REPORT OF PROCEEDINGS BEFORE

GENERAL PURPOSE STANDING COMMITTEE NO. 2

INQUIRY INTO COMPLAINTS HANDLING WITHIN NSW HEALTH

At Sydney on Wednesday 24 March 2004

The Committee met at 9.30 a.m.

PRESENT

Reverend the Hon. Dr Gordon Moyes (Chair)

The Hon. Patricia Forsythe
The Hon. Peter Primrose
The Hon. Amanda Fazio
The Hon. Christine Robertson

CHAIR: Welcome to the fourth public hearing of the Committee's inquiry into complaints handling procedures within NSW Health. Each morning I have read a very long statement, which I do not propose to do today, concerning the terms of reference and also the issues of privilege which we have in this Committee. I have also taken some time to remind witnesses to remember the ethical and legal implications of disclosing personal information about patients. I have also underlined the fact that this inquiry is very interested in systemic issues within complaints handling but not the culpability or otherwise of particular individuals.

I remind you that the Committee has previously resolved to authorise the media to broadcast sound and video excerpts of its public proceedings, and that copies of the guidelines for the broadcast of proceedings are available from the table by the door.

In accordance with the Legislative Council guidelines for the broadcast of proceedings, a member of the Committee and witnesses may be filmed or recorded. People in the public gallery should not be the primary focus of any filming or photographs. In reporting the proceedings of this Committee, the media must take responsibility for what they publish or what interpretation is placed on anything that is said before the Committee. If you wish to have any messages delivered, they should be delivered through the attendants or Committee clerks. Would you please turn off any mobile phones during the proceedings.

WENDY ELIZABETH McCARTHY, Chair, NSW Health Participation Council, affirmed and examined:

CHAIR: Would you like to make an opening statement?

Ms McCARTHY: Yes. I will preface my opening statement by saying that we have circulated to the members of the Committee notes on the Health Participation Council, which I will assume you have been able to read. The notes talk about when the council was established, the terms of reference, the kind of activities we have been pursuing, and council membership. Of course, I am very happy to take questions on that later.

I was persuaded to accept the offer to chair the Health Participation Council nearly two years ago because I believed that it offered an opportunity for consumers to put themselves at the heart of the health system. Whenever I have gone out to speak publicly about the council, I have encouraged consumers—by consumers, I mean the community—to speak up and find their voice.

Over a long life of advocacy in health and other issues—in health, I have been a consumer advocate of one kind or another since 1967—I have believed that a healthy system is a system which does respond to the needs of the people it is there to serve. A problem with mature systems often is that they lose sight of that. I saw the Health Participation Council as part of a sequence of activity which offered a way of getting consumers built into the system. This is a truly challenging thing to do; I am under no illusions about how hard it is. But that is the aim: to advise the Minister on consumer and community participation so that we, as a community, have input into how the system serves our needs.

In the 18 months since the council has been in existence we have done a lot of thinking and engaged in a lot of consultation around the State to ensure that we are moving in the right direction systemically. One of the interesting things I think we have done is to sponsor advocacy training for consumers through the TAFE system. That has been a very successful thing, because it is actually quite challenging for people to speak up against any system. Often in health, of course, you are at your most vulnerable when you need to find your voice. So the advocacy system has been good. The community forums have been successful.

CHAIR: Could you elaborate on the TAFE system? I assume you are running some kind of seminars, courses or classes?

Ms McCARTHY: No. We asked the TAFE sector to express its interest, to look at how they might run advocacy programs. The TAFE system trialled it in three areas, and the feedback from the people who have been there has been good. There have been two interesting outcomes. The first is that people want to become involved in the system, and the second is that they found that they have a whole lot more confidence and, of course, knowledge about how the system works. Just finding out how the system works is challenging.

We have totally revamped our book, which has now been group tested and micro-searched. It has been a fairly tedious effort to try to get it into truly friendly English, and it is probably as good as we can do at the moment. The book talks about "You and Your Health Service—Your Rights and Responsibilities". It is a revamp of a previous book, which we have tried to bring into contemporary language. We have used the book to encourage people to be involved and be responsive to what is happening in the system.

We have run an annual consumer conference. At the last conference, which I think was probably the most interesting, we took a theme of what works best and what does not work in terms of getting consumers involved. Again, I would love to say to you that I have a rocket science answer. It is not. It is certainly about information. It is about consumers helping to change the culture so that they are not looked upon as outsiders but as integral partners in the process of health delivery.

Of the couple of hundred people who came to that consumer forum from all around the State—and we have done that twice—we have had some remarkably interesting, successful interventions demonstrated, in terms of interventions in the system to get to be more consumer responsive.

I sit on the New South Wales Clinical Council as a consumer representative, and that is quite a breakthrough because the remainder are all clinicians. We have managed to push members of our group or our nominations, or people we have persuaded and encouraged, to be representatives on statewide committees. I think that has been really useful as well. The Ambulance Service was an interesting one. We had a lot of complaints. You hear complaints vicariously about the Ambulance Service and waiting times. Some of us, including myself, have had a personal experience which made it even harder at the time.

We got to the ambulance people to come in and brief us about what they were doing and what they were trying to do, and they then invited us to be part of their committee. One of the members of our group went along. That has been typical of the kind of interaction we have tried to get. We have asked as many parts of the system to come in, tell us what they do, and say, "We want to be a partner in that." So we have managed to move the consumer into as many decision-making parts of the system as we have been able to identify. However, I am sure that there are still many parts of that I have not found that would need to be identified.

I think probably the only thing I would add to that is that after 18 months, because it was built into the establishment of the council, we went through a review process. 18 months is quite a short time to be reviewed, because with a group of 22 you have really only just got the relationships established and developed an understanding about what you know and who is going to do which parts of the work program. In any event, we have been through that review process, and it has been with the Minister since 8 March.

It was quite a wide review. We asked chief executive officers, area health services and area health councils. We have tried to establish a relationship with area health councils on the grounds that they are the bodies that have been sitting alongside the service delivery throughout the State. By and large, the results have been fairly interesting. There is no doubt that from the review and from our experience there it is a very strong role for consumers to play in the culture, learning and delivery of all health services in New South Wales.

CHAIR: There are a number of issues on which we need to have some guidance from you, particularly concerning complaints handling procedures. Have any members of the community brought to you issues concerning complaints handling procedures, and what is your overview of that?

Ms McCARTHY: I cannot think of particular examples of complaints handling procedures per se. We get generic complaints such as "people are not listening to us". For example, we had a lot of complaints about finding your way through emergency departments so we organised for a review for how the consumer finds his or way through emergency departments. We assumed the competency of clinical service. Instead, we looked at things like signage, access in terms of parking, handling of people at the desk and flow through of the system. We hired somebody to write a report on that. We as a council then went out and tested it in a whole variety of places. Certainly we found there was a great deal that could be done to be more consumer-friendly.

CHAIR: Did the 22 members of the council go to various health centres?

Ms McCARTHY: Not, all but probably 12 or 13.

CHAIR: They went in with their arm in a sling looking for a service?

Ms McCARTHY: They went and sat in the emergency departments and observed. They did not identify themselves until subsequently. They just watched what was happening. We found that things could be so easily fixed up like signage from a main road. People are stressed and they do not know where they are going and there is no sign. They could not park because the doctors were parked outside and there was nowhere for the customer or the patient to park. They are almost trivial things but they are not trivial in terms of accessing the system. That was an interesting exercise.

We then asked Amanda Adrian who was the health complaints person to join us at our meeting in Dubbo and to brief us on the kinds of issues of what she was doing and what we could do in that sense to prevent complaints. We saw our role, when we heard those kinds of things, as what could we do to make it better? The emergency department was then a neat little exercise. In a sense, revamping this into something a bit more friendly was another response to that. We were interested in what she had to say not just about the handling of complaints on which we were briefed but the kinds of advocacy programs that she was looking at establishing, and some of which she was trialling at the time, on how to stop complaints.

The generic complaint that we would hear probably most was "I don't know who to go to when I want to change something". That is a sort of lower-case complaint. "I am not in strife necessarily at this time when I want to do this, but I am not quite sure how to find the information, and don't give me a web site address because I don't have a computer. How do I find the answer to the question?" The second one would be "Can I stay with my mother, sister, auntie, child et cetera when we go into the hospital? If I have to leave them who do I contact to make sure they have got someone looking after them" as opposed to the clinical process.

There has been a lot of generic interest, I think, in the idea that the patient in a health facility needs advocacy. As I have spent a significant part of my life doing that, maybe my antenna is up to hear that, but people know that when you are an older person in an emergency department it is very important to have somebody there who is looking out for you.

CHAIR: Is your emphasis not necessarily on doing something but making sure someone is doing it?

Ms McCARTHY: I think that is right.

CHAIR: For example, you called in the HCCC and said they should be more proactive in prevention and complaints handling in the system.

Ms McCARTHY: That is right.

CHAIR: Is the role of your council to look at the complaints pathways, even though the book you produced is about rights and responsibilities?

Ms McCARTHY: Complaints pathways is an interesting one because that phrase came up at a meeting we had in the Central Sydney Area Health Service, I think. Our standard procedure or protocol is we hold a health forum in the area for non-government organisations or people who are interested. In some ways it is a way for people to let off steam and talk about what it is bothering them in the area. We came back and we said "What is the complaints pathways for people like that?" because at that forum, particularly, there were a lot of people who had issues about the siting of mental health facilities. They, as a mental health lobby, claimed they had not been consulted. We went back and talked about how we could make it a better system. We cannot actually do that ourselves. We have to cause the system to be responsive in a sense. We are kind of internally saying to the Minister that we do not think this is working.

A better example is that we had quite a few complaints about isolated patients travel access—known as IPTAAS in the health system. People kept saying to us that the major health issue is transport, not just in rural areas but in urban areas as well—they cannot get to their treatment because they cannot afford it, they do not have access to transport, let alone affordable transport, they do not have a bus or a train that goes in a direct way and they are a little bit frail or what can we do if they are having chemotherapy. So we have worked consistently with the department to try to get a better answer. I do not think we are there yet.

We have got some resolution on the IPTAAS issue that was about the amount of money, should it be a 200, 250, 300 qualifying rate that was paid per kilometre for treatment.? The IPTAAS lobby group wanted it to be the same Australiawide. The department had a view that said there were other ways to look at it. The really interesting resolution, as it is at the moment, is that we have made a big difference to looking at transport across the State, and at the same time we have got a resolution for IPTAAS to bring it into parity with the rest of the country. That is a kind of complaints pathway. We will try to push the system and we will try to give some satisfaction to the particular, hopefully with the residue that we leave somebody a little bit more aware of how to make this work next time.

CHAIR: Did you publish the report on the emergency departments?

Ms McCARTHY: It has certainly been circulated. I will have to take that on notice. I will bring it back to you.

The Hon. PATRICIA FORSYTHE: The terms of reference of the council refers to "initiating and reviewing policies being developed by the New South Wales Department of Health". The committee received a background paper entitled "Complaints Handling Procedures and Equality Agenda", dated March 2004. Did your council receive a copy? Have you been asked to look at it? Did you have any input into its preparation?

Ms McCARTHY: Our executive officer had input into it. I received a copy of it yesterday. I believe that all council members were sent a copy yesterday. Yes, the internal part of the system. I had discussions with him.

The Hon. PATRICIA FORSYTHE: Twice during your presentation you referred to changing the culture of consumers being seen as outsiders. All of the good policies in the world will not count for anything if cultural issues are not addressed. How deeply embedded in the system is the cultural issue? Is there some willingness to actually change it? If so, from where is it coming?

Ms McCARTHY: That is the $64 question. There is a spoken and really strongly intended commitment that consumers must be partners in health. I think there is an understanding that that means there will be some changes in the culture. I think there have been some but it is still a struggle. It is a struggle for people, and that is no different from any other system that I have dealt with in my life. How you achieve cultural change in an organisation which is constantly in the public eye, and dealing with life and death issues, is really hard. It depends on a lot of people being prepared to take risk, and risk when you are under fire is really a hard thing to take. It depends a lot on trusting the people you have in those positions, so perhaps I can take a little bit more risk than some people in the department because I am not a part of it, yet I really support what it is trying to do because I understand how difficult that is.

On the other hand, it has to learn to be a little bit more speedy and responsive to change, and to risk taking. If somebody saw that on the front page of the paper they would say "Don't take a risk with our lives." They could say that, but in terms of the culture, I think the fact that I have been made a part of the clinical council and when I say that, the Health Participation Council, is a breakthrough. There is a willingness, and 18 months down the track I think we are still working out if this is the best way systemically to help change the culture. I think it probably is, and if it is not I am not sure that we know the answers yet. I wish I did. We probably would say, in terms of sharing culture, that they would be the group that we would like to see we enhance our links with.

The Hon. CHRISTINE ROBERTSON: I am interested in this issue because your membership, although very representative of every interest group in the State in relation to health, does not necessarily represent the localisation that occurs in the area health councils. Can you tell me how they actually communicate with you? Is there a process where the information goes back? They are more general community people, are they not?

Ms McCARTHY: Yes, they are general community people and in various areas they reflect the area they are in, but they are also constituted quite differently and that is their charter. For example, the Northern Rivers Area Health Service chooses theirs on the basis of interest, so there is an indigenous council, a clinical council, et cetera. Others choose it on the basis of geography, a bit like local government, so they arrange it like that. We keep in touch with them. We have done an audit on them since we have been there because that was part of our brief when we were established.

We meet them at the annual consumer forum. We speak to them when we go out to the area. We use them, I suppose, as our partners in health throughout the system. What we have been working through is whether we should set up—in fact, I am going to Orange next week to talk to the Orange group, the Central West group—a peak area health council body, which is really us and them, and then we have the formal indicators on how we will perform annually. That is work in progress and an idea that we are just evolving at the moment.

The Hon. CHRISTINE ROBERTSON: My other question relates to the booklet again. Have plans been put in place to make sure that it actually gets to the community?

Ms McCARTHY: No, but there will be. There is every intention that there will be and, again, an automatic system response is to put it in health places; an automatic response from me is to put it in newsagents or post offices.

CHAIR: Yes, indeed.

Ms McCARTHY: That is work in progress too, and, to be fair, we have not really had that discussion, except peripherally because I know that you need it before you get sick.

CHAIR: Public libraries, neighbourhood centres, senior citizens centres?

Ms McCARTHY: Yes. We have looked at a program in the New South Wales public library, which is putting Health online and it has been trialled for a year and it is a really lovely program. We are looking for some extra funds to have a community on line program in every library in New South Wales. We have received a submission on it and it would be a really nice thing to do.

The Hon. PETER PRIMROSE: How does your organisation relate to other groups such as the Medical Error Action Group?

Ms McCARTHY: There is no direct relationship. We are a stand-alone group. We go out seeking our relationships and work our way through the system.

The Hon. PETER PRIMROSE: Do you have any interaction with them at all?

Ms McCARTHY: I have not, no.

The Hon. PETER PRIMROSE: In light of some of the things you have said already, can you cite what you would regard as some very good examples of practice at the moment in relation to community and consumer input in New South Wales? Are there any things you can point to which are examples of good practice?

Ms McCARTHY: Yes, and every year we have the health awards and one of the categories is consumer participation. They range from areas like Wellington, where everyone decided to lose weight together, which was a lovely program. The thing that was interesting about that is that when people relate to each other and talk to each other about the process, a lot of information that seems peripheral is exchanged very effectively. It is a wonderful learning program.

There was another program on birthing on the North Coast where the entire system of birthing was changed—the clinical services for birthing were changed—because of the work of a group of particular women; I cannot remember the name of the project but that was a very good one. Another outstanding project was one near Warialda in the North West where a group of local people became involved in indigenous housing—a housing and health and education dream to work together. For the service delivery of all of those things, everyone made adjustments in order to solve some of the systemic issues and that seems to be a remarkably successful program, so there are some really good programs out there.

What you worry about is that they are seen as pilots and they do not become systematised. That is the next challenge, but people know that is the challenge. If they make that their program, that is fantastic, and I believe our job at the centre is to work out how to make that part of the system.

The Hon. AMANDA FAZIO: I wanted to ask about the promotion of better communications as part of community participation in health. We have heard a fair bit of evidence by people, particularly in the complaints handling area, that a lot of these problems could be nipped in the bud if there were better communications between patients and medical practitioners, nurses, et cetera. In terms of health participation, it seems to me that promoting better education would be an essential part of that. Apart from the booklet you have been talking about that will be made available in the best places—

Ms McCARTHY: I do not even assume that people can read, but go on.

The Hon. AMANDA FAZIO: What else have you been doing to promote better communication in the health system?

Ms McCARTHY: I think we have been encouraging area health services to do that and we have been encouraging them to cross some of those silos, like some of the programs they have been involved in. In a more particular way, many of us have gone on to seek important clinical groups within the department. For example, I have been on the Guidelines for Death and Dying, Advanced Care Directives and Care of Older People. A very clear focus we have had there is to encourage communication between the clinicians and the customer; just saying that all of the best care happens when people have a conversation first. It sounds trite but actually it is one of the issues.

If somebody walks in and looks over somebody who is in the prone position and does not engage in conversation, you will not get the quality of care that you could get if the consumer is better informed. It is about trying to encourage clinicians to keep listening to the consumer and saying that those conversations really matter. There is plenty of evidence around the world that those conversations get better health outcomes.

In other terms, let me think of things that we have done specifically. I think probably most of all just being a part of as many parts of the system as we can to encourage that. I cannot think of any other particular examples. Can I take that on notice to see if I can think of something that is useful—certainly, being involved in policy development and being involved in some of the programs.

CHAIR: That has been most helpful. Are there any other questions?

The Hon. AMANDA FAZIO: This question might be seen as being a bit cheeky as Dr Arthur Chesterfield-Evans is not here, but we have heard a lot of evidence from people about the hierarchy within the health system in terms of more senior doctors being at the top of the pecking order, working your way down through to the nurses—

The Hon. CHRISTINE ROBERTSON: And they have their own pecking order.

The Hon. AMANDA FAZIO: That is right—and the way in which that inhibits the flow of information and flow of communication between patients and the people who are treating them, because people are not going to question them. The ordinary doctor doing his rounds thinks there is something wrong with a patient, so he or she goes off to get somebody more senior, and then a visiting specialist will come in but the patient is just lying there and nobody is telling them exactly what is going on. Have you been doing any work to help break down that hierarchy so that the flow of information is much better? I know it is a little bit outside the terms of what the Health Participation Council is doing, but people may not feel they can question or ask, from a consumer viewpoint, because a lot of people would not even be game to ask the first doctor who hovers around their bed—

Ms McCARTHY: First, information is the key. If you have information you feel so much more able to ask questions. One of the significant issues for consumer participation is better informed consumers—information, information, information, and, of course, in a way that people take notice of and absorb it. Second, you have outlined a scenario that may happen in some places but, I am afraid, in many places not only is there not a medical practitioner, a specialist or anyone else to consult, it is left to the clinician who is there right at the moment, who is usually the nurse.

It is no secret to anyone, because I was doing this in the seventies, that I am a great supporter of enhancing the nursing role and I believe nurse practitioners are a very effective way of spreading the load and keeping close to the consumer. Anecdotally, we hear that and personally, of course, having nursed a mother dying in hospital two years ago just when I started this job, I observed probably more keenly than I might otherwise how difficult it is. That would also lead to my earlier remark when I said that we should find a way in which we can have our advocates with us when we are in hospital. In other parts of the world, at least in New Zealand and the United Kingdom, there is a patient advocacy system, which is run by volunteers, where people going into hospital—unlike my mum, who had me and my sisters—can get someone from the community to be with them. Often, even if you know what question you want to ask, you are already disadvantaged because you are ill when you are in hospital. It is about information but I think an advocacy system would probably help us quite a lot in dealing with the system, and it seems to be working really well in those two places.

CHAIR: I noted in the work of the council that you had indicated last year you would be looking closer at the issues of complaints handling. Could we encourage you to do that. In the evidence that has been presented to us already there are very serious and widespread issues concerning complaints handling procedures and although we will be making recommendations on this, it is the sort of thing that the Health Participation Council should have on its agenda and we would encourage you to do that.

Ms McCARTHY: Thank you, we will.

(The witness withdrew)

ALLEN ROBERT THOMAS, Director, Medico-Legal Strategic Policy and Training Division, Australian Medical Association, sworn and examined:

CHAIR: Would you like to make an opening statement? We have some papers from you, but perhaps you might like to go through those first.

Mr THOMAS: I would like to add to the submission that has been provided to this honourable Committee that I would recommend and make available to the Committee at a later stage, a supplement to the *Medical Journal of Australia* dated 15 March 2004 that deals with a number of issues relating to best practice and evidence in medicine. I have only had a chance to scan this on the way in, but I think it probably goes more to restate the problems rather than finding solutions. But I would recommend it to the Committee and make it available as supplementary reading for you.

CHAIR: Thank you, that would be very desirable. Would you like to speak to your submission?

Mr THOMAS: The submission, as you will note, deals with organisational issues rather than individual complaint issues. Nevertheless, in the context of the important matters that have been considered by this Committee, I considered it appropriate that perhaps this submission should come forward.

The Hon. PATRICIA FORSYTHE: Could you contrast the Hunter system of complaints handling with the South Western Sydney Area Health Service, for example?

Mr THOMAS: I believe the system at Hunter is a developing art; it has not reached the state of perfection, if you like, or the level that we would like to see it develop to. My anecdotal advice, in speaking to a number of senior clinicians and administrators in Hunter and other areas, is that the system, and I think mainly through lack of resources, has not been rolled out to the extent that it should. AIMS in the Hunter Area Health Service has been a good step in seeking to bring forward statistical data that will assist in clinical governance, but it seems to have stalled not only in the Hunter in terms of what they are able to extrapolate from the information that is gained from the software program associated with clinical incident reporting, but there seems to have been very little, if at all, roll-outs into other area health services.

The Hon. PATRICIA FORSYTHE: Take us through the process of the clinical incident in the Hunter. What would be the feature of that system that marks it as something that is different?

Mr THOMAS: The feature of the system is that there is a dedication, if you like, to clinical incident reporting in a structured form, which allows other information, hopefully, to be gathered from that, which would eventually result in feedback to the area, the different entities within the area and individuals to assist in quality assurance of service delivery.

The Hon. CHRISTINE ROBERTSON: Thank you very much for an excellent, well thought out submission. I recognise that it is not specifically about complaints. It certainly gives us a good overview. I was interested to read paragraph 5, which talks about unequivocal assurance to the then Minister for Health in relation to participation in the governance processes.

CHAIR: That is my question, too. It is a good one.

The Hon. CHRISTINE ROBERTSON: I have been heavily involved in trying to set up governance processes within an area health service. There were some difficulties in getting medical practitioners and other health people involved in the process, or getting them to want to own the process. There was even some anger. Do you have any thoughts on that?

Mr THOMAS: Yes, I would say that there is probably still a very high degree of suspicion and uncertainty about the process, particularly relating to the de-identification of data. As I said later on in the submission, the privilege that should be attached to committees considering whether clinical incidents are of a nature that need to be reported there would need to be some privilege attached to those reporting and consideration mechanisms to ensure that we do not find where there is a system failure that it can be sheeted home to an individual. It may very well be that at the end of an inquiry into a clinical incident there may be human error, but it has to at least start with a structured system rather than going direct to the clinician or the allied health professional involved and seeking to sheet home blame there.

The Hon. CHRISTINE ROBERTSON: We had very good evidence yesterday morning from a young medical officer in relation to hierarchy and elitism and getting these things. Do you think anything is happening to break that down? Is there movement, such as "You're not having that bit of information, it's mine"?

Mr THOMAS: I have not been aware of that. As I have said in my submission, there is a strong culture of learning within the health system between consultants and doctors who are only doctors in training or moving through the system. If what you have indicated is in evidence to a marked degree it would be a tragedy. Doctors, as other professionals or any of us, learn only through their mistakes and following on from those mistakes appropriate guidance and counselling. I would sincerely hope that what you have just indicated may have been an isolated incident, and there can be strong personality clashes between junior doctors and their consultants. We have had situations where supervising doctors have had difficulties with junior doctors, and junior doctors with senior doctors in terms of their supervision for higher qualifications moving through the college system. I would like to think that they would be isolated incidents rather than of frequent occurrence and systemic in the system.

The Hon. AMANDA FAZIO: Yesterday a witness made the point that it was too late once people were working in the health system to then try to get them to come to grips with the concepts of clinical governance and appropriate responses to complaints handling, and suggested that it is something that ought to be included in training for health professionals before they hit the system. Do you have any views on that?

Mr THOMAS: I would think that as an organisational position the AMA would agree with that, in that the more learning that can be provided to students or doctors in training before they enter into a system would be most beneficial. We are concerned that clinical governance should not be a blunt instrument to force change. It should be a subtle instrument that is guided and assisted by appropriate evidence and data that comes out of quality and quantitative assessment of clinical incidents.

The Hon. PATRICIA FORSYTHE: Does the current structure of Health mitigate against a quality system? I am thinking in particular the area health system. From other witnesses we have had some criticism of that.

Mr THOMAS: I am sorry, could you repeat the question?

The Hon. PATRICIA FORSYTHE: Whether the actual structure of the health service itself mitigates against the development of a good quality assurance system. They have had some criticism, for example, of the area structure.

Mr THOMAS: I believe that in the areas that does create a problem, and the reasons I have indicated that in my submission is that there are never any resources or money quarantined to provide assistance to the clinicians or allied health professionals in that particular area. What happens is that the area health service gets a budget, the budget is very rarely quarantined off into clinical services, nursing services, hotel services and laundry services. What happens is that most of them are trying to manage with a budget that is not adequate. There have been significant savings or efficiencies, I believe, over the years relating to significant reductions in bed numbers right across the State. To my non-economic mind that can only mean that there has to be better productivity from all of the service providers, which has resulted in fewer patient bed days.

If that occurs the best place for those efficiencies and savings to be directed is back into the system to be quarantined for quality assurance. Once again, I know this is a trite saying, prevention is better than cure in these circumstances. If we can develop a system appropriately resourced to ensure that the quality assurance systems lead to appropriate clinical governance, which in turn lead to education of the profession and other allied health professions in better service delivery it means then that we do not have this situation where complaints process is going to be the driver, if you like, of huge amounts of money out of the system rather than the education through a proper process of quality assurance.

The Hon. PATRICIA FORSYTHE: We have just had an announcement of the restructure of the HCCC. Does the AMA have a view about the proposed changes?

Mr THOMAS: We have been seeking to get more detailed information about that. We have not had that as yet. We were highly critical of the previous, perhaps not the structure of the HCCC, but certainly the legislation that limited the HCCC to not comment on resource issues when dealing with complaints. We found that to be a significant failure in the legislation. In other words, if you have an investigative body it would be our view that it must be given almost total investigative powers rather than to be constrained by its own Act in providing all of the responses that it feels should be provided in terms of investigating a complaint.

CHAIR: You said to our question concerning the system encouraging opening an active discussion for improvement in clinical care that the AMA was of the opinion that although it attempts to encourage that, and you did not really finish what you were saying. I assume that you are saying that in reality it does not happen or something like that?

Mr THOMAS: It happens to a limited extent. I believe that all the goodwill in the world is there, including that from NSW Health, with which we are active opponents from time to time. But I believe on this issue—

CHAIR: The attempt is there.

Mr THOMAS: The attempt is there but if the resources are not there all the goodwill in the world and all of these very relevant documents they put out—about clinical management, evidence based, clinical pathways—are just useless unless it can be funded properly.

CHAIR: Do your members make complaints to you about non-performance in the area of handling complaints?

Mr THOMAS: I qualify this by saying that I was in attendance in the public area when the doctors from Camden and Campbelltown were giving their evidence. Those comments have been made to the AMA. As I have indicated, we would not raise these as a singular issue through the NSW Health complaints process; they would be raised as organisational matters with the Minister for Health or the director-general, with whom we meet regularly.

CHAIR: Although Camden and Campbelltown were featured, have you had complaints of a similar nature from other area health services?

Mr THOMAS: Yes, we would have had similar complaints.

CHAIR: Which areas stand out in your mind?

Mr THOMAS: You will forgive me, Mr Chairman. We take many phone calls. I could make that information available by going back through our telephone records.

CHAIR: For example, one witness said that there were more complaints about the lower North Shore than other areas. Others would have the view that it might be around the Western Sydney Area Health Service. Do you have any comment, without going back and checking?

Mr THOMAS: Only to say that in many circumstances they would be parochial comments. If a doctor works in Royal North Shore and he has a difficulty there he contacts us. We contact the administration and then a process starts. We do deal regularly with the concerns of the medical staff council rather than individuals. But we do not discount what an individual says to us. To ensure that we are getting a broad picture of the concerns we would ask a doctor who telephoned in the circumstances you mention, "Have you brought this to the attention of the medical staff council ?" We allow that process of filtering to make sure that we are not dealing with a vexatious or frivolous matter. It is given a broader context before a large group of doctors, who would be salaried. Also, the administration may be in attendance at those medical staff counsel meetings. If it comes back to us through the medical staff council we would be reasonably assured that what we have been provided with is accurate information.

The Hon. CHRISTINE ROBERTSON: Do you find that the kinds of complaints that come from medical officers are in relation to the system or things that have happened to them in the system or do you usually find that there is a system problem, a conflict problem, or a clinical problem?

Mr THOMAS: All of that. We would deal with it generally as an issue that a particular doctor has with the administration. The end of our inquiry, involving the administration, may establish that it has been a system error. It may establish that a junior doctor has a personality conflict with a senior medical administrator, or it may, as you have indicated, establish the human error in terms of poor patient outcome from the service delivery by the doctor. So it encompasses all those things. But I must say that of those three parameters that you have provided one would not come to my mind as being more prevalent than the others.

CHAIR: Has the AMA had complaints from member doctors about the length of time the HCCC has taken to get into some complaints?

Mr THOMAS: Yes, and I have been involved personally in guiding doctors through that process where complaints have not been finalised for up to 2½ years. That is just absolute justice denied to all concerned—to the patient and the doctor.

CHAIR: Indeed. What is the quantum of complaints about the HCCC?

Mr THOMAS: Over the past five to six years the AMA has had regular meetings with the HCCC about its complaints review processes. On a number of occasions we may be able to deal with them by a telephone call on behalf of the doctor to the HCCC to try to find out where the complaint is in the process. On a number of occasions we cannot. In terms of the quantum I would say that for the majority of complaints that are notified to our members there would be a concern about not only the processes of the HCCC but the length of time to come to resolution. In terms of numbers, I am not able to indicate whether there have been 100, 200 or 300. I do know that there have been three or four major issues that we have been involved in concerning individual doctors. That is before both the HCCC and the medical board.

The Hon. AMANDA FAZIO: We have heard from a number of witnesses that the health complaints system introduced in New South Wales, which was developed by the Veterans Administration in the States, is world's best practice in terms of complaints handling systems. Would you agree with that statement?

Mr THOMAS: I do not have a detailed knowledge of that process. I have been fairly well entrenched with issues with the Minister and the HCCC and NSW Health so I do not have a good knowledge of that. I know of it but not about it.

The Hon. AMANDA FAZIO: In general, apart from buckets of money, what do you think could be done to improve the way that complaints handling is dealt with?

Mr THOMAS: First of all, I do not believe that it would require buckets of money. It requires a well structured and planned system to be put into place that all can have confidence in—the patients who bring a complaint through the Health Care Complaints Commission, as it may be structured in the future, the clinicians to enable them to have the confidence and no suspicion about being able to declare what they believe has been the cause of the clinical incident, and also the privilege of the committees or the peers who might be examining that incident to ensure that they are not going to be subject to any legal action or whatever. The resources that are available to NSW Health I believe should be able to cope with that. As I said in my submission, there have been some excellent documents that have come out relating to quality assurance, risk management and peer review but to this stage they have been underresourced.

The Hon. AMANDA FAZIO: We have heard some evidence about a no-blame complaints system. Do you think that is really the way to go?

Mr THOMAS: It is the way that the system or the structure should commence. At the end of the finding of a committee of that type it may very well be that this has been clinical error or procedural error. But at least with the confidence of open disclosure, no retribution, the clinicians I believe would feel far more confident in disclosing what needs to be disclosed to allow an appropriately constructive peer review committee to deal with the issue.

(The witness withdrew)

DAVID IAN BROWN, Solicitor, Legal Manager, United Medical Protection and Australasian Medical Insurance Ltd, sworn and examined:

CHAIR: Mr Brown, I have read out a formal statement about your responsibilities and the care you must take on divulging patient information without their consent, and issues such as that have absolute privilege connected to them. Even though issues may be discussed before other courts the consensus of legal opinion is that we have a precedence on other matters so we can discuss issues that are sub judice if you so choose. In what role do you appear today, is it private or are you representing a group?

Mr BROWN: I represent United Medical Protection and its insurance subsidiary, Australasian Medical Insurance Ltd.

CHAIR: The Committee has received a submission from the organisation. Do you wish to make an opening statement or speak to that submission?

Mr BROWN: By way of opening statement I will put in context our involvement in complaints in NSW Health. United Medical Protection is a medical defence organisation which, through its insurance subsidiary, provides indemnity to medical practitioners in relation to civil claims for damages, disciplinary matters and, therefore, complaints matters as well as coronial inquests. United also provides a medico-legal advisory service to its members, mans a telephone advisory service and provides written advice. That is the context in which we see complaints. To some extent we see individual situations and incidents and sometimes we are able to see trends emerging out of those.

Apart from handling those individual complaints and incidents we have a commitment to education and risk management services. Particularly in the last three or four years the organisation has had a major increase in focus on the risk management provision of those services. Also we have had a major involvement in the open disclosure project and being part of the group that was consulted, and we provided advice in relation to that project. We were strongly supportive, and still are strongly supportive, of the open disclosure project, which we see as a significant starting point us. Perhaps it is not a starting point, but a significant step in changing some of the culture about adverse incidents in health. That is all I want to say as an opening statement.

CHAIR: With the number of patients who want to take legal action against practitioners for various reasons, and you call them defendants, have you seen significant numbers of complaints that the system has not worked for people?

Mr BROWN: It is hard to deal with that on a numerical basis. Often there is an element in litigation that there is dissatisfaction with the communication process, with the handling of a complaint. So we often see that there is a breakdown in communication, which has fuelled the litigation, caused anger and concern. That is certainly one of the messages which we send out to our members. Often the major concerns are not the technical-clinical matters but communication issues and that the proper follow-up with an adverse incident occurs. It is certainly a feature that is in a lot of claims that we see.

CHAIR: Can you quantify that in any way, perhaps as a percentage?

Mr BROWN: I am aware of one study that was done a couple of years ago within our organisation which suggested something like 60 per cent of claims against surgeons involved an issue of communication failure. That is a pretty rough statistic but that is the order of things.

The Hon. AMANDA FAZIO: Does United Medical Protection [UMP] believe that there is a culture of blame within NSW Health and a willingness to share information about errors and systems failure? How do you reconcile that from your organisation's viewpoint; that is having an open complaints handling system versus doctors being concerned about legal liability?

Mr BROWN: I think it is a changing environment. We are very aware of the work being done to change the environment towards a more open system. We think there is a long way to go. In participating in open disclosure, yes we had a role in saying that there are legal issues, we do have concerns, but we needed to correct a misunderstanding that medical indemnity organisations are in favour of closing the doors, remaining silent, not addressing problems up front. Certainly our advice to members is to deal with adverse incidents and problems when they arise, to speak frankly, to not disappear from the scene and to get involved in proper support and follow-up. That was the perspective we gave to the open disclosure project; that we would reinforce that with our members.

The Hon. AMANDA FAZIO: You said that there is a need to improve communication, because it plays such a critical part in problems and complaints. The Committee has heard evidence that training on issues such as clinical governance and complaints handling should be included in the education of medical practitioners before they hit the health system. Do you support that? Do you think there should be greater emphasis on communication training in the training of medical practitioners?

Mr BROWN: Absolutely. We strongly support that view. We see the communication process, to take the example of surgery, starts before a procedure is undertaken. There has to be a frank exchange between doctor and patient about the options, the risks, and those sorts of issues. If there is an adverse event, there can be a further frank discussion which marries up with the previous discussion, and we see a breakdown in that process. We are often concerned that practitioners do not appreciate the need to have that frank and open discussion before treatment, about the options and risks. Since the early 1990s, that has obviously been a feature of litigation against doctors; not so much with clinical-technical failures, but failure to properly communicate, to warn, to provide options and to discuss potential adverse outcomes. That was a major feature of the 1990s.

The Hon. AMANDA FAZIO: Do you think patients and their families have unrealistic expectations about what can be done to ensure good patient outcomes? These days one must be fairly ill to get a bed for more than a few days in a public hospital. Do you think people are aware of the likelihood of death? Do your members have to confront the unrealistic expectation that people will always be saved or their conditions improved?

Mr BROWN: I think there are some unrealistic expectations and there is certainly room for improvement in addressing those expectations. It is obviously part of the changing view of all professionals, including doctors. They no longer have some sort of elevated status; they are regarded as being human. But people sometimes forget that they cannot work miracles and that they work within the strictures of the public system where there will be systems problems and so on. I think it is a serious issue that many patients do not fully appreciate.

The Hon. CHRISTINE ROBERTSON: I do not have a handle on what the expression "open disclosure" means for your people.

Mr BROWN: At the moment, as I understand it, it has the status of a standard that is there for adoption by public hospitals. So it is particularly relevant to public hospitals at the moment but potentially has future applications to the broader health industry. It involves providing a set of principles and a process for dealing with adverse incidents in terms of disclosure of what has occurred and follow-up investigation, provision of information and apology to patients.

CHAIR: It may assist you to know that the HCCC ran a special project called Open Disclosure.

Mr BROWN: We may be talking at cross-purposes.

The Hon. CHRISTINE ROBERTSON: That is all right. I want to hear your comments.

Mr BROWN: When I talk about open disclosure I am referring to the development of a national standard for open disclosure in public hospitals. That involved consultation with a wide range of stakeholders, including the HCCC. But I am not sure that that is the context in which it mentioned open disclosure.

The Hon. PATRICIA FORSYTHE: What is the obligation on your member doctors when they are involved in an adverse event?

Mr BROWN: From our perspective or under open disclosure?

The Hon. PATRICIA FORSYTHE: From your perspective.

Mr BROWN: They are required to make notification of the incident as early as possible.

The Hon. PATRICIA FORSYTHE: To you?

Mr BROWN: Yes, to us. We follow up from there.

CHAIR: Do you take a statement from the doctor at that time?

Mr BROWN: It depends very much on the nature of the notification.

CHAIR: On the basis that that which is presented closest to the event is more likely to be accurate than that which is presented afterwards, when you get a complaint do you request it in writing in full? Do you take statements?

Mr BROWN: It depends on the nature of the notification. Obviously if there is a serious complaint we would be minded to do that, yes. We would give the member advice about the preservation of contemporaneous records and those sorts of issues.

The Hon. PATRICIA FORSYTHE: Is there any requirement on you as an insurer that would impact on open disclosure?

Mr BROWN: There is a general requirement in our insurance policy—and I think in most insurance policies—about not encouraging claims and not making admissions of liability. Obviously that is a point of tension: Doctors will feel constrained that they cannot speak frankly to a patient.

CHAIR: They cannot say, "I'm sorry, but".

Mr BROWN: We certainly say that, notwithstanding the wording of your insurance policy, you certainly can say, "I'm sorry".

CHAIR: "I'm sorry it happened" not "I'm sorry, I made an error".

Mr BROWN: I think that would depend on the circumstances. If there has been a frank error and it is absolutely clear that an error has been made it would not prevent the doctor from saying, "I've made an error"—in fact, we would encourage it.

CHAIR: I am not reflecting on UMP; that is the policy of all insurance companies.

Mr BROWN: Probably our main concern is the bringing into existence of statements, whether written or oral, that could be misleading. In other words, if a frank error has occurred—someone has operated on the wrong site, for example—it will ultimately make no difference to us whether the doctor admits as much straightaway. It is more complicated when a doctor feels distressed, guilty or whatever about an outcome and may make statements when he or she does not have the full facts or understand what has given rise to the problem. So you can bring into existence statements that are quite misleading. That is why I say it depends on the case.

The Hon. AMANDA FAZIO: This inquiry is looking into complaints handling within NSW Health. I am not sure whether you are in a position to provide us with this information, but what is the ratio of cases that you have to deal with from public hospitals versus private hospitals versus private practice?

Mr BROWN: I do not know that I can give a very accurate answer to that question. In relation to civil claims, for example, we did some work a number of years ago in an attempt to identify the difference between private practice and public practice. The results vary from specialty to specialty, but it was a comparatively low percentage in public practice giving rise to civil claims. In other words, in relation to our members the substantial majority of civil claims involving suits for damages arose from private practice not public hospitals. I cannot tell you the answer in relation to disciplinary complaints.

CHAIR: Do you have an opinion about how NSW Health handles its complaints?

Mr BROWN: Yes, in terms of formal complaints to the Health Care Complaints Commission, we have made submissions previously. One of our major concerns is the concept of the culture of blame. We are concerned that when an adverse incident occurs hospital administrators, for example, may feel the need to refer those matters to the Health Care Complaints Commission—or, indeed, to other bodies, including the Medical Board, Pharmaceutical Services and the ICAC—almost as a matter of course in our experience, which unfortunately will escalate the issue.

In the hospital context, that is often concerning because there may be a mesh of personal problems and systems problems and it may not be appropriate that the hospital administrator makes that judgment. We have had some unfortunate cases of that kind, in which sometimes a doctor has frankly said, "I have been involved in this adverse incident," and the hospital administrator has simply signed a statutory declaration stating, "I complain," attached the doctor's statement and sent it to the Health Care Complaints Commission. That is the sort of conduct we would regard as troubling. It is troubling in terms of quality issues, because in that environment people are not going to co-operate and are not going to deal with the systems problems and the quality problems.

The Hon. AMANDA FAZIO: Would you promote the idea of conciliation with regard to these claims, rather than a person latching onto a lawyer to see what they can get out of the system?

Mr BROWN: Absolutely. We are strongly in favour of the range of methods to prevent litigation or give early closure to an issue, whether it is conciliation, mediation or direct discussion.

The Hon. AMANDA FAZIO: Do you think there is scope for conciliation to take place when the incident has occurred in a New South Wales State hospital?

Mr BROWN: Yes, I do. I believe it should be. There may be practical difficulties in the hospital system at present, but it should be a feature. It needs to be done in a realistic way. There can be immediate action taken to ensure that the patient is aware that a matter is being followed up and they are going to receive proper follow-up care, and there may need to be a short period of time allowed to gather the material before people go off half cocked. But subject to that, if you can conciliate a matter, you should do so.

The Hon. AMANDA FAZIO: We have heard evidence that the system of health care complaints put in place in New South Wales is very good. There seems to be an issue about how the system is working at the moment. Do you have any suggestions for positive improvements in complaints handling within NSW Health?

Mr BROWN: We have had some particular problems in matters involving the Health Care Complaints Commission. We think that some efforts have been made to try to improve the operation of the commission. One of the major problems has been delay. Another significant problem relates to matters that just hang around in the system for years, causing stress to everyone involved. We think there have been problems with the way matters have been investigated and assessed.

The Hon. CHRISTINE ROBERTSON: By the Health Care Complaints Commission?

Mr BROWN: That is correct. One of our concerns in that regard also has been what we consider an inadequate separation of the functions of investigation and prosecution. Whereas in other environments those who are charged with the responsibility of investigation would not then assess their own work before prosecuting, in our view that has been part of the culture of the Health Care Complaints Commission. It has led to some matters progressing to the Medical Tribunal and dragging on for years when there is really no substantial evidence to support the complaints.

We have had specific concerns about the quality of medical evidence obtained in relation to peer review of doctors' practices, often based on incomplete documentation or incomplete assumptions, and therefore giving rise to a report which is not really of much weight. We have had concerns that matters which proceed to the professional standards committees of the Medical Board can give rise to difficult situations in which a practitioner is not entitled to representation, which is a very difficult environment if there is a frank dispute as to the facts, as there are often is. They are some of the concerns we have expressed about that process.

The Hon. CHRISTINE ROBERTSON: This inquiry came about because of nurse practitioners not having their complaints dealt with appropriately within the system. Have you heard from your medical officers what happens if they lodge complaints about incidents relating to the practice of another practitioner or other clinical people?

Mr BROWN: They rarely end up with us, unless it is in the context of an industrial problem, for example, where there is concern about the history of non-co-operation by a fellow practitioner which impacts on whether they should continue to be part of the roster and those sorts of issues, rather than straightforward complaints.

The Hon. CHRISTINE ROBERTSON: Do you think that is because the people you represent are better able to handle themselves in the system to achieve the outcome they want?

Mr BROWN: By comparison with nurses? I think that may be so, yes.

The Hon. AMANDA FAZIO: I would like to know your organisation's view about the revamping of the Health Care Complaints Commission and the creation of teams to address the backlog of investigations.

Mr BROWN: We think it is a positive development. It is obviously a brand-new development and we have to see what happens over the next 12 months, for example. We hope that it will shift the backlog. In particular, we hope that it will differentiate between matters where there are some real concerns and trivial matters that have been hanging around for long while. We will be watching over the next 12 months, and hopefully there will be a big change.

(The witness withdrew)

(The Committee adjourned at 11.22 p.m.)