



HCCA Submission to the Senate Community Affairs References Committee Inquiry into the Medical Complaints Process in Australia

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HCCA SUBMISSION TO SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE INQUIRY:
MEDICAL COMPLAINTS PROCESS IN AUSTRALIA

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1. General Comments

HCCA is pleased to provide this submission to the Senate Inquiry into the Medical Complaints Process in Australia. Robust and accessible complaints processes are essential to the delivery of a high quality, safe, Australian health system that meets health consumers' needs and is valued by us.

It is important to recognise there is not one single process relating to medical complaints in Australia. Currently, the processes vary between jurisdictions and between different kinds of health care sites and types of health care. Examples in our submission are therefore informed mostly by our members' experiences of the ACT health complaints system and the consumer feedback mechanisms in place in the Canberra public hospital system. Individuals clinics and practices sometimes also have their own processes, which complement or supplement the statutory system. However, given the importance of consumer and family complaints to improving the safety and quality of health care we believe a more consistent framework across all jurisdictions and different health care settings would be desirable.

Unless medical professionals are well trained and supported in their workplaces they cannot deliver good patient care. As human beings, all health professionals make mistakes. A best practice, patient centred system ensures that health professionals learn from these mistakes. Not all mistakes or sources of complaint involve preventable patient harm. Sometimes, there is inadvertent, but nonetheless significant, discourtesy or disrespect shown to patients and their families. This can result in risk and distress to the patient and their family and an unnecessarily stressful and poor experience of care. All of these experiences, if reported as complaints, provide rich opportunities for learning. Unfortunately, there is a well-documented culture of blame and denial in medical settings, which has resulted in a tendency for medical professionals and healthcare organisations to ignore or dismiss patients' and families' complaints and to view these as threats rather than as opportunities to learn and improve.

Our key message is this:

- **Complaints can drive positive change and therefore all health services and practitioners need to have mechanisms to capture the consumer voice to identify and respond to patient safety issues.**

Health consumers face numerous structural barriers in our current medical complaints processes. These include:

- Lack of awareness of consumer rights;
- Lack of knowledge of the medical complaints process;
- Lack of support through the complaints process; and
- Lack of understanding of the formal methods used by health services to obtain consumer feedback.

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An improved medical and healthcare complaints system in Australia will work to reduce these structural barriers and thereby enable and support consumer complaints as opportunities for healthcare improvement.

In this submission HCCA comments primarily on matters relating to consumer complaints about health professionals and health services. However we also comment on health and medical professionals' complaints of bullying and harassment by their colleagues. As a consumer organisation, HCCA address both of these issues because there is strong evidence that the professional culture in which medical professionals work impacts directly on the quality of care delivered to patients.

This submission begins by detailing the key issues of concern for consumers in making complaints about a health service or health professional. This is the focus of our submission, as it identifies principles that should be at the heart of any reform of the medical complaints process in Australia. These principles include:

- That consumers should know they have a right to complain about their care, and know where and how to do so (including in the case of complaints about private medical specialists);
- That the complaints process should recognise and minimise the personal toll to consumers of making a complaint;
- That clear information should be provided to consumers about the medical complaints process, including the role of agencies involved, likely time-frames and possible and likely outcomes of their complaint;
- That complaints are taken seriously, learnt from and acted on (at the level of the health professional, the health service and the health system); and importantly,
- That the outcomes of the complaints process and any change resulting from it are communicated to the consumer.

The submission then responds to each of Terms of Reference for this Inquiry, identifying key issues including that:

- The prevalence of bullying and harassment in Australia's medical profession presents risks to patient safety that must be addressed, including through improved medical education and training of medical students, junior doctors and experienced doctors (in particular those in supervisory roles) (TOR A);
- Barriers to medical practitioners reporting bullying and harassment must be addressed, in order to ameliorate the risk to patient safety created by workplace cultures in which this conduct is tolerated (TOR B);
- From a consumer perspective medical complaints processes are complex, unduly difficult to navigate, and often fail to deliver the outcomes consumers hope for and expect (TOR C-E);
- Medical complaints processes could be improved by:
 - The adoption of "no wrong door" or "single entry point" approaches;
 - Improved communication with consumers about the expected timeframes and likely outcomes of complaint processes;

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- A continued focus on encouraging and supporting patient and consumer feedback mechanisms as opportunities for quality improvement (TOR C); and
- Providing avenues for consumers who are seeking an apology, further information and/or acknowledgement of responsibility to achieve these outcomes, including through restorative approaches (TOR D);
- The National Regulation and Accreditation System (NRAS) should be further strengthened including by introducing improved processes for engaging consumers (TOR E);
- A quality improvement approach in which medical professionals are required and supported to reflect on and learn from *each incidence* of complication is preferred to benchmarking of complication rates, not only because a quality improvement approach is demonstrated to deliver safe and high quality care but also because of the absence of data required to establish a meaningful benchmark (TOR F);
- It is not desirable to require consumers to sign a declaration that their complaint is being made in good faith, as this would present an unhelpful additional barrier to complaint-making (TOR G); and
- Adoption of restorative practice approaches within the medical complaints system would provide for better outcomes for consumers and support the delivery of safe, high quality care (TOR H).

In making this submission, HCCA draws on extensive consultation with health care consumers in the ACT.

2. Medical and healthcare complaints: Key issues for consumers

2.1. HCCA's interest in this area

The members of the Health Care Consumers Association (HCCA) have a strong, long standing interest in improving complaints processes across our health systems. In 2002-2003 we worked on a project with the ACT Government and ACT health services to develop consumer feedback standards. These were the first standards of their kind developed in Australia. This joint project was in response to the action outlined in *Quality First*, the 2001 ACT Health Quality and Safety Plan, namely to “*ensure there are consumer feedback mechanisms for comments, opinions, satisfaction, suggestions for improvement and complaints relating to all aspects of services and care*”. HCCA's view then was that complaints drive change and all health services need to have mechanisms to capture the consumer voice to identify patient safety issues. This remains our view.

HCCA conducted community consultations, key informant interviews and focus groups with consumers to raise awareness of the importance of consumer feedback, to help identify the barriers to giving and receiving feedback and to identify ways to improve the consumer feedback process. These consultations informed the development of the *ACT Health Consumer Feedback Standards – Listening and Learning*,¹ which are still in use in ACT Health. This work informs HCCA's understanding of the reasons why consumers make complaints, the considerable barriers that exist to deter

¹ ACT Health (2003) Consumer Feedback Standards – Listening and Learning

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consumers from providing feedback and complaints, and our practical suggestions about how to enable complaints and feedback and to use these as opportunities for healthcare improvement.

2.2. Why do consumers make complaints?

Overwhelmingly, the consumer response to this question is that they want to improve the service for others. Consumers regularly tell HCCA that they made a complaint so that the health service would know about the issue or issues they experienced, and then be able to make improvements. Consistently, consumers tell us that they make complaints about the quality and safety of health care:

- So that the system learns from mistakes;
- To have medical professionals be more accountable;
- To have their poor experience validated;
- To receive an apology; and
- To receive information and explanations that satisfy their need to know what happened, what went wrong and, if there are long term health effects, what they need to do.

2.3. Barriers to consumer complaints

There are many barriers to providing feedback to health services. These include language barriers and cultural and social issues. In addition, our emotional response to what is happening to us as we use a healthcare service, and our level of confidence, affect the extent to which we feel that we can voice our concerns. Consumers often access health services when they are at their most vulnerable, at a time when they or a loved one need health care. As a result, they can be anxious, scared, angry, distraught, even grieving. It is also difficult for consumers to provide negative feedback to a service on which they rely for their care and wellbeing. This is especially the case when consumers require specialist medical interventions, which often take place in emergency or life-threatening situations and frequently involve receiving care from a medical practitioner who they do not know and did not chose. Health consumers are also often concerned that if they complain about a health professional or health service, the quality of care they or a loved one receives will be jeopardised. Health consumers often fear that they will experience hostility or discrimination from staff, or be negatively labelled as a “difficult” or “unreasonable” patient if they complain about their care. This is the lived experience of some complainants, and as such, they act as a “warning to others”, who may then choose to remain silent and not report their experiences “just in case”.

Consumers report that making complaints is time-consuming and has a personal cost. This can involve not only monetary cost (for example in terms of time taken away from work to pursue a complaints process), but also a significant emotional cost. Consumers make health complaints despite these personal impacts. Health services and the medical complaints process in Australia must recognise these personal impacts, and put strategies in place to empower and enable people to make complaints and to provide feedback. The power dynamic that exists between health and medical professionals and consumers is extremely unequal. Making a complaint in the context of this relationship can be daunting or even threatening for consumers, especially those consumers who have an ongoing need for a particular service.

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Consumers need to be supported so that they are not a single “lone voice” commenting on the quality of services received from a medical practitioner or health service.

Consumers have reported to HCCA occasions when the care they received was compromised as a result of having made a complaint. Consumers also reported having services withdrawn as a result of making a complaint. Fear of retribution is reported by many consumers, in particular those with chronic or ongoing conditions where there is a continuing need to use the services into the future. This was identified as the strongest deterrent to making complaints. One HCCA member commented:

“When you have a need for ongoing care, whether that is mental illness or a physical illness like COPD, your care is a revolving door, you’re going to be there again and again and you need the door to open for you”. HCCA Member.

The consumer concern is that services will be withdrawn or the quality of the care they receive compromised if they provide negative feedback or pursue a formal complaint process. Carers of people with chronic conditions have also alerted HCCA to their reluctance to complain for fear of reprisals from health service staff. Sometimes consumers do not report matters in a timely manner because of this fear. For example, a consumer who had a terminal condition asked for her complaints to be relayed after her death by a consumer advocate friend, so that there would be no repercussions as she was dying and at her most vulnerable.

Mental health consumers in the ACT have expressed a particular reluctance to make complaints. Many are fearful about how this could affect their treatment, as complainants are often identifiable by service staff. This increases their anxiety levels and does not assist their recovery. One consumer, when asked why they do not complain about the treatment they receive, commented:

I never complain about my care. I can’t afford to. I’ll be back there again and I don’t want them taking it out on me.” HCCA Member.

The ACT Mental Health Consumer Network, a HCCA member organisation, has a strong understanding of the structural barriers that deter mental health consumers from reporting incidences of poor care to healthcare providers:

Many mental health consumers are among the most disadvantaged in our society, often without stable or safe accommodation and living on very low incomes. They are vulnerable to discrimination on a range of bases, and have high levels of interaction with the health system, too often involuntarily. For mental health consumers in the ACT, many are reluctant to make complaints through the medical complaints process as they find the process overwhelming and complicated, requiring a lot of commitment. Too often mental health consumers feel unsupported; they should have further assistance and have access to advocacy whilst going through the process of making a complaint. They should not have to go to conciliation without representation. ACT Mental Health Consumer Network.

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Mental health consumers have also shared the view that they *don't want to be too visible*. It is concerning that consumers with an ongoing need to access health services and the health system do not believe they are in a position to improve it or to challenge poor quality care by providing feedback or complaints.

Many health consumers experience complaints processes as a form of trauma, not only because of the nature of their complaint but also because the complaints process occurs at a time when the person is very vulnerable and the fear generated can seem overwhelming. Instead of complaints being a way to provide quality lessons for the health system and to rebuild the trust of the consumer and families in health care, medical complaints processes can often create further trauma and suffering. Given the extensive time that can elapse from the original admission or treatment and the resolution of the complaint, particularly when a consumer pursues a formal complaint process that may involve multiple agencies, it is likely that this experience may lead to long term psychological distress, anxiety, depression and even Post Traumatic Stress Disorder.

Although we hear assurances that the health sector is moving away from a culture of blame, HCCA has been involved in many complaints and feedback processes where we have observed that health professionals continue to respond to complaints defensively. We have witnessed staff working through a process to identify the complainant, even when complaints were made anonymously. We have observed health service staff minimising, trivialising or dismissing the consumers' concerns because the consumer was "difficult", or had "unrealistic expectations" of care. Consumers have shared their experience of being negatively labelled by staff after making a complaint or commenting on the quality of care they or their family or friends received. Consumers reported being labelled as a whinger, a difficult patient, hysterical, or stressed. These labels work to undermine the legitimacy of the feedback or complaints provided by these consumers, and they reflect a concerning attitude of disrespect and distrust toward consumers as well as a lack of commitment to consumers' right to provide feedback about their care. HCCA's experience in this area is reflected in the national and international literature, where it is well-established that medical professionals too often view complaints as "unwarranted attacks on their commitment and competence" and as a result take a defensive and dismissive stance toward complaints and complainants. This precludes the medical professionals in question, and the healthcare organisations for which they work, from understanding consumer experiences and learning from consumer complaints.²

Consumers are often not in a position to raise their concerns and make comment during the episode of care. This can be due, for example, to ill-health, the intense nature of interactions with healthcare services in emergency situations, or a consumer's sense of reliance on medical professionals and reluctance to challenge medical authority during the duration of their interaction with the medical professional or service. It is often when they return home that they have the time and distance to reflect on their experience. Some consumers carry with them stories of things that have gone wrong with their care for many years, but have felt unable to talk to the

² Australian Council for Safety and Quality in Healthcare (2005), *Complaints Management Handbook for Healthcare Services* (Commonwealth of Australia), p7.

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provider about their experience. This bad experience continues to shape each subsequent encounter with health services. As a result, patients are denied the opportunity to heal from a negative experience while clinicians are denied the opportunity to learn. This undermines the trust necessary for a good on-going doctor patient relationship.

The barriers to making complaints are also significant for young people and young carers. Young people need to have significant confidence and support in order to engage in formal complaints processes. Many young people and young carers experience a sense of invisibility as users of our health system. They may experience low levels of self-esteem, they may not value their own efforts, and they may be excluded from details about care plans for themselves or, in the case of young carers, for the people they care for. This is disempowering and contributes to poorer outcomes. It is no surprise that they do not make complaints.

Many of these issues are echoed by people with chronic conditions. HCCA hears first-hand from consumers how difficult they and their families find it to make complaints or even to give feedback to practitioners. Many consumers do not want to “rock the boat” as they like their doctor and do not want to compromise that relationship. People with complex and chronic conditions often spend many years trying to assemble a team of health professionals they can trust and who can work with them to optimise their health and wellbeing. They value this highly and as a result at times they prioritise these relationships and continuity over the quality of care they receive. Additionally, consumers may accept what they recognise as inadequate healthcare because they are deterred by the considerable time and effort involved in leaving one healthcare professional and “starting over” with a new, unknown practitioner. This is a particular concern for those with chronic or complex ongoing health issues.

In short, HCCA sees that there are a number of structural barriers for consumers in our current medical complaints processes including lack of:

- awareness of consumer rights;
- knowledge of the process;
- support through the complaints process;
- understanding of the formal methods used by health services to obtain consumer feedback; and
- confidence that feedback and complaints will be received openly, with respect and in a spirit of learning and improvement by health and medical professionals.

An improved medical and healthcare complaints system in Australia will work to reduce these structural barriers and thereby enable and support consumer complaints as opportunities for healthcare improvement.

2.4. Empowering consumers and enabling complaints

Consumers will only give feedback, or make a complaint, if they feel that the health service and its staff will listen to and act on the information they give and will not discriminate against them on the basis of their feedback.

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It remains the case that consumers often are not provided with sufficient or appropriate information about where and how to make a complaint about a healthcare service or medical professional, or about the process that will follow once a complaint is made. In particular in the case of specialist medical services, consumers require information about how and when a complaint made through a health service's complaints process will be passed to the individual medical practitioner/s in question, and if relevant, to any other regulatory agencies. Consumers also require clear information about the likely outcomes of their complaints process, and whether and how any specific outcomes or action arising from the complaint will be communicated to them at the conclusion of the process. It can be particularly difficult for consumers to understand how and where to make a complaint about private medical specialists and practitioners. This is an area where particular effort should be directed to improve consumer knowledge of the complaints processes. Given that many consumers make complaints primarily in order to see improvements for future users of the service or system, it is important that complaints processes do conclude with feedback to the consumer.

Consumers who have limited English language proficiency, either because of their level of education attainment and/or cultural background, do not always want to make a formal complaint but do want their concerns and comments to be noted and changes made. Indeed, **many consumers may want to make an informal comment rather than a formal complaint.** When things go wrong consumers want to know that changes have been made to ensure it will not happen to someone else. However, many consumers will feel daunted by the prospect of making a formal complaint, and will want to avoid being perceived as *making a fuss*. This is consistent with the principles that underpin the Australian Open Disclosure Framework, the national framework aimed at supporting medical professionals and services to communicate openly with consumers about adverse events in healthcare.³ Health services and medical professionals should provide opportunities for informal feedback as well as formal complaints to be heard and acted on. Learning how to receive feedback from patients in a respectful manner is a skill which can and must be taught to all health professionals. This includes not only new students but also experienced practitioners. The model of apprenticeship, where junior staff learn from senior staff, means that modelling of engaged and respectful feedback must start with those already practising as well as those who have yet to begin.

Consumers need to be told they have the right to comment on the care they receive at every step of the service delivery process, from their initial interface with the practitioner/ system and throughout the treatment and aftercare process. It is not sufficient for health services to rely on posters in waiting rooms to communicate to consumers about their right to make complaints and provide feedback. Many consumers will not be in a position to take in and understand this information while they are at the health service. It is important that treating health and medical professionals reiterate the opportunities that exist for feedback and complaints to be made as people progress along a treatment path. Healthcare organisations must continue the difficult but worthwhile work of changing professional cultures so that

³ Australian Commission on Safety and Quality in Health Care (March 2013) *The Australian Open Disclosure Framework*.

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feedback and complaints are received in good faith rather than dismissed, and regarded as opportunities to learn and to improve the safety and quality of care delivered.

In preparing our submission HCCA spoke with a number of consumers in our membership and networks. One consumer commented:

“How do you know how to complain if you don’t even know you can? I was completely ignorant of my rights. I didn’t know how their system worked.” HCCA member.

Consumers need to be assured that feedback is valued and that there are systems in place to support them to comment on their care. This needs to take place on admission to hospital or entry into a program of care, or in the initial consultation with a new doctor. It needs to be repeated at a number of different points throughout the episode of care. Consumers need clear answers to the following questions: *Where do I go? Who do I talk to? What do I have to do?* There needs to be consumer-friendly information about feedback and complaints process developed and made available in a variety of formats and media. Consumers often have a particular interest in knowing that their complaint will be relayed to the specific medical or healthcare professional/s involved, and in being advised when this has occurred. This option should be communicated to consumers when they make a complaint.

The formal mechanisms used by health services exclude many consumers. Writing letters and completing forms assume a high level of English language proficiency, and this is problematic for some consumers and so excludes them from the process. Print based forms and letters also make it difficult for consumers with sight impairment. The message is clear: there will not be one approach that suits everyone and health services need to be flexible enough to meet the needs of people. Face-to-face meetings as an alternative to written complaints processes should be encouraged, where this is the preference of the consumer. Openness to the role of advocates in assisting consumers to make complaints is essential. An advocate can assist a consumer to navigate what can be the drawn-out and personally challenging process of making a medical complaint or providing feedback. In order to support consumers to overcome the structural barriers that prevent complaints, and to maximise the potential of consumer complaints to improve healthcare, consumers should be advised of their right to access assistance from an advocate, and supported to do so.

Training for healthcare consumers in providing healthcare feedback, and more generally in actively participating in healthcare, will also assist to improve the medical complaints process in Australia. Consumers have as much as health and medical professionals to benefit from greater knowledge and confidence in communicating openly about their healthcare, taking an active role in their healthcare, and in particular from having practical strategies to successfully and respectfully approach what can be difficult conversations about poor or adverse outcomes, or difficult healthcare experiences. Consumer organisations have expertise and a role to play in this area.

3. Response to the Terms of Reference

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a. The prevalence of bullying and harassment in Australia's medical profession;

There is strong evidence to suggest that bullying and harassment are tolerated in many medical and health workplaces. As a consumer organisation HCCA's concern is that this workplace culture has a corrosive effect on the quality of healthcare.

Health care is a very stressful sector and people working in health services deal with high stakes, high emotion situations on a regular basis. Fatigue is a well-documented experience of health practitioners, especially junior doctors. All of these factors contribute to the intensity of the environment and the need to support workers. Unless staff are well trained and supported in their workplace they cannot deliver good patient care.

Good communication and effective team work are essential factors to support high quality patient care. In contrast, dysfunctional team environments are now recognised as a factor that contributes to adverse patient outcomes as well as poor patient satisfaction with services:

A dysfunctional team environment will invariably lead to errors and preventable adverse outcomes. As the authors of a recent British study pointed out, "Ultimately if the culture of bullying results in demoralized staff working in a caring profession, it is the patients who will suffer."⁴

This also applies to complaints in health care. There is a well-documented culture of blame which has resulted in the tendency for staff to view complaints as a threat rather than as an opportunity to learn. Teams that do not learn from their mistakes are ill-equipped to improve the quality of care they deliver to their patients. Effective teams are open to feedback and complaints, and consider these as learning opportunities.

There is now increasingly clear evidence that medical workplaces in which bullying and harassment are tolerated are unsafe for patients. The Joint Commission, an independent, not-for-profit organisation that accredits and certifies around 20,000 health care organisations and programs in the United States, reviewed behaviours that undermine a culture of safety and bullying and concluded that harassment featured prominently:

"Intimidating and disruptive behaviours can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviours that threaten the performance of the health care team."⁵

⁴ Farouque, Kamal and Enrico Burgio (2013), 'The Impact of Bullying in Healthcare', (*The Quarterly*, Royal Australian College of Medical Administrators).

⁵ The Joint Commission, 2008, *Behaviours that Undermine a Culture of Safety*, Sentinel Event Alert, Issue 40, July 9, 2008.

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Australian medical professionals acknowledge that bullying and harassment is widespread. For example, the Royal Australasian College of Surgeons (RACS) has found that bullying is a longstanding cultural issue between senior clinicians and trainee clinicians that dates back decades. In the ACT we have a particular interest in this issue as bullying and intimidation of staff is well documented at Canberra Hospital. A 2014 review of maternity services at the hospital documented “top-down” bullying by senior staff that made it extremely difficult for junior medical staff to confidently perform their roles.⁶ In an environment where junior medical professionals are unable to voice concerns or raise issues with their supervisors, the risk of medical mistakes and adverse outcomes is likely to be significantly heightened.

The ACT Minister for Health, Simon Corbell MLA, engaged KPMG to conduct a review into the clinical training culture at Canberra Hospital. Released on 8 October 2015, the ACT Opposition Spokesperson for Health, Jeremy Hanson MLA spoke in the ACT Legislative Assembly on 28 October 2015 and described the report as “damning”, citing the report as stating that the hospital’s “management provided positive reinforcement for aspiring bullies.”⁷ Mr Corbell responded that:

“The KPMG report is very clear. Our problem is no better, but it is no worse, than the circumstances that are faced across training hospitals across the country.”

The Minister admitted that poor behaviours such as bullying, inappropriate interpersonal relationships and emotional intimidation had been allowed to persist for so long and that these behaviours were prolonged and normalised.⁸ HCCA is concerned that a culture that accepts and condones bullying is not conducive to good patient care and must be addressed. Further, where a culture condones bullying in the staff, there is evidence that this can reduce empathy towards patients and can lead to disrespect and bullying of patients.

Medical professionals frequently work as key members of multidisciplinary teams. They lead, mentor and are role models for their colleagues. The extent to which medical professionals relate to their colleagues professionally and with respect is an important factor in determining the quality and safety of care delivered to patients. Thus, the importance of medical education that directly addresses bullying, harassment, teamwork, communication and conflict resolution cannot be underestimated. Equipping junior medical staff and medical and healthcare students with this information is an essential strategy to respond to workplace cultures in which bullying and harassment are tolerated, and defensiveness to complaints is normalised.

b. any barriers, whether real or perceived, to medical practitioners reporting bullying and harassment;

6 McIlroy, Tom (7 November 2014) ‘Worst in Australia’ – Canberra maternity unit under pressure, *The Canberra Times*, Accessed 26/03/2016 <<http://www.canberratimes.com.au/act-news/worst-in-australia-canberra-maternity-unit-under-pressure-20141107-11ihtv.html>>

7 Legislative Assembly for the ACT: 2015 Week 12 Hansard (28 October), Accessed 26/03/2016 <<http://www.hansard.act.gov.au/hansard/2015/week12/3737.htm>>

8 Legislative Assembly for the ACT: 2015 Week 12 Hansard (28 October), Accessed 26/03/2016 <<http://www.hansard.act.gov.au/hansard/2015/week12/3737.htm>>

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Under-reporting of bullying and harassment by colleagues and in particular of junior medical staff by senior medical staff is well-documented. Mistry and Latoo (2009) identified the following reasons for the underreporting of bullying:

- Fear it will make matters worse;
- The belief that nothing would be done about it;
- Concerns about confidentiality;
- Fear of possible victimisation;
- Concerns of being labelled a troublemaker;
- May be seen as an admission of failure; and
- A degree of learned tolerance that may imply that the behaviour is acceptable.⁹

Given the negative implications for patient safety of medical workplace cultures where bullying and harassment are tolerated¹⁰, every effort should be made to address these barriers to reporting incidences of bullying and harassment. This includes by directly addressing these issues in medical student training and the ongoing professional education of medical practitioners, especially those who are in supervisory positions in training programs.

c. the roles of the Medical Board of Australia, the Australian Health Practitioners Regulation Agency (AHPRA) and other relevant organisations in managing investigations into the professional conduct (including allegations of bullying and harassment), performance or health of a registered medical practitioner or student;

There is significant confusion from a consumer perspective about where they should report conduct of concern. This is the case whether or not they wish to make a formal complaint about their treatment. For example, a patient may want to express concern about a doctor's technical or communication skills or they may want information about what actually happened to them. They may need the information for their further treatment or they may need information for their own peace of mind. There are multiple places a consumer can go if they are not satisfied with their care or have an unexpected poor outcome. For example, in the ACT, there is a hospital based complaints and feedback system, and a statutory system for health complaints through the Human Rights Commission. There is the Medical Board of the ACT, including its role as delegate of the Medical Board of Australia. There is also AHPRA. Where someone dies in hospital there might even be a separate coronial process. In a small minority of cases, patients or families choose to use the litigation system. Consumers often do not know what the reporting lines are between the various bodies involved in these different processes, nor what the different roles of these

⁹ Mistry, Minal and Javed Latoo (2009), *Bullying: A Growing Workplace Menace*, *British Journal of Medical Practitioners* 2009:2(1)23-26.

¹⁰ For example, bullying and harassment are generally found within steeply hierarchical organisational structures with significant power differentials, which have been shown to silence those lower down the hierarchy, even when patients are put at risk of harm by errors made by more senior staff. Helmreich RL and Merritt AC. *Culture at Work in Aviation and Medicine – National Organisational and Professional Influences*. 1998 Ashgate Aldershot (England): for status differential, see pages 39-41; for power distance, see pages 57-58.

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bodies are. They are rarely aware of what will occur after they report conduct of concern via any of these processes, nor how varied the processes of these different potential sites of complaint are, or what the likely or potential actions afterwards may be. From the consumer viewpoint the medical complaints process and the roles of the agencies involved are unclear and unduly complex.

There is frequently a disjuncture between the outcomes consumers hope for and expect from a medical complaints process, and the outcomes that complaints-handling bodies are mandated to deliver. Research has shown that the main drivers for patients to complain are: wanting to know what happened, wanting an apology for the harm that has occurred and wanting someone to accept responsibility for making sure that the issue is addressed so that no-one else is harmed. The evidence base is also clear that it is only when these normal human expectations have been thwarted that people seek to litigate, even where the costs arising from the harm are significant and ongoing. When consumers cannot get the information they need, they understandably perceive this as implicit evidence that a failure somewhere is being “covered up”. Litigation generally requires the consumer to be sufficiently angry (for example about what appears to them to be a “cover-up”) to pursue this course, which is costly and uncertain and makes it highly unlikely that the doctor-patient relationship will ever be able to be repaired. In almost all instances litigation is an option of last recourse, taken when all other avenues have failed.

Australia’s complex medical complaints handling system rarely delivers on consumer expectations of how complaints should be handled and the outcomes hoped for. The adversarial nature of some complaints processes and the opaque nature of others mean that the needs of patients and their families are seldom delivered. Those who have a health care complaint want to be listened to, to have their concerns acted on, and to get feedback about the changes that have been implemented to address their concerns. Reform effort should focus on improving consumer and complainant understanding of the likely outcomes of the different medical complaints processes, provision of information about likely timeframes and good communication about the process and the progress of complaints. Those who complain should always be informed of the outcome of their complaint. It is also desirable that the current range of complaint forums be considered to see if they can be simplified and integrated in a way that stops patients and families from having to reiterate the often highly distressing circumstances they have experienced in health care.

Medical complaints processes aim to discipline and regulate professionals and deliver fair process, while also responding to consumer concerns. In reality, complaints processes are often not “fit for purpose” for these disparate aims and as a result fail to achieve either disciplinary/regulatory or consumer outcomes. Consumer expectations and outcomes are about a relationally focussed process, where both provider and patient need to be heard in a restorative context, particularly where a consumer wishes to continue to see a doctor after making a complaint. By contrast, regulatory and disciplinary aims have to do with whether a provider has breached a certain standard that has been determined by peers and Government and risks further breaches in future. While these two distinct sets of aims may overlap, the resolution of each involves different “balances of interest” and, in many cases, very different end points. The forensic nature of regulation/discipline aims may require more formal processes.

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One way to balance these distinct aims, while also making the complex complaints process easier to navigate, is to ensure that there is a single “front end” or point of entry to the system, where a consumer can initially lodge their complaint. From this may flow connected but different “pathways” down which a complaint is sent once notified. A complaint could go down two pathways: one seeking resolution with the consumer, and the other identifying appropriate ways of increasing patient safety (for example improved professional supervision arrangements for a medical practitioner, further training for the practitioner, or at the most serious end, the ability to stop the person acting as a doctor).

This approach would reduce consumer confusion and allow regulatory agencies to compile and draw on a more complete database of consumer concerns. However, such a mechanism might discourage consumers from providing feedback on less significant, but nonetheless concerning experiences they have. Ensuring that processes such as the Consumer Feedback mechanism in the ACT continue to capture these issues and opportunities for improvement is essential. Consumer feedback processes of this kind also allow less formal discussions to be held between doctors and patients about how the patient’s experience of their care could be improved.

In the ACT, consumers can make notifications directly either to the Human Rights Commissions or to AHPRA and have their issue directed to the appropriate agency or dealt with as a joint investigation. This co-regulatory function works well for consumers in this jurisdiction. However, consumers would benefit from greater information and transparency in this process, including better communication from the agencies involved about why an issue has been dealt with by one agency rather than the other, and what the outcome is.

d. the operation of the *Health Practitioners Regulation National Law Act 2009* (the National Law), particularly as it relates to the complaints handling process;

In recent years there have been a number of inquiries into complaints management in the health system. Overwhelmingly, consumers have spoken about our lack of confidence in the transparency and fairness of complaints handling. For example, the 2014 Inquiry into the Performance of the Australian Health Practitioner Regulation Agency received submissions that highlighted consumer concerns with the current complaints systems including:

- delays with the notification process;
- inadequate communication between AHPRA and consumers involved in a notification;
- confusion over the roles of AHPRA, the Boards and the health complaints commissioners in each jurisdiction; and
- the inadequate rights of notifiers.¹¹

¹¹ Parliament of Victoria, Legislative Council, Legal and Social Issues Legislation Committee (March 2014) Inquiry into the Performance of the Australian Health Practitioner Regulation Agency, p.90.

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All of these issues contribute to a lack of consumer confidence in the notification processes, systems and decision making, as has been discussed in the rest of this submission and particularly in section (c) above.

However, it is important to recognise that consumers generally consider that the national nature of the legislation to be very useful, as it ensures that poor practitioners are not simply able to cross jurisdictional borders and continue harming patients elsewhere.

What is needed is a different model which makes it easier for consumers across Australia to express their concerns to a doctor, with the help of an advocate where desired. Where this informal process is not able to resolve the matter or the doctor will not talk with the patient or family, consumers then need to be able to escalate the matter simply and swiftly and, to be able, where they desire it, to seek a restorative conference with the doctor so that they can find out what happened, look at what needs to be done to prevent it happening again and to get assurances about what will be done and by when. This could also involve setting up proper communication channels so that the person is given periodic updates on progress towards the change for example implementation and progress reports as well as any evaluation of the change.

The complaints handling system should be changed to ensure that a consumer who is seeking an apology, further information or a fair hearing has access to a process that can deliver these outcomes; regardless of whether or not the issue raised is also appropriately dealt with as a notification by APHRA or by other complaints-handling bodies.

e. whether the National Registration and Accreditation Scheme, established under the National Law, results in better health outcomes for patients, and supports a world-class standard of medical care in Australia;

The intention of the National Registration and Accreditation Scheme (NRAS) is to improve the nation-wide consistency of practice standards and the management of registrants who are unable to practice safely. This is essential to ensuring a safe and high quality health system for Australians. Although many health consumers will be unaware of the specific regulatory and legislative frameworks that apply to health and medical professionals, the community has a clear expectation that health professionals and people who work in health settings are strictly regulated.

In HCCA's view while NRAS is an appropriate national approach to regulation and accreditation, it must be strengthened including by:

- Ensuring a permanent and robust mechanism for independent reporting and performance monitoring of NRAS, which includes mandated and appropriately supported consumer representation. This would ensure the scheme is monitored against its aims in ways that are accessible to the public;
- Ensuring that future proposals for professionals to be included in the National Scheme take into account consumer perceptions of the risk posed by those professions, as well as evidence of risk to consumers presented by those professions and their representative bodies. Consumer organisations can play

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- an important role in understanding and communicating consumer perceptions of risk and potential harm posed by healthcare professions; and
- Providing greater powers for the National Boards to pursue alternative dispute mechanisms in cooperation with consumer and community organisations and Health Services Commissioners and similar agencies. This would require predictable and consistent funding and resourcing in order to ensure strong consumer participation in these processes.¹²

f. the benefits of ‘benchmarking’ complaints about complication rates of particular medical practitioners against complication rates for the same procedure against other similarly qualified and experienced medical practitioners when assessing complaints;

From a consumer perspective, the preferred approach would be to mandate and support treating doctors, and the healthcare teams and organisations within which they work, to meaningfully reflect on and learn from *each incidence* of complication to determine what went wrong or could have been done better *in that case*. This approach is more likely to lead to quality improvement and to deliver consumer safety than a defensive approach to benchmarking complaints about complication rates.

Although HCCA is strongly in favour of improved outcomes reporting in healthcare, a fundamental problem with this proposal is the paucity of relevant and useful data in most areas of medicine upon which to base this kind of benchmarking data. While there are specialised registries in a limited number of areas, for example joint prostheses and neo-natal intensive care, the capacity to produce benchmarks that are clinically meaningful across healthcare is at present very limited. Even in examples such as the National Joint Replacement Registry¹³, where data is available about the relative performance of different prostheses, government have shown a marked reluctance to use this data to govern the use or purchase of various devices, with known risks of harm.

Overall in health care, there is very little systematic recording of patient outcomes and follow-ups in the community to determine if outcomes were as expected or whether there were post-hospital complications. In particular, the systematic collection of patient outcome data require a system which can review: the prospective diagnosis on first examination, the final diagnosis after appropriate testing, the expected outcome of treatment, the outcome post-treatment and where necessary, at appropriate times into the future for example three and six months after discharge. There is no such data collected in most areas of health care.

Even where there are benchmarks and there is a capacity to externally evaluate levels of harm, for example in the case of hospital acquired infections, practitioners often

¹² Health Care Consumers’ Association ACT, HCCA Submission for the Review of National Registration and Accreditation Scheme for Health Professionals, Submitted 10 October 2014.

¹³ Australian Orthopaedic Association National Joint Replacement Registry, accessed 14/04/2016 <<https://aoanjrr.sahmri.com>>

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acknowledge that even where performance is better than benchmarks, many of the infections reviewed were preventable on current knowledge.

In essence the proposal to benchmark complication rates is a highly approximate measure of the quality of care. This is not satisfactory from a consumer perspective. A better approach would be to ensure that in every case of healthcare complication, the care team and the doctor reflect on the complication to determine what could have been done differently or better *in that case*.

There are two ways of looking at mistakes, whether in medical settings or elsewhere. One is that mistakes are failures of character or signs of incompetence. This is a pathway to secrecy, shame and continued problems. However, a mastery approach sees each mistake as an opportunity to learn and improve and make care safer. It would appear much more appropriate to encourage reflection and humility in doctors, and to truly start to look at the outcomes of care in the way we describe above, rather than to spend time on defensive bench-marking.

g. the desirability of requiring complainants to sign a declaration that their complaint is being made in good faith

In HCCA's view it would not be appropriate to require health consumers to sign such a declaration before bringing a complaint against an individual health or medical practitioner. As detailed earlier in this submission, multiple barriers exist that deter and prevent consumers from complaining about the health care they receive. The focus of policy and practice change in relation to medical complaints should be to reduce barriers to consumer complaints, and to support both complaints and feedback as opportunities for healthcare improvement. Introducing a requirement to sign a declaration would constitute a significant additional barrier to complaints-making and as a result should not be considered. Anonymity is essential to encouraging consumer feedback and complaints and to a robust complaints-handling process, and should be protected in any change to the current medical complaints process in Australia.

As detailed earlier in this submission, there is strong evidence that medical and health professionals under-report the incidence of bullying and harassment by their colleagues. While requiring a complainant to sign a declaration of good faith may be intended to prevent vexatious complaints, it risks having the more significant and troubling effect of deterring people who are experiencing bullying and harassment from making a complaint. Given the recognised link between workplace cultures in which bullying and harassment are tolerated, and preventable adverse patient outcomes, every effort should be taken to reduce barriers to health professionals' complaints about workplace bullying and harassment.

h. any related matters.

An improved medical complaints process would allow for and would prioritise restorative practice.

The principles of this approach include that it:

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- Is focused on relationships, between and among the various parties involved. Its aim is to establish or re-establish just relationships between the parties – that is, relationships that reflect values of trust, dignity and care or concern;
- Seeks to identify the underlying causes and implications of an incident or harm. This allows a fuller understanding of the problem and identification of what went wrong, what could remedy the situation and what could be done better in future;
- Is flexible and responds to the particular context in which the problem or incident occurred;
- Allows for problems, improvements and solutions to be identified by those involved in and closest to the situation; and
- Is participatory in design, in that all those with a stake in the process or situation are involved in working together to seek resolution and learning.¹⁴

In all these ways restorative practice is in contrast to the adversarial approach that predominates in Australian medical complaints-handling processes.

This approach would encourage health professionals, consumers and healthcare organisations to address feedback and complaints in the context of the already-established relationship between the health consumer and the medical or health professional about whose conduct the consumer is concerned. At present, medical complaints processes, and feedback processes, frequently damage the relationship between consumer and professional, often beyond repair. In many instances, this is not the outcome that consumers desire. Rather, consumers want to see issues addressed and the quality of care improved – both for themselves, in the context of their ongoing reliance on and relationship with a health professional; and for others. Restorative practice also allows for consumers, practitioners and healthcare organisations to address issues through an approach grounded in partnership, transparency and a commitment to restoring dignity and respect where these have been damaged. Where appropriate and sought by consumers, restorative processes could be pursued before, or alongside, disciplinary or other formal processes already provided for by medical complaints processes.

Incorporating restorative practice approaches into the medical complaints system would assist in moving toward an improved complaints system including by:

- Addressing a primary barrier to consumer complaints, namely consumers' concern that their ongoing relationship with treating medical professionals will be damaged and their quality of care negatively affected; and
- Reorienting the complaints and feedback process toward transparency, learning and quality improvement and away from blame, denial and dismissal.

¹⁴ Llewellyn, Jennifer *Governing Relationships: An International Workshop Exploring a Restorative Approach to Governance*, Monday, July 21, 2014 Lord Nelson Hotel, Halifax, Nova Scotia, see also Jennifer Llewellyn, "Restorative Justice: Thinking Relationally about Justice" in J. Downie & J. Llewellyn (eds.) *Being Relational: Reflections on Relational Theory & Health Law and Policy* (Vancouver: UBC Press, 2011).

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This is a practical way to address consumer needs and concerns in the complaints process, and to deliver safe, high quality care. Adoption of restorative practice would support the other improvements to our medical complaints system that HCCA has proposed in this Submission, among them:

- Simplification of the unduly complex complaints processes, including by adoption of 'no wrong door' and 'single entry' approaches, improved communication with consumers about complaints processes, and openness to the role of consumer advocates;
- Introducing mechanisms to better balance and deliver on consumer outcomes as well as regulatory and disciplinary goals;
- Continued commitment to and resourcing of high quality consumer feedback mechanisms at the health service and system level; and
- Improved training for medical students, junior doctors and experienced professionals (particularly those in supervisory roles) in receiving and giving feedback.

The Health Care Consumers' Association of the ACT

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