care Complaints Commission and the NSW Medical Board work hand-in-hand, both acts need substantive revision at the same time. So far there have been piecemeal amendments to both acts, which is not adequate to ensure clarity and consistency required in applying the legislation.

4.2 Representation at Professional Standards Committee Inquiries (S177 HCCA)

Section 177 of the *Health Care Complaints Act* was subsequently amended to allow the practitioner to have a non-legal representation before the Professional Standards Committee Inquiry. The non-legal representation was in part to address and the imbalance that was created by the complainant being represented by a trained HCCC advocate. In our submission, application of s177 is problematic. Whether or not an advocate is legally qualified is an artificial device to avoid over-legalistic process.

UNITED has had recent experience in providing assistance to medical practitioners who have been prosecuted under the new legislation in the ACT. In the ACT the medical practitioner is allowed legal representation for a Professional Standards Committee Inquiry. UNITED has found that legal representation has become a much simpler and more effective way of assisting the practitioner who is being prosecuted. There is no necessity in the hearing for there to be an interchange between the non-legal advocate and the solicitor advising the practitioner as there is only one person, the legal representative who is acting for the medical practitioner. Although it is relatively early days of a new system in the ACT it appears not only to be efficient but also appears to be very fair to the medical practitioner. The ACT also has the advantage (as does the NSW Nurses Professional Standard Committee Inquiry) of having available a transcript which is an appropriate record of the proceeding.

UNITED remains of the view that the legislation should provide for legal representation by leave of the PSC. The fact that PSC's are inquisitorial in nature and are not bound

[5] SCI, Chap. 3, p. 33
[6] JPC, Dec. 2003, p.2

by the rules of evidence makes them analogous to coronial inquiries. Participants in coronial inquiries are entitled to legal representation by leave of the coroner. The concern that legal representation will create an over legalistic and drawn out process has certainly not been UNITED's experience in the ACT. In fact UNITED's experience has been exactly the opposite. Through legal representation legal issues have been identified more quickly and determined more efficiently.

The current legislation is also unsatisfactory in that it depends heavily upon all parties identifying and agreeing to apply the "spirit" of the provision.

5. Further Information/Clarification

UNITED would be pleased to provide clarification of further information in relation to the above submission. In this respect the UNITED contact officer is:

Ms Helen Turnbull
Legal Manager (Disciplinary Services)
UNITED Medical Protection