Buddle Findlay HPCA Seminar 2004

Complaints Procedures: HDC's Current and Future Approach

Aim of HPCA Act and amendments to the HDC Act

The Health Practitioners Competence Assurance legislation provides a consistent framework for the regulation of health practitioners and seeks to improve the processes for complaints against health practitioners to ensure they are resolved expeditiously and fairly with adequate communication between the various agencies involved.

Both the review of the HDC Act (October 1999) by the first Commissioner Robyn Stent and the Cull Report on the Review of Processes concerning Adverse Medical Events (March 2001) identified a number of limitations with the current complaints systems. These included:

- difficulties accessing the appropriate complaints mechanisms
- time delays
- multiple investigations
- poor interaction between agencies
- lack of information sharing
- no mandatory reporting
- no power to suspend before charge
- no real compensation.

The reports recommended changes aimed at:

- streamlining complaints mechanisms
- improving agency interaction
- giving the Commissioner greater flexibility in deciding the most appropriate way to resolve consumer complaints.

Overview of key reforms to complaints process

The HDCA Act incorporates many of these recommendations. It makes explicit the Commissioner's power to deal with complaints in the most appropriate way and at the lowest possible level. It introduces more flexibility in the options available. After receiving a complaint the Commissioner will be required to make an initial assessment, including preliminary enquiries if necessary, to decide what action, if any, to take. The Commissioner can decide to take no action, if action is "unnecessary or inappropriate". As well as having the option of referring the matter to an advocate for low-level resolution there will be a new option of referring the matter to a provider for resolution, or calling a mediation conference, without the need for formal investigation. It is anticipated that investigation will be reserved for the most serious matters. Under the new Act, the Commissioner may also refer a complaint to certain statutory officers, the relevant authority, ACC or the Director-General of Health. In any case, the Commissioner can exercise more than one option, and can revise his or her assessment at any time.

These reforms will assist HDC to achieve the simple, speedy and efficient resolution of complaints at the lowest appropriate level. They will necessitate greater interaction between HDC, providers, registration authorities, and other agencies involved in complaints processes.

I will focus on the impact of the reforms on the interface between HDC and the other bodies involved in complaints processes, including:

- circumstances where the Commissioner may take no further action on a complaint as a result of previous investigation by another agency
- referral of a complaint for resolution, including to providers, registration authorities and other agencies
- reporting responsibilities both by the Commissioner and back to the Commissioner.

I will also summarise briefly the changes to processes for bringing proceedings against providers.

No action

The Commissioner's discretion to take no action on a complaint is currently limited. Once the changes to the HDC Act come into effect, the Commissioner will have a broad discretion to decide to take no action on a complaint. The Commissioner may decide to take no action on a complaint if he or she considers that, having regard to all the circumstances of the case, any action is unnecessary or inappropriate (s 38(1)). This provision is similar to the current section 37(2), but the discretion may now be exercised upon receipt of the complaint (ie, prior to an investigation), as well as at any time during the course of an investigation.

There are certain matters the Commissioner needs to take into account when deciding to take no action. Each case will be considered on its own merits. However, two examples may be:

Prior investigation by an independent agency

The Commissioner may decide to take no action where the matter has been fully investigated already by an independent agency (eg, District Inspector, Coroner) and an HDC investigation is unlikely to shed further light on the matter. A key factor for consideration will be whether there is evidence that the recommendations of the independent review have been implemented.

Prior investigation by the provider

The Commissioner may decide to take no action where the matter has been fully investigated by the provider and there is good reason to believe that the review, although not independent, has been thorough. HDC will consider whether the provider investigation included external review and consumer involvement. If the investigation appears to have uncovered the relevant causes/problems, an HDC investigation is unlikely to add any further information. This might apply in the case of a good sentinel event report that clearly identifies the problem as systems issues rather than issues confined to individual providers (eg, negligence or incompetence), and reports implementation of appropriate remedial action.

In such cases further action may be unnecessary, because we already know what went wrong, and why, and steps have been taken to prevent a recurrence. These factors will weigh against the need for an independent HDC investigation. The key issue becomes what an HDC investigation (or any other action) would add, apart from the not insignificant feature of the independence of our office. If it appears that, even if we proceed to investigate, at best we are likely to find the same defaults that the earlier review has already uncovered, *and* the provider has attempted to rectify the situation with the individual complainant (eg, by meeting and apology) *and* has changed its policies to prevent a recurrence, s 38(1) may be invoked. Cases where there appears to have been a serious shortcoming but prompt resolution and remedial action, will pose tricky decisions – there will still be a need for accountability of seriously derelict providers, even if working within a flawed system.

Example
Staff at a diagnostic laboratory mixed up two laboratory slides: one that contained a sample of fluid removed from the abdomen of a patient undergoing surgery for ascites, and the other from a patient whose ovarian cyst was being removed. As a result of the mix-up the ovarian cyst was diagnosed as being cancerous and the woman unnecessarily underwent a total hysterectomy. The laboratory concerned had acknowledged its responsibility for the error, undertaken a comprehensive investigation, identified how the error had occurred, implemented procedures to eliminate the possibility of such an error recurring and visited the patient's home to make an apology and reimburse the patient for losses incurred as a result of the error. Nothing further would have been gained from an HDC investigation.

After discussion with the patient, she decided to withdraw the complaint. Under the new legislation, a decision to take no action could have been made by the Commissioner following an initial assessment.

HDC interface with other agencies
The HDC Act currently permits co-operation between the Commissioner and a number of agencies involved in the health and disability sector and, in practice, this occurs as a matter of course. There is already much closer co-ordination amongst agencies as a result of the protocols put in place in 2000/2001. Depending on the circumstances, the interface may involve consultation on the best way of dealing with a complaint, a referral of the complaint to the other agency, or the sharing of risk information.

However, the HDCA Act mandates co-operation and information sharing between the Commissioner and a number of agencies and persons. The new Act is intended to further improve co-operation so that relevant information can be analysed and acted upon to identify public safety concerns and minimise duplication of process.

Where the Commissioner refers a complaint to another agency for resolution, the Act requires the agency to report back to HDC (s 35). The Commissioner will need to be satisfied that an appropriate outcome has been achieved. HDC has the ability to review the outcome of referrals to ensure the matter is adequately resolved, any compliance issues addressed, and independent oversight maintained. The Commissioner is not

precluded from taking further action if not satisfied with the reported outcome (see s 33(3)).

This mechanism confirms the Commissioner as the initial recipient of complaints about providers of heath care and disability services, and safeguards the rights of consumers to access an independent statutory agency with responsibility for ensuring that each complaint is appropriately dealt with.

Referral to specified persons or other agencies
The HDC Act currently provides both for referral of complaints to certain statutory officers – the Chief Ombudsman, the Privacy Commissioner, and the Chief Commissioner under the Human Rights Act – and more generally to other appropriate (but unspecified) persons where this is in the public interest. Section 59(4) gives the Commissioner wide discretion to refer a matter to an appropriate person or authority where the Commissioner considers this is "necessary or desirable in the public interest". This may occur at any time. Examples include referral to the relevant health professional body (professional conduct concerns), Medsafe (concerns about dangerous or inappropriate prescribing) or a District Inspector (concerns about compulsory assessment or treatment). There is no formal oversight retained by the Commissioner in relation to such referrals.

New section 34 of the HDC Act will allow the Commissioner to refer complaints to other agencies or persons involved in the health and disability sector, including:

- ACC (if it appears the consumer may be entitled to cover)
- the Director-General of Health (if it appears there are systems failures or the practices of the provider may harm the health and safety of the public)
- registration authorities (if it appears from the complaint that the competence of the practitioner or his or her fitness to practice or appropriateness of his or her conduct may be in doubt).

While each complaint will be assessed on its merits, the referral of a complaint about an apparent breach of the Code to such agencies will often be concurrent with, rather than instead of, any action taken by the Commissioner on the matter because of the respective roles and purposes of the various agencies. The different agencies will obviously continue to have important and distinct roles.

Referral to provider
DHBs have often conducted an internal or sentinel event investigation into the matter the complaint relates to, and are willing to disclose the report to the patient/family and HDC. In cases where a thorough and comprehensive report has been prepared, there may be nothing to be gained from commencing an investigation. The Commissioner may refer the complaint back to the provider for resolution with complainants, or call a mediation conference to resolve any outstanding issues for the complainants.

A referral back to the provider for resolution may be made only if the complaint does not raise public safety questions. Preliminary enquiries may reveal that the provider is well motivated to resolve a complaint which may never before have been brought to the provider's attention. Sometimes consumers do not want the assistance of an advocate,

and mediation may be an unnecessary formality. A referral to the provider will enable resolution of the complaint directly. If such a complaint is then resolved, it will be unnecessary for the Commissioner to take any further action.

Example
HDC received a complaint relating to a patient's care over a year or more by providers from many disciplines, all within one DHB. The patient complained of her "year of hell". She acknowledged that taken in isolation the matters she complained of could appear trivial, but their compounding effect had a serious effect on her health. After discussion with the CEO, and with the patient's agreement, the DHB took over the complaint, looked into it, met with the patient and achieved a speedy resolution which satisfied the patient. She rang my office to report the positive outcome before the DHB had reported back. This complaint would have been difficult and lengthy to investigate and the outcome would probably not have been so positive.

The onus is on providers to show that when complaints are referred back to them, they have the capacity and the goodwill to achieve satisfactory resolution. The flexibility under the new Act is a powerful tool to provide simpler and speedier resolution of complaints, but it must work effectively to ensure consumers' rights remain protected. This is safeguarded in the Act by the reporting requirements back to the Commissioner following all referrals to a provider for resolution.

Referral to ACC
The role of ACC is to provide rehabilitation and compensation, not complaints resolution. The philosophy underpinning ACC investigations is therefore substantially different from HDC investigations. ACC may, but often will not, examine underlying systems causes that contributed to a patient's injury. As a matter of practice, when HDC commences an investigation into whether the treatment of a registered health professional is of an appropriate standard, the ACC Medical Misadventure Unit is notified and a request made for any information the ACC holds that is relevant to the investigation. Material in the ACC file can form part of the information considered. It may not be necessary to seek duplicate information from providers, only to inform them of what we already have and request supplementary information tailored to HDC purposes.

Under the new legislation, which enables the Commissioner to make an initial assessment of a consumer complaint before deciding on the most appropriate course of action for resolution, information from an ACC file may be requested and considered. Where advice from an ACC independent advisor suggests no evidence of substandard care, this advice may form the basis of an HDC decision that there was no apparent breach of the Code, and therefore no jurisdiction to investigate the complaint.

Referral to registration authorities
Standards and competence
Registration authorities have a distinct and important role in the setting of professional standards for the protection of the public. They are the appropriate agencies to receive referrals of concerns about a practitioner's competence and fitness to practise, and are enabled by law to conduct confidential competence reviews. To date, the Medical

Council has been the only registration authority empowered to undertake competence reviews, but under the HPCA Act all registration authorities will have this power. It is a valuable way to maintain the competence of practitioners for the protection of the public.

Professional Conduct Committees
Currently, all complaints received by registration authorities must be referred to the Commissioner. The HPCA Act clarifies that only patient care complaints – ie, complaints alleging that the practice or conduct of a health practitioner has affected a health consumer – must be referred to the Commissioner. Registration authorities will retain a limited complaints resolution role, dealing with issues that typically do not involve patient care, for example criminal activity (such as ACC fraud) and professional conduct issues (such as self-prescribing and misleading advertising). This is very much more limited than currently. Complaints Assessment Committees will disappear and be replaced by Professional Conduct Committees (PCCs), so named to reflect more accurately their new role. The referral of a complaint to a registration authority for action through a Professional Conduct Committee would usually be *instead of* any action by the Commissioner.

Commissioner's reporting responsibilities
Notification of investigation and outcomes
Currently, on receipt of a complaint about a registered health practitioner, the Commissioner has discretion to notify the relevant professional body of the complaint (s 38). In practice, whenever an investigation of a health professional is commenced, the registration authority is notified of the complaint and the investigation. At the same time a request is usually made for any information the registration authority holds that is relevant to the subject matter of the investigation. Once notified, disciplinary action is suspended until the Commissioner or the Director of Proceedings notifies the professional body that no further action is to be taken under the Health and Disability Commissioner Act.

In the future the Commissioner will be *required* to notify the responsible authority of any investigation under the Act (s 42(1)).

Similarly, the HDC Act currently gives the Commissioner a discretion whether to notify the relevant health professional body of the result of an investigation where the Commissioner decides to take no further action. The Commissioner is required to notify the registration body only where he or she proposes to take further action. In future, the registration authorities must be informed of the result of investigations involving their members *whether or not* a breach is found (s 43(2)(d)). The new requirement reflects current practice.

Watchdog function
The HDC Act currently envisages that the Commissioner keeps alert to the possibility of wider public safety issues, which may be referred to the relevant authority where appropriate (s 59(4)). Referral to the appropriate person or authority is mandatory only where the Commissioner considers there is evidence of any *significant breach of duty or misconduct* by the provider (s 48).

Reporting competence concerns
The HPCA Act obliges the Commissioner to notify the appropriate registration authority if he or she "has reason to believe that a health practitioner may oppose a risk of harm to the public *by practising below the required standard of competence*" (s 34(2) HPCA Act). The required standard of competence is defined to mean "the standard of competence reasonably to be expected of a health practitioner practising within that health practitioner's scope of practice" (s 5(1)). This will involve an assessment of whether the practice meets the standard of care and skill reasonably expected of a practitioner within the relevant scope of practice. There is some debate about whether it covers a one-off incident (in which case a Right 4 breach may be sufficient) or ongoing substandard practice. It is arguable that 'practising' requires a pattern of practice as opposed to a one-off incident. However, depending on its gravity, a single incident may reflect on the standard of one's practice.

Reporting practice concerns
The HDC Act as amended imposes a broader obligation, as it obliges the Commissioner to notify the appropriate authority if he or she "has reason to believe that the practice of a health practitioner may *pose a risk of harm to the public*" (s 39(1)), ie, it is not limited to reporting competence concerns, but concerns associated with the practice of a provider generally, which could include reasons related to ethical or professional conduct. It focuses on potential harm to the public, rather than on competence.

The Commissioner is also obliged to notify the Director-General of Health in such cases if he or she "has reason to believe that failures or inadequacies in the systems or practices" of a provider "are harming or are likely to harm the health or safety of members of the public" (s 39(2)).

Reporting to the Commissioner
The health and disability sector agencies that receive a referral from the Commissioner are required to report what action, if any, has been taken in relation to the matter. For example:

- if a matter is referred to the ACC, ACC is obliged to report its cover decision to HDC
- if a matter is referred for competence reasons, the authority is required to report to the HDC on its action.

In addition, the HPCA Act (s 35(1)) requires the responsible authority to promptly notify ACC, the Director-General of Health, HDC, and the employer when it has "reason to believe that the practice of a health practitioner may pose a risk of harm to the public". (Notification to a practice partner or associate is discretionary – s 35(2).) There is some confusion about the purpose of this provision, as the registration authorities will themselves usually be the appropriate agencies to receive such referrals and follow up concerns via a competence review, and/or placing conditions on practice.

Changes to Proceedings
The functions of the Director of Proceedings are set out in section 49 of the HDC Act.

Currently, when a matter is referred to the DP, the file is reviewed and contact is made with the complainant and the provider. The consumer's wishes are discussed, as well as his or her availability and willingness to give evidence at a hearing. Providers are invited to submit a further response. The DP then makes a decision about taking proceedings against the provider, taking into account

- all information on the investigation file
- the consumer's/complainant's wishes
- the provider's response
- the public interest.

These steps will now occur as part of the Commissioner's 'provisional opinion' process. Furthermore, the Commissioner will be empowered to refer one or more providers, rather than "that matter" as a whole (s 45(2)(f)).

In future where a provider is referred, the Director of Proceedings will be able to make a decision

- without giving the provider a further opportunity to be heard
- without seeking the views of the complainant or aggrieved person
- without mandatory consideration of the public interest in issuing disciplinary proceedings.

In practice, the quality of the evidence, the wishes of the complainant, and the public interest in bringing proceedings in appropriate cases will remain relevant considerations for the Director of Proceedings.

The wishes of the complainant
From an objective standpoint, there may be sufficient evidence to proceed without the consumer, irrespective of his/her wishes. In serious matters, that has happened, and no doubt will continue. An unwilling complainant can be summoned to give evidence, but this is problematic since

- briefing the evidence may be difficult or impossible
- the quality/strength of the evidence may be unsatisfactory
- the nature of the evidence may be unpredictable/unknown
- there may be adverse consequences for the consumer, eg deterioration of health.

The reality is that the wishes of a consumer/complainant will remain a relevant consideration for the DP.

The public interest
As the Director of Proceedings is a statutorily appointed and publicly funded prosecutor, the public interest will always guide his or her actions. The public interest includes:

- safety and protection of the public
- maintenance of professional standards
- education of the public and other health professionals
- transparency of process
- accountability of providers for their conduct.

In practical terms, the new proceedings system will shorten the length of time between the referral and the decision to take proceedings – which will in turn shorten the time from HDC investigation report to any disciplinary or HRRT hearing.

Summary

The changes resulting from the HPCA Act and the amendments to the HDC Act significantly enhance the Commissioner's power to deal with complaints appropriately. They should reduce duplication of process and enable early resolution. The new legislation seeks to ensure a balance between resolution for individuals and protection of the public. The risk for HDC is that there will be increasing requests for revision of an initial assessment of a complaint (ie, potential delays at the front end) and more litigiousness at the end of investigations (ie, challenges to proposed DP referrals by providers, and pressure from complainants to find a breach and enable access to the Human Rights Review Tribunal). My hope is that the changes will nonetheless reduce the toxic effect of current complaints processes on complainants and providers – and help HDC achieve its statutory mandate of "the fast, simple, speedy, and efficient resolution of complaints".

Ron Paterson
Health and Disability Commissioner
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