
Health Consumers' Council

SUBMISSION

National Registration and Accreditation Scheme for the Health Professions

Consultation on

***Proposed arrangements for handling complaints, and
dealing with performance, health and conduct matters***

November 2008

Health Consumers' Council Submission

Background

The Health Consumers' Council is a community based organisation representing the consumer's 'voice' in health service policy, planning and service delivery. The Council provides an advocacy service to health consumers experiencing problems in the health system. Advocacy in respect to complaints about health professionals has occurred primarily in respect to doctors with the Medical Board and dentists to the Dental Board, and to a lesser degree, psychologists, physiotherapists and nurses. The Health Consumers' Council advocacy service has a continuous and significant involvement with consumers making complaints about health service providers to the state health complaints commission, the Office of Health Review.

The Health Consumers' Council acknowledges that the advent of complaints mechanisms for health consumers arose from the growing loss of confidence in the established self-regulatory processes for dealing with consumer complaints about doctors and other health professionals. The management of the regulation of practice, including the determination of sanctions for misconduct, was also perceived to require greater accountability, for regulation to be done and also seen to be done. Medical Boards were retained, with another option being provided to the community of complaints bodies that are generally built on an 'alternative disputes resolution' foundation. Complaints bodies are intended to enable both consumers and providers to avoid the intense scrutiny of conduct that occurs in a legal or forensic setting. The threshold for dealing with medical misconduct in the criminal justice system is very high, by virtue of the historical focus on Medical Boards and self-regulation, often leaving consumers feeling that justice for victims of medical negligence is an elusive reality.

The Health Consumers' Council would not expect a new national system for dealing with complaints in health care to further distance consumers with complaints from access to robust scrutiny of their claims and justice for injuries caused by negligent practice. Where medical complaints processes are used to deal with matters outside the courts and criminal justice system, those processes should not provide a haven from accountability for the clinicians who should not enjoy the privilege of working in medicine.

In this submission we refer in large part to medicine and to doctors as a specific group. At other times we refer to the domain of health care as a service delivery sector that involves many health professional groups, as well as the machinery of facilities and management. We may also refer to other health professional groups separately.

The Health Consumers' Council recognises that medicine and the provision of health care services is a unique enterprise that shares some features with transactional services provided in other domains while at the same time involving complex human factors that set these activities apart. Health care in its essential form is a prescribed relationship that allows for one individual to have access to the physical person and private health information of another and requires a particular service dynamic that

involves the offer of care in exchange for trust, loss of privacy, and risk to safety. Health care can involve extraordinary feats that save, sustain and improve life.

It must be openly stated and declared that medicine and health care also operate within the marketplace and provide a significant potential for the generation of wealth and many forms of power and influence. The interplay between health care as a service to humanity and as a means for power and wealth, is rarely explored in the public arena, either by medical professionals or the non-medical community. However, for the purposes of regulation, it is the Health Consumers' Council's view that the exploitation of the health care relationship for economic gain requires explicit focus and description in any complaints/regulatory/sanction system relating to medicine. The inherent risks in health care and the severe imbalance in knowledge that often characterise the doctor patient relationship places consumers and health care funders at considerable risk of harm and economic exploitation.

Broad comments about the proposed complaints handling system

Guiding Principles for the complaints processes must be enshrined in the legislation

Transparency

- Open proceedings at all levels
- Publication of findings
- Reasons for referral to panel or tribunal
- Explanations for non-acceptance of a complaint
- Return to the complainant for clarification of facts during the complaint process

Accessibility

- Complaints can be accepted verbally and drafted for the consumer by Board staff
- Foster use of advocates to assist complainants
- One-stop-shop for complaints referral at a national level

Fairness

- No advantage for one party over another

Timeliness

- No tolerance for delays
- Respond in the public interest over the practitioner interest

Redress

- Put things right for the complainant where possible

Consumer invisibility

One of the most significant criticisms held by consumers of the existing Medical and other Board processes is the separation of the consumer complainant from the complaint and the assumption of the complaint by the Board. It is arguable that this

denies natural justice to the complainant by limiting their capacity to comment on the information provided by the respondent. The proposed system reflects this tradition in the most obvious way by making very little reference to individual complainants and appearing to build a system that will serve the convenience of the Boards and the respondents. The proposed arrangements appear to systematically exclude consumers or inversely, make no provision for systematically facilitating consumer access to the system.

Soft definitions of high-order unacceptable behaviour

The categories of Performance and Conduct do not provide sufficient explicit definition of behaviour understood by the community to be abhorrent, negligent or unacceptable. It is this community standard that needs to be included in the offered definitions of 'unsatisfactory professional conduct'. It is out-dated for the professional standard to be the only reference for conduct that is unacceptable. Exclusive reference to peer standards, particularly in the area of economic exploitation, merely extends the luxury of self-regulation to the profession instead of reducing this emphasis.

Vulnerability of disciplinary processes to litigious delays

It is the Health Consumers' Council's observation that medical practitioners, either personally or through their insurance mechanisms, rely heavily on legal defensiveness to manage their response to complaints. At its extreme expression, this is demonstrated by litigious delaying tactics and evasiveness, allowing the practitioner to continue with any conduct that may be the subject of the complaint. This comment is of particular significance for matters that are referred to the tribunal level for examination. Any new arrangements need to have the capacity to require a practitioner to respond to a Board in relation to a complaint.

Reliance on state tribunals to exercise the disciplinary objectives of the health practitioner Boards

The WA state tribunal has a focus on mediation for the settlement of matters that come before it, including matters referred by the Medical Board. This is absolutely contradictory to the purpose of 'escalating' a case to a higher justice process, where mediation may allow for loss of public access to the process, no publication of the outcomes of the proceedings and the loss of the power to sanction other than by agreement of the party subject to the complaint.

Specific comments about what is needed in a complaints handling system

Calling a spade a spade

Complaints need to be called complaints, not 'notifications'. This consultation did not rely on 'notifications' as the word around which the consultation turned. Failure to use the word complaints is a retrograde step and could be seen as a cynical device to make the process inaccessible to the public. It is reasonable to refer to claims by peers and other agents in the health care service machinery, as notifications because this closely

reflects what such reports will be. Non-medical people, recipients of health care services/consumers will complain, not notify.

The national registration and accreditation scheme must provide a one-stop-shop to the community for the making of complaints and the navigation of the processes for raising a concern about a health care matter. This should be truly national, recognising varied time zones across the country and be able to re-direct people to the appropriate state service, facilitated by a human contact not just electronic technology. The 'consumer's journey' in making a complaint needs to be demonstrated by a diagram or flowchart that will describe what can be expected at each jurisdiction.

National agency as a standard setter and monitor of Board performance

The current proposed arrangements do not meet the best practice ISO Standard 10002-2006. It is critical that the national agency set the rules for the management of complaints and monitor the compliance with these by the states. The complaints handling system needs to be genuinely national, despite the devolution of the management of the complaints to the state level. This means that complaint categories need to be consistent across the system, markers for timeliness of resolution need to be nationally consistent and penalties for like offences across the country need to be recorded and reported at least annually.

Separation of notifications from complaints

As stated earlier, it is the view of the Health Consumers' Council that the term complaints should be used exclusively for issues raised by consumers with a grievance with the conduct or competence of a doctor or other practitioner. Notifications can then be the reports made to Boards about practitioner conduct or clinical practice by others in the health system. A requirement for mandatory reporting of concerns about a health care practitioner by other practitioners is a necessary component of the national scheme. Mandatory reporting, with accompanying 'whistleblower' protection laws, will serve to foster public confidence in the complaints component of the national registration and accreditation system.

Immediate suspension powers

Immediate suspension powers are critical for the public protection, underpinned by the principle of fairness.

9.3 Legal representation for registrants at panel hearings

Background

With the introduction of the State Administrative Tribunal (SAT) in WA, the Medical Board was provided with a two-tiered process where serious complaints are referred to SAT and other matters dealt with by a Professional Standards Committee (PSC) at the Board level. The PSC allows practitioners to be represented by a lawyer and the proceedings are closed to the public. The attendance of lawyers for a practitioner creates a dynamic within the process that reflects the quasi-judicial setting of the tribunal and can increase the risk of the process being slowed unduly.

There is a further issue with legal representation that needs to be addressed. The interpretation of the meanings behind the categories of offences must be done by the Board or Panel and should not be interfered with by lawyers for the respondent. These interpretations when published as part of the reasons for decisions, allow for the development of a body of knowledge about what constitutes conduct that is unacceptable. The involvement of defensive lawyers in these interpretation processes can be a complicating factor.

The Health Consumers' Council supports Option 4a which allows for a third party to assist the registrant but that this person cannot be an Australian legal practitioner.

It is reasonable to expect some registrants to feel overwhelmed by the process and to need some level of support, including someone who can speak for them, with the leave of the Panel. This provision allows for fairness to be reflected in the process for registrants.

9.4 Confidentiality of panel hearings

The closing of panel hearings to the public is extremely problematic for the maintenance of public confidence in the management of complaints about doctors. It is reasonable for hearings about the health of a practitioner to be closed, however, other hearings that involve both performance and conduct must be open as a rule, with the option for the presiding member of the panel to rule for some degree of confidentiality to apply. Where a health professional board has the power to determine where a matter will be referred (panel or tribunal), there is still scope for these decisions to be interpreted as protective and defensive in the practitioner's favour when one or both of these forums is closed as a rule. The distinction between 'performance' matters and 'conduct' matters will not always be clear or self-evident and so the allocation of a matter to one or another process may appear protective of a practitioner by virtue of one process being closed. Transparency is a critical first order principle to apply in the operations of health practitioner boards.

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