PARLIAMENT OF NEW SOUTH WALES

REPORT OF THE COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

The Handling of Health Care Complaints in Western Australia (July 2002)

November 2002

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FUNCTIONS OF THE COMMITTEE

The Committee on the Health Care Complaints Commission was appointed in 1993. Its functions under Section 65 of the *Health Care Complaints Act 1993* are:

a. to monitor and to review the exercise by the Commission of the Commission's functions under this or any other Act;

b. to report to both Houses of Parliament, with such comments as it thinks fit, on any matter appertaining to the Commission or connected with the exercise of the Commission's functions to which, in the opinion of the Joint Committee, the attention of Parliament should be directed;

c. to examine each annual and other report made by the Commission, and presented to Parliament, under this or any other Act and to report to both Houses of Parliament on any matter appearing in, or arising out of, any such report;

d. to report to both Houses of Parliament any change that the Joint Committee considers desirable to the functions, structures and procedures of the Commission;

e. to inquire into any question in connection with the Joint Committee's functions which is referred to it by both Houses of Parliament, and to report to both Houses on that question.

COMMITTEE MEMBERSHIP

Legislative Assembly

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

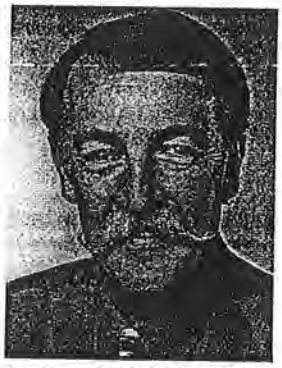
Mr Jeff Hunter MP
Chairman

Ms Marie Andrews MP
Vice-Chairman

Legislative Council

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

Mr Wayne D Smith MP



Mr Peter W Webb MP

Secretariat

Ms Catherine Watson, Committee Manager
Ms Jackie Ohlin, Project Officer
Mr Keith Ferguson, Committee Officer
Ms Glendora Magno, Assistant Committee Officer

The Hon Dr Brian Pezzutti
RFD, MLC

The Hon Henry Tsang
OAM, MLC

The Hon Dr Peter Wong
AM, MLC

Study Delegation:

Mr Jeff Hunter MP (Chairman)
Hon Henry Tsang OAM, MLC
Hon Dr Peter Wong AM, MLC
Mr Peter Webb MP
Ms Jackie Ohlin (Project Officer)

ITINERARY

10 July 02:

Office of Health Review

Mr David Kerslake, Director

Australian Medical Association

Mr Michael Prendergast, Executive Officer (Legal)

11 July 02:

Education and Health Parliamentary Committee

Hon Michael Board MLA (Chair)
Dr Chris Burns, MLA, Northern Territory Public Accounts Committee
Ms Erin Gauntlett, Principal Research Officer

Public Accounts Parliamentary Committee

John D'Orazio MLA(Chair); Monty House MLA (Deputy Chair); John Bradshaw, MLA
Ms Andrea McCallum, Principal Research Officer

Medical Board of Western Australia

Professor Con Michael, Chair; Ms Anne White, Board Member; Mr Simon Hood, Registrar

12 July 02:

Medical Defence Association of Western Australia

Ms Catherine Carroll, Legal Counsel

CHAIRMAN'S FOREWORD

This study trip was conducted as a part of the Inquiry into the Procedures Followed During Investigations and Prosecutions Undertaken by the Health Care Complaints Commission in response to that Inquiry's Terms of Reference.

The ambit of the HCCC in New South Wales is far broader than any of its interstate counterparts in relation to investigations and prosecutions.

The Committee therefore believed it was critically important to visit those organisations in some other jurisdictions which collectively undertake a similar range of functions as those of the HCCC.

In Western Australia, this included the Office of Health Review, the Western Australian Medical Board and the Australian Medical Association, all of whom receive and deal with health care complaints.

While other health professional boards also receive and process complaints the Committee's principal focus in this instance lies with the medical profession, and its' interactions with health care complaints and prosecutions mechanisms.

The Committee delegation also took the opportunity to seek the perspective of organisations integrally connected with investigations and prosecutions functions, such as the Medical Defence Association of Western Australia. The Western Australian Parliamentary Committees on Education and Health, and Public Accounts (which recently completed an Inquiry into Visiting Medical Officers) provided valuable reference points for the Committee delegation.

The Committee delegation was appreciative of the frank and wide-ranging discussions afforded through meetings with parties during the visit. These have provided valuable information and insights to assist the work of the Inquiry.

Jeff Hunter MP
Chairman

The Handling of Health Care Complaints in Western Australia

10 July 02:

Office of Health Review

The Office of Health Review is the complaint resolution body in Western Australia. It does not act as an advocate for complainants, rather, its role is to bring an impartial perspective to each complaint, and work with parties to achieve a fair resolution.

Director, David Kerslake noted that NSW is often described by other Commissioners and stakeholders as a more adversarial and prosecutorial system. He indicated that the OHR works cooperatively with stakeholders and, as a result, believes they have achieved a less adversarial model and outcomes.

In all but one case, the OHR has been able to resolve a remedy by negotiation with the parties. In that instance, the Director had proposed to a respondent that he apologise. That didn't occur, and the Director had to take legal action to get the respondent to respond.

The OHR apparently works well because of the flexibility of the model. If there are questions about the competency of a practitioner, then the matter can be referred to the appropriate Board early in the process, or at any point in the process, during an investigation.

The OHR has 13 staff, and handles about 1500 complaints per year. It has legislated roles in the areas of conciliation and investigation, but the Director noted that most of the work is conducted informally. A matter is only sent to conciliation *if there is a case to be answered.*

The Director indicated that there will always be a proportion of complainants unhappy with the outcome. He mentioned that in the research which has been done, 80-90% indicate that they are happy with the process, but only about 50% were happy with the outcome. However, they generally accept it.

In relation to peer reviews, the Director made the point that the OHR does not "go shopping for an opinion until we get the answer we want". He indicated that there is no formal Peer Review panel, but a group of individuals who provide opinions (he noted that most of the medical opinions are obtained free of charge).

In preparing a report, the OHR formulates a list of questions which it 'runs past' the complainant. These are then given to an independent expert.

Under the Act, a complainant cannot have legal representation, but can have an advocate. The Health Consumers Council is resourced to provide advocacy services, although this body has, in the past, expressed concern that the OHR does

not act as an advocate. The Director believes it would be inappropriate for the OHR to do so – impinging as it might on the impartiality of the OHR. He commented that the NSW practice of conducting conciliations outside the HCCC and maintaining advocacy inside "seemed the wrong way around".

Re compensation, the OHR acknowledges that one of the difficult issues is that of determining what is fair. If it comes to a question of compensation, the OHR will advise the complainant to get their own legal advice (the complainant pays for this) .

The OHR has a policy of de-identifying information where at all possible. Medical records are de-identified before being handed over. The names of advisers are not disclosed, in the interest of obtaining honest and forthright advice without the prospect of the individual being dragged into court. Should a respondent indicate that the peer review was 'off the mark', the OHR would seek to determine the reasons for this.

The OHR encourages its staff to be scrupulously impartial in its written communications.

The OHR believes that a strong point of their legislation is the fact that if the Director refers a matter to a Board, it must investigate the matter. Approximately 1% of cases are referred on to a Board, per annum. The weakness is, if the relevant Board conducts an Inquiry, there is no capacity for the Director to appear as a witness.

Re the timespan for resolution of a case, the Director indicated that the OHR has no significant backlog. It closed 104% of cases last year. He noted that some other Commissioners refer to this as "Clearing the swamp!" The OHR has a monthly monitoring of case-loads.

The Director put their success in dealing with complaints in a timely manner down to flexibility, saying that where legislation contains time limits, if these are followed religiously, it is impossible to apply flexible solutions. For example, you might not write automatically to a respondent to query a fee for service if the OHR investigator can work out for themselves (using an AMA schedule of fees) that the fee charged by the respondent was reasonable.

A further weakness in the Act, according to the Director, is that it contains no "own motion" powers – ie the capacity to examine public interest issues. The Director reports to the Minister for Health. and reports annually to Parliament (through the Minister). The Director may also do a public report to Parliament at any time.

Australian Medical Association

The Committee met with Mr Michael Prendergast, Executive Officer (Legal).

He indicated that the AMA was one of the instigators in the formation of the Office of Health Review. The AMA had felt that there were too many complaints proceeding to the Medical Board that were vexatious or superficial.

The AMA has its own internal complaints system. Through that process, Mr Prendergast noted, there are not always 'happy' outcomes (ie for the doctors). He suggested that this vindicated the view that the OHR was not about 'protecting' doctors (which some had suggested seemed to be the case).

He indicated that the OHR is "not exactly as we would like it". In general, in the short time it has been in operation, it has worked well. He indicated, however, that there were some elements of a 'Star Chamber', and concern at times at the capacity of individuals to be over-zealous or taking a subjective view. He felt that this had upset some sub-specialties at times, and the AMA has had to move as a consequence to 'hose things down'.

There is general acceptance, however of the approach the OHR adopts, as a conflict resolution vehicle, not a punishment vehicle.

Mr Prendergast indicated that he had no concern with the apparently close relationship between the AMA and the OHR – suggesting that he would be more concerned if there was not close communication between the two bodies.

Regarding the Medical Board, Mr Prendergast indicated that over the last 10-12 years there have been significant developments in terms of the rigour applied by the Board, and how it deals with medical practitioners – he felt that the Medical Board had become more accountable. This had assisted the perception of natural justice to all parties in the processes and from the community standpoint, the processes are perceived to be rigorously applied.

Mr Prendergast indicated that there had been a reasonable reduction in the number of cases being directed to the Medical Board since the establishment of the OHR. He felt, however, that there had not been a commensurate reduction in the number of complaints directed to the AMA.

The AMA does not, however, track and log all complaints, considering it administratively difficult to deal in this way with telephone calls. He noted that the AMA tries to get complainants to put the complaint in writing. The AMA then responds by outlining options to the complainant, including going to the OHR.

Mr Prendergast believes that there is an expectation of the profession to 'get it right'. Sometimes, he suggested, they don't. By and large, he noted, the Medical Tribunal is credible, but felt that there is room for improvement. He believes it is important to raise the bar to improve standards. He noted that there is no judge on the Tribunal,

but a senior lawyer had chaired proceedings until recently (the person has now been made a Justice of the Supreme Court). He commented that the person's rigour and passion had meant that Tribunal decisions had 'taken a quantum leap'.

The AMA believes the system is working quite well. It was concerned that if the system is made to appear more legalistic, there is a danger of becoming adversarial rather than inquisitorial.

The AMA believes it has supported consumers, arguing it has 'no truck' with repeat offenders among practitioners, or with individuals who are recalcitrant. The AMA does offer advice on the process, or guidance to practitioners who have come to the AMA for advocacy, if they have a complaint against them at the OHR. Mr Prendergast noted that there had been a couple of instances where a complainant has been running parallel actions, but these tend to be picked up on quickly.

Approximately 80-85% of the doctors in the state of WA are members of the AMA.

On the issue of compensation, Mr Prendergast noted that the AMA is not happy with the practice, and would prefer to avoid it, or have it used very sparingly. Their preference is for parties to agree and for some compromise to be reached.

On the Health Consumers' Council, Mr Prendergast noted that this was set up as a requirement under the Medicare agreement. It is established, with a charter to advocate on behalf of consumers. He indicated that the Council does a good job, but also wears an emotional mantle. There was a concern that the Council tends to represent those who are happy to be involved in the movement, not health consumers as a whole – nor would it be possible for them to do so.

There is also a concern about the potential for a conflict of interest because the Health Consumers' Council is government-funded. The AMA would be reluctant to see the Council more involved in either the Medical Board or the OHR. – as this may be interpreted as 'loading up' those vehicles with rights, rather than responsibilities.

On the medical indemnity issue, Mr Prendergast noted that it is a very real concern for practitioners, and in particular, rural GPs. He indicated that premiums of $60-100,000 are not uncommon. One matter they have been trying to grapple with is trying to get a rigorous indemnity process into the public sector.

The AMA and the ACCC clashed over the issue of the VMO agreement, a matter about which the State Parliament is currently conducting an Inquiry – the Inquiry into the Use of Visiting Medical Practitioners in the WA Public Hospital System.

11 July 02:

Education and Health Parliamentary Committee
and
Public Accounts Parliamentary Committee

The study delegation held a joint meeting with members of the Committees, including Hon Michael Board MLA (Chair), Ms Erin Gauntlett, Principal Research Officer, Education and Health Committee; and John D'Orazio MLA(Chair), Monty House MLA (Deputy Chair), John Bradshaw, MLA, Ms Andrea McCallum, Principal Research Officer, Public Accounts Committee.

Dr Chris Burns, MLA, Northern Territory Public Accounts Committee also attended the meeting.

Members addressed the progress of the current NSW Parliamentary Inquiry and the progress of the WA Inquiry into Visiting Medical Practitioners.

The Inquiry, titled "Inquiry into the Use of Visiting Medical Practitioners in the WA Public Hospital System, is being conducted by the Public Accounts Committee. Terms of Reference for the Inquiry include:

That the Public Accounts Committee examine and report on the use of visiting medical practitioners (VMPs) for the provision of medical services in the Western Australian public hospital suystem, with particular reference to:

1. use of VMPs in the public hospital system;
2. terms and conditions of engagement of VMPs; and
3. compliance and accountability within an output based management framework.

The Committee has received evidence from the Australian Medical Association (WA), the Rural Doctors' Association, Health Service Boards, Government Departments, local Councils, medical specialists and medical practitioners around the State.

At the time of the visit, the Inquiry was continuing.

The Education and Health Parliamentary Committee is also conducting a current Inquiry into the Role and Interaction of Health Professionals in the Western Australian Health System.

Medical Board of Western Australia

The study delegation met with Professor Con Michael, Chair; Ms Anne White, Board Member; and Mr Simon Hood, Registrar.

The Registrar outlined the complaints pathway followed by the Medical Board, with a flow-chart designed to help the Board achieve ISO 9000 accreditation.

Mr Hood indicated that complaints referred to the Board are recorded on a standardised form and sent directly to the Board. The Board then contracts practitioners who can 'work the complaint up' to the point where the Board can form a view. The complaint may then be referred to the Board's Complaints Sub-Committee and/or to the OHR.

The Board's contract practitioners (3, with a 0.8FTE Complaints Coordinator and full-time administrative support) were engaged a year ago. One advantage of their involvement is that they can also prepare a detailed response to be sent back to a complainant.

A small proportion of these complaints (3-5%) go back to the OHR for conciliation.

If the Board has made a decision on a complaint, it cannot refer it to the OHR, but it can refer the complaint before dealing with it.

In 90% of cases coming before the Board, there is not further action required, but the Board can, and does, invite practitioners in for counselling as required.

There is no distinction, in the WA system, between cases dealt with by the equivalent of a PSC and the Medical Tribunal. The Board is hoping that, under the new Act, it will have the capacity to reprimand practitioners.

Of the 11 Board members, at any given time 5 are on the Medical Tribunal. The Board is currently dealing with 165 cases – it may conduct up to 20 inquiries in a year. Some cases go back to the mid-1990s. A simple complaint may take between 3-4 months to deal with (where there is no breach of the Act) but an average of 12-18 months is more usual, where there is a *prima facie* case).

The Board members suggested that modern thinking would indicate the need to separate investigations and prosecutions roles. The Chair indicated that the Board had been challenged on just that point, where counsel had requested that doctors who sat on the Complains Sub-Committee not sit on the Tribunal.

The Board's peer review process involves selection based upon identification of the specialty area – names of people prepared to offer an objective opinion are put forward . However, where the specialty is a small field or it is not possible to obtain an objective opinion, interstate or overseas peers are called upon. The Board provides all documentation relating to the case to the peer reviewer.

The Board attempts to interview each practitioner under investigation. It considers this process to be a worthwhile investment.

All complaints are investigated by the Board.

It was noted that the Board is commencing to make more use of Directions hearings to receive evidence 7-10 days before the Tribunal meets.

The Medical Board uses the Inquiry as a forum to provide practitioners with multiple opportunities to respond.

Hearings before the Board are closed, and matters regarding impairment, etc are conducted 'in-camera'.

Appeals to the Supreme Court are possible on points of law or process.

Professor Michaels indicated that one of the most important forthcoming challenges will be that of competency assessment – in part to address the concern that nine times out of ten the Board may not have the necessary information to allow the case to be taken further.

The Board surveyed complainants and respondents in 2000-2001, and received an extremely negative response regarding the Board's processes- as a result there is more explanation now offered about the process, and about the decision.

The study delegation learned of a WA Government initiative to replace nearly 40 Western Australian tribunals and boards (including the Medical Tribunal) with a single, one-stop shop for handling appeals and disciplinary matters.

It is proposed that the new tribunal will be presided over by a Supreme Court judge, acting as president, two District Court judges acting as deputy presidents and several full-time and part-time sessional members.

The Western Australian Civil and Administrative Review Tribunal Taskforce Report on the Establishment of the State Administrative Tribunal contains more detailed information about its proposed structure. The Report can be accessed via the Western Australian Government website (details in the Attachment to this report).

12 July 02:

Medical Defence Association of Western Australia

The study delegation met with Ms Catherine Carroll, Legal Counsel with the MDAWA.

The MDAWA spoke very highly of the Medical Board process, believing it to be very effective, because the Board is obligated to inquire into cases. Ms Carroll indicated that the vast majority of cases do not proceed beyond correspondence with the practitioner concerned, seeking an explanation.

Ms Carroll indicated that the MDAWA believed practitioners would benefit from knowing more about the process that occurs after the complaint goes to the Complaints sub-Committee. Currently, they are not told, and only know the process anecdotally. MDAWA believes there could be a greater level of interaction between the Board and the practitioners.

Ms Carroll noted that if a matter proceeds to formal notice of an Inquiry, the early stages can be very legalistic. While an interview may be appropriate, the manner in which it is regarded in an evidentiary trail is problematic. In principle, however, MDAWA believes that having an interview is useful for the clarification of issues, but parties would have to be careful that the content is not regarded as evidence.

The MDAWA believes the OHR process regarding settlement of compensation claims works beautifully. MDAWA does not take the view that settlement equates with an admission of guilt. Similarly, the MDAWA has no problem with the notion of 'splitting' of a complaint, so that a compensation claim can be handled separately from issues being handled by the Medical Board in relation to the same case.

The MDAWA has concerns about procedural fairness where written documentation is 'elevated' by the system to a level of evidence regarded as proof, without being tested. An example was provided of a statement by a practitioner which is included in notes as part of a hospital's documents, but the practitioner was not cross-examined, so the veracity of the statement was not tested.

In the same way, the MDAWA, while understanding why quasi-judicial tribunals exist, feels that sometimes they 'sail close to the wind'.

The MDAWA believes that, although *de novo* appeals are 'hideously expensive', they should be allowed, as they overcome possible deficiencies in quasi-judicial bodies, including the way rules of evidence are dealt with.

The MDAWA covers about 95% of medical practitioners in WA (of a 'pool' of approximately 5000.

Ms Carroll indicated that she could not imagine a circumstance where a medical defence organisation would encourage doctors not to respond to the complaints body.

Attachment:

Additional documents

Office of Health Review: *Annual Report 2000-2001*

Medical Board of Western Australia: *Complaints Pathway,* January 2002

Medical Board of Western Australia: Annual Reports, access via website:
www.wa.medicalboard.com.au

Western Australian Civil and Administrative Review Tribunal Taskforce Report on the Establishment of the State Administrative Tribunal, Michael Barker QC (Chair), July 2002. Access via website:
www.justice.wa.gov.au