FIRST MEETING ON THE ANNUAL REPORT OF THE HEALTH CARE COMPLAINTS COMMISSION

REPORT OF THE JOINT COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

MAY 1996

Parliament of New South Wales

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ISBN: 0 7310 8858 1

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Functions of the Committee

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

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

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

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

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

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

The Joint Committee is not authorised:

a. to re-investigate a particular complaint; or

b. to reconsider a decision to investigate, not to investigate or to discontinue investigation of a particular complaint; or

c. to reconsider the findings, recommendations, determinations or other decisions of the Commission, or of any other person, in relation to a particular investigation or complaint.

Membership

Legislative Assembly

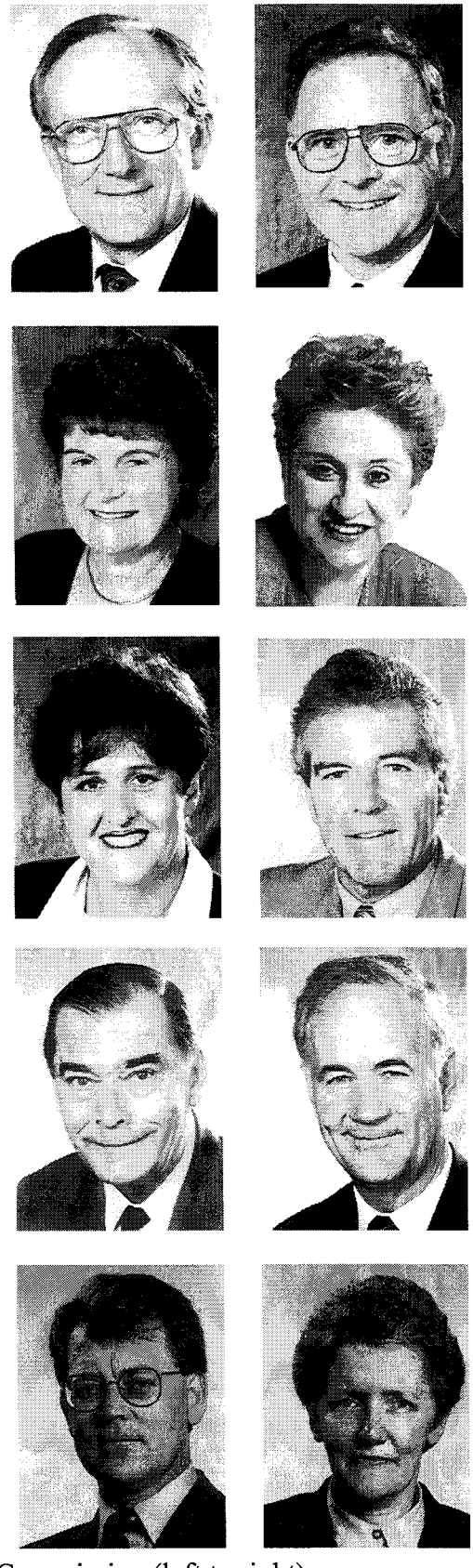
Mr John Mills MP - Chairman
Mr James Anderson MP
Ms Marie Andrews MP - Vice-Chairman
Ms Marie Ficarra MP
Ms Jill Hall MP
Dr Peter Macdonald MP
Mr Stan Neilly MP
Mr Bill Rixon MP

Legislative Council

The Hon Elisabeth Kirkby MLC
The Hon Dr Brian Pezzutti MLC
The Hon Patricia Staunton MLC

Secretariat

Ms Ronda Miller - Clerk to the Committee
Ms Catherine Watson - Project Officer
Ms Hilary Parker - Assistant Committee Officer



Joint Committee on the Health Care Complaints Commission (left to right)
Mr John Mills MP (Chairman), Mr James Anderson MP, Ms Marie Andrews MP (Vice-Chairman), Ms Marie Ficarra MP,Ms Jill Hall MP,Dr Peter Macdonald MP,Mr Stan Neilly MP, Mr Bill Rixon MP, The Hon Elisabeth Kirkby MLC, The Hon Dr Brian Pezzutti MLC, The Hon Patricia Staunton MLC

Chairman's foreword

The Health Care Complaints Commission of NSW is made accountable to the people of New South Wales in a number of ways. One is through the requirement to present to Parliament an Annual Report of its activities. Another is through the establishment by statute of this oversighting committee of the Parliament, the Joint Committee on the Health Care Complaints Commission, one of the functions of which is to examine each Annual Report and report to Parliament on matters related to the Report.

The Joint Committee has examined the Annual Report covering the first twelve months of operation of the Commission as an independent investigatory body. Prior to 1 July 1994, the investigation of health care complaints was undertaken by the Complaints Unit inside the NSW Department of Health.

The examination was conducted in public, in the form of a Parliamentary hearing, and in the presence of the media. The transcript of the day-long hearing is contained in this report.

Such a process provides a two-way opportunity in accountability. The Commission is able to speak out about its considerable successes in maintaining high standards of health care, to defend its performance and to communicate that message to the public. Members of the Joint Committee, and through them the constituents they represent and community groups including consumers, are able to raise their concerns about the functioning of the Commission and debate important issues with the Commissioner.

The Joint Committee decided to seek the views of several organisations which are closely involved with the work of the Commission, from either the health professionals' or consumers' perspectives, concerning the issues raised in the first Annual Report of the Commission. Much valuable information and insight was obtained, and the Committee expresses its appreciation to those people who appeared before us to give their views, and assist us in our task of review.

Statements, submissions and documents tabled at the hearing are contained in appendices to the report, along with follow-up correspondence from the Commissioner. Sections 3 and 4 of the submission tabled by the Medical Consumers Association, being of a general nature not related to the 1994-95 Annual Report, are not reproduced herein; copies can be supplied on request to the Joint Committee.

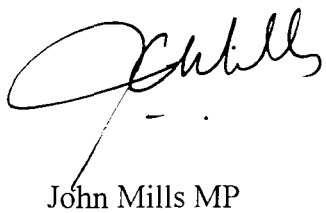
The evidence the Committee received from various groups during the review of the Commission's first Annual Report raised a variety of important issues. The Joint Committee intends to revisit many of these in its future inquiries into the Health Care Complaints Commission's functions and operations.

From an accountability point of view, this report is in parallel with the examinations of Annual Reports by Statutory Joint Committees of the Parliament oversighting the two other independent investigatory authorities in NSW, the Ombudsman and the Independent Commission Against Corruption.

At the hearing, the Registrar of the Health Conciliation Registry made the offer for members of the Joint Committee to attend a simulated mediation/conciliation so as to better understand the process. Several members of the Committee accepted the offer and attended the session in February, and we thank the Registrar for the understanding gained through that exercise.

Finally, I wish to acknowledge the assistance of Parliamentary staff in the conduct of the public hearing and in the preparation of this report: Ms Catherine Watson, Project Officer; Ms Hilary Parker, Assistant Committee Officer; and Ms Ronda Miller, Clerk-Assistant (Committees). Their hard work and sound advice enable the Joint Committee to carry out its work. Thanks are also made to the Parliamentary Reporting Staff (Hansard) and Printing Services.

I commend this report to Parliament.



John Mills MP
Chairman

Introduction

This report details the proceedings of the Joint Parliamentary Committee's first meeting with the Health Care Complaints Commission and other relevant groups to discuss the first Annual Report of the Commission which was tabled in Parliament on 14 November 1995.

The Joint Parliamentary Committee is required under Section 65(1)(d) of the *Health Care Complaints Act* 1993 to "*examine each annual and other report made by the Commission and presented to Parliament under this or any other Act and report to both Houses of Parliament on any matter appearing in or arising out of any such report*".

As a consequence of its meeting of 22 November 1995, the Joint Parliamentary Committee resolved to hear from the Health Care Complaints Commissioner, the Health Conciliation Registrar, two major medical disciplinary boards: the Medical Board and the Nurses Registration Board, and two consumer interest groups: the Consumer Advisory Committee to the Health Care Complaints Commission and the Medical Consumers Association of NSW about issues arising from the Health Care Complaints Commission's first Annual Report.

While the following collation canvasses a wide range of issues concerning the Commission, the Committee identified in advance the following four areas as ones of particular interest:

1. Conciliation

Page 19 of the Annual Report outlined that only 59 of the 1787 complaints the Commission received were able to be referred to conciliation last year. The Committee was interested in the following issues:

* the adequacy of resources presently allocated to this area;
* any problems with current structures which prevent complaints being referred to conciliation;
* more detail as to the overall success/failure rate of the process (ie why was it unsuccessful in 15 cases);
* the number of cases in which compensation was awarded and anticipated trends for this;
* the Commission's experience of other parties' commitment to the process;
* any other options to facilitate more complaints going to conciliation;
* the average cost of conciliation and whether the process is cheaper than investigation.

2. Implementation of Policy Changes Recommended by the Commission to Health Service Providers

Page 26 of the Annual Report explained that the Commission monitors the extent to which its recommendations are implemented within the relevant authority. The Committee was interested in following up:

* actual rates of implementation;
* methods by which implementation is monitored;
* options open to the Commission should implementation of recommendations not occur.

3. Complaint Handling

Page 54 of the Annual Report gave average times taken to handle complaints. The Committee was interested in the following issues:

* comparisons between 1994/1995 and previous experiences of the Complaints Unit;
* percentage and length of the longest standing complaints;
* any potential mechanisms or resources which could be implemented to cut times taken in complaint handling;
* differences with other states/other systems and NSW advantages or disadvantages;
* particular difficulties which characterize the cases that take longest to complete;
* the main reasons for declining to investigate complaints (p 12).

4. Funds and Resources

The Committee was interested in the following areas:

* the current budget allocation to the Commission;
* any submissions made to the minister for Health for additional funding and the outcome of these requests;
* anticipated use of these funds, if granted;
* implications for the Commission if the funds are not granted;
* the implications for the budget of court awarded costs against the Commission;
* the expenditure breakdown for the different sections and divisions, eg Operations Division, Policy Section, Administration.

REPORT OF PROCEEDINGS BEFORE

JOINT COMMITTEE ON THE HEALTH CARE COMPLAINTS

At Sydney on Wednesday, 20 December 1995

The Committee met at 9.30 a.m.

PRESENT

Mr J.C. Mills (Chairman)

Legislative Council	**Legislative Assembly**
The Hon. Elisabeth Kirkby	Mr J. Anderson
The Hon. Patricia Staunton	Ms M.T. Andrews
	Ms M.A. Ficarra
	Ms J.G. Hall
	Dr P.A.C. Macdonald
	Mr S. Neilly
	Mr B.W. Rixon

MERRILYN MARGARET WALTON, Commissioner, Health Care Complaints Commission, Level 4, 28 Foveaux Street, Surry Hills, and

GAIL BARTON FURNESS, Deputy Commissioner, Health Care Complaints Commission, of 28 Foveaux Street, Surry Hills, affirmed and examined:

CHAIRMAN: Did you receive a summons issued under my hand to attend before this Committee?

Ms WALTON: I did.

Ms FURNESS: Yes.

CHAIRMAN: The Health Care Complaints Act 1993, section 65, part 1D requires the Joint Parliamentary Committee to examine each annual and other report made by the commission and presented to Parliament under this or any other Act and to report to both Houses of Parliament on any matter appearing in or arising out of any such report. The first annual report of the Health Care Complaints Commission was tabled in Parliament on 14 November, 1995.

Today's hearing is part of the Committee's process of examination of the first annual report of the Health Care Complaints Commission. As part of that process the Committee determined to hear from the commission and other parties involved with the commission so that we may assess how the commission is carrying out its functions under the act and whether it is achieving the goals expected of it by the Parliament and the community. Before we begin with any questions from me and members of the Committee, do you wish to make an opening statement?

Ms WALTON: Yes, I do. I would like to refer the Committee to section 95 which outlines those requirements of reporting that the commission must do. It covers generally numbers and types of complaints, outcomes and disciplinary matters and so forth, but the one I specifically want to focus on in this introductory statement are the time frames for investigations. I am aware both from my own experience in the commission, from the community, from consumer groups and the profession, there is a concern of the time taken for investigations in the commission and this has historic reasons in terms of volume and lack of legislative framework which now the commission has.

I would like to spend a few moments saying what the commission has done in relation to trying to address the time taken. Four strategies have been focused on. The first is staffing submissions we have made and the Committee may well want to ask questions about those staffing submissions. The second one is we have made submissions to the Minister to establish the patients' support office as an outreach service to have local resolution of complaints appropriately undertaken.

The third area is the commission itself reviewed its assessment policy where, for example, in October the commission took on 25 per cent of the complaints referred to the commission. In November that was reduced to 12 per cent of complaints, because clearly if we do not have an increase in staffing resources we need to look at our

modus operandi, which includes looking at other places in the health system for complaints.

Part of the assessment review is more complaints being assessed for conciliation and having greater reliance on area health services, hospitals and districts to investigate and resolved complaints locally that are appropriate for them. I must preface that by the commission must take on those complaints that raise public health or safety issues or complaints concerning significant clinical issues.

The fourth strategy is meeting with medical defence unions, registration boards and the Department of Health in order to get some agreed protocols. At the moment the historic relationship with medical defence unions and the commission and previously the Complaints Unit was not harmonious. It has been aggravated by significant tension in terms of perceptions of the role of the commission.

We have had now two meetings with medical defence unions in an attempt to get some agreed protocols which include things like giving over medical records early so we can actually make appropriate assessments rather than having the investigation prolonged because of the lack of getting access to information.

So they are four strategies the commission has taken in an attempt to reduce the time frames taken and clearly these strategies are not short term. They are long term. Some of them are mid way and some are new, and in relation to resources and staffing submissions, of course, they have been done. So I just wanted to let the Committee know about those things and I am happy to answer questions about any of those strategies.

CHAIRMAN: May I start the examination and questioning by referring to the area of conciliation, page 19 of the annual report which, for example, outlines that of the 1,787 complaints the commission received last year, only 59 were able to be referred to conciliation. I believe the Committee would be interested in issues such as the adequacy of resources presently allocated to that area, any problems that you have with current structures that prevent complaints being referred to conciliation, and perhaps more detail as to the overall success and failure rate of the process. For instance, why was it unsuccessful in the 15 cases that were reported as being unsuccessful.

Ms WALTON: Before I answer that question, I need to give some information to the Committee about what information the commission is legally able to hold about the conciliation registry. The conciliation registry is totally separate from the commission. We can refer matters for conciliation once we have obtained consents from the parties. Once it goes to conciliation, the only information we are given is whether it was satisfactory or unsatisfactorily resolved or whether it has been referred back to the commission for investigation.

If the conciliation registrar is appearing before the Committee they may have to give some information about the resources because that is not our jurisdiction. In relation to the resources of the commission to process conciliation complaints, and I might just advise the Committee that the total number of complaints being assessed for conciliation, which is different from those where successful consents are gained, has been

246 complaints to now. So, since the annual reporting period of June 1995 to now, there has been a significant increase in the number of those complaints.

Those 246 complaints represent 13.5 per cent of all complaints received in the period. So we are assessing 13 and half per cent of complaints for conciliation. Of these, 101, 41 per cent, were successfully referred to the registry following consents from both parties.

CHAIRMAN: So that is from 1 July this year?

Ms WALTON: That is total since we started. A further 89 complaints, 36 per cent, are in the pipeline awaiting consents and in 22 per cent, 56 complaint consents were not obtained. The complainant declined where we had a consent from the respondent in 48 per cent of the times. The respondent declined in 20 per cent, and both declined in 32 per cent, so really the complainant declined was almost 80 per cent of our unsuccessful attempts to refer for conciliation, not the respondent. Of course, consumers can request a review after an assessment and less than 5 per cent of those complainants requested a review of the assessment.

When we refer a complaint for conciliation, we must obtain consents, because it is a voluntary process. That involves a lot of discussion on the telephone and the resources at the moment are one conciliation officer. We have applied in our staffing submission made in June 1995 for an additional conciliation officer in anticipation of the increase in complaints we would be receiving and referring. That was not successful, but at this stage we are managing in terms of the case load of referrals for conciliation.

Some of the structural problems, when the bill was being debated there was a view from consumer groups and, indeed, the Complaints Unit at the time, that the conciliation registry should have been part of the commission in terms of getting continuity of flow of the complaints. At the moment what happens is, we have to obtain the consents, then it is referred to another body and the consumer and respondent have to deal with two groups of people. The first body has to obtain the consents and then it is into another process.

In future, when the Act is being reviewed, we would probably like to flag consideration of merging, putting the registry back with the commission and not having it separate. The other structural problem is that conciliation can only be offered to complainants at the beginning, during the assessment phase. We think conciliation should be offered at any stage, even during an investigation or after an investigation, where the information becomes evident that it is not going to go to disciplinary action, it is not a public health or safety issue but the consumer would like an opportunity to confront or be present with the provider or the hospital and have some answers or indeed maybe even apologies, then that should be appropriate. We could refer that but at the moment the Act prohibits us from doing that.

CHAIRMAN: Do any members of the Committee have any follow-up questions on conciliation matters?

The Hon. ELISABETH KIRKBY: Can you tell me if you believe there is any validity in the theory that conciliation is not a suitable way of handling these types of complaints, that it does not work in this setting although in other area it might work?

Ms WALTON: The information to date of the outcomes of conciliation is that agreement was reached in 58 per cent and we are talking now about 101 matters. No agreement was reached in 19 per cent. The conciliation was cancelled or referred back to the HCC in 17 per cent and pending is 6 per cent, so over half reach agreement. But I do have to say I do not think conciliation is appropriate for complaints concerning significant clinical issues which raise issues of competence or public health or safety issues. There are certain types of complaints which necessarily must be precluded, like assaults, inappropriate sexual relationships, physical assaults, quality of care which raises issues of standards. Those types of matters I don't think should be, but I must add in Victoria and New South Wales those matters are conciliated.

Ms FICARRA: You mentioned staffing submissions and resources. Would that have anything to do with the percentage of clients and patients that are taking up conciliation as a course of resolution? Is there room for improvement in staffing or resources provided that would enhance the percentage of patients that chose reconciliation or its success rate?

Ms WALTON: I cannot speak for the registry in terms of success rates, but certainly in terms of our resources, we do not make a decision based on whether we can do it or not. We actually make the assessment based on the type of complaint and its appropriateness, and to date there is no delay in referring matters. I think the process takes a couple of weeks to get to the registry, so at this stage for conciliation of complaints, and that is not investigation, I might add, there is no delay and no current indication but, of course, if we had 1,000 complaints going for conciliation it would be totally different.

Ms FICARRA: Are the conciliators from within, internally in the commission or are they external consultants?

Ms WALTON: The conciliation registry can give you information on that, but they are a panel of external conciliators appointed by the Minister who report to the registry. We have nothing to do with them.

The Hon. PATRICIA STAUNTON: On page 19 of the annual report, which is the page that deals with this issue of conciliation, you say at the foot of the page on the lefthand side, "If the commission is of the view that a complaint would best be resolved through conciliation", and if I stop there, you have indicated some of the areas where you do not believe conciliation is appropriate. Do you have a set of criteria that says a particular type of case is one that may lend itself well to conciliation, given your statement that would seem to suggest that, and if so, what are they?

Ms WALTON: This has been a difficult area for us because it is a new area. At the end of one year we are going to evaluate, and I am answering your question backwards, all those successful conciliations, in terms of what clusters of complaints were

successful, like is there a special type of complaint; but how we assess it at the moment is, if there is a pattern of practice complaint, like other multiple complaints, we do not refer it for conciliation. The Act says we must investigate if it is a significant clinical issue and to come to that decision we get advice from our medical advisers or peers of the person in terms of whether this is a known side effect or risk.

We have a re-submit system, so we refer the file to an officer who gets some records, talks to people and makes a recommendation back to the assessment committee. If it is public health or safety we cannot refer it either. Those complaints which seem to do best are where there are no other complaints about the provider; it is a treatment issue, but where there has been very poor communication between the parties. There has been an attempt at local resolution and failed and it seems like there is an adversarial situation where if we can get the parties to talk, we will resolve it.

So it is a clinical issue but we have assessed via a consultation process that it is not significant. If it is not going to be potential disciplinary, we will often consider whether, if prima facie it was proved, what would we do with it. If we are not going do anything with it in terms of disciplinary action, we offer conciliation.

The Hon. PATRICIA STAUNTON: If conciliation fails, then the commission is required to press on if the complainant insists?

Ms WALTON: No, not at all. In fact the Act prohibits us. It is really an either or situation. We either assess it for someone else, decline, the commission will take it on or we can offer conciliation, and obviously there are various other things we can do. If we offer conciliation and the complainant does not want it, they can request a review. We must review that decision. If we still say conciliation, the complainant says no, we close the file.

The Hon. PATRICIA STAUNTON: But if you then review it and say you think there may be some substance to it--

Ms WALTON: We will investigate it, but it has not been referred to the conciliation registry by that stage. The assessment must take place in the commission. Usually the complainant does not consent to it and they request a review.

The Hon. PATRICIA STAUNTON: The reason I am asking you these questions is that the likelihood of a person being complained about rather than the complainant agreeing to undertake conciliation could well prove difficult if they thought that the prospect of further disciplinary action and ultimately legal consequences will flow, notwithstanding the fact that they had agreed to undertake conciliation. Would you not agree that there would be that apprehension?

Ms WALTON: Except the Act does not allow us to do it. The conciliation registry can refer back if an issue comes up during conciliation which raises significant public health or safety issues, but we are not told what it is. It is only referred back to us, and that has happened in one case. In relation to respondents, they have only declined in 20 per cent. Only 11 respondents have said no. So, the evidence is that the respondents

are actually willing to go down this pathway of conciliation. In terms of legal action, there is nothing to prevent a consumer making a medical negligence claim if they are in conciliation.

The Hon. PATRICIA STAUNTON: That is the point I am making, that the likelihood of getting co-operation from respondents if there is potential legal action hanging over their heads, given the sort of advice they would be getting, would be absolutely remote, would you not agree?

Ms WALTON: Except the medical defence unions are encouraging doctors to participate in that process.

The Hon. PATRICIA STAUNTON: It must be all the ones they feel pretty safe about.

Ms WALTON: No. All I can say is that the figures do not bear that out.

CHAIRMAN: Could I follow up that last comment and ask you what is your experience of other parties commitment to the conciliation process? You mentioned that the medical defence unions are changing--

Ms WALTON: There was a concern by the commission of what we perceived as the level of encouragement of doctors to participate in conciliation, because basically there is not a lot of incentive for respondents to participate. We must investigate certain complaints. If we are not going to investigate, which is our first requirement to consider, then they know they are not going to be investigated by the commission so why would they participate. But, again, the evidence is they are co-operating.

We met with the medical defence unions, and as I said, we have met twice now and they have agreed to encourage members to participate in the process. At this stage, I have no reason to think that the conciliation function will do anything but improve and be better accessed. I might just add, over 200 matters we have assessed for conciliation. The conciliation here is very different to Victoria and Queensland. In those states, 50 matters in Queensland in the last annual report went for conciliation, but they conciliate damages during their conciliation process. We do not do that in New South Wales.

The Hon. ELISABETH KIRKBY: In order for you to have the ability to conciliate damages, what changes would have to be made to the Act?

Ms WALTON: I think there would have to be some provision made in the Act to allow third parties to be involved in the process, like the medical defence unions and advisers to the complainants. Because when you are getting into mediating or conciliating large sums of money, if there is a concern the consumer needs some good protection and the respondent needs advice.

The Hon. ELISABETH KIRKBY: Is it possible for the consumer to be legally represented at conciliation?

Ms WALTON: They are not legally represented.

The Hon. ELISABETH KIRKBY: Independent advice?

Ms WALTON: Yes.

CHAIRMAN: Is conciliation a cheaper process than investigation?

Ms WALTON: Of course. I mean the evidence is consumers are satisfied with the outcomes, it is quicker, it is more humane in the sense that people are talking and resolving a complaint, but it should never be seen as a replacement for looking at standards and the public interest in terms of ensuring people are competent and conduct themselves properly. It should not be used to avoid that process.

Mr ANDERSON: You said that conciliation is only available at the start of a complaint, not during the process of the investigation. Is there any reason for that? Is there any reason that the legislation was drawn that way?

Ms WALTON: I think our experience since then has shown there are many times during an investigation where the information that we have obtained from an investigation shows there is nothing significantly serious that is going to go to disciplinary action, but the complainant, because maybe there has been a death or some misunderstanding, needs an opportunity to have some face-to-face contact. That is not available at the moment. All we do is offer our own processes, but I think it would be much better for there to be proper exchange with the people who gave the treatment.

CHAIRMAN: I think it might be appropriate to move on to the area of complaint handling. I know one of the issues that has been flagged for concern in the past and is still present relates to what is on page 54, the time taken to resolve complaints. I know you addressed this in your opening statement, but 50 per cent were closed within 130 days of their receipt. The average time taken to deal with complaints finalised last year was 379 days.

What do you think the are the major reasons that 50 per cent of the complaints take over 130 days and some of them may well go for many, many years? Are there structural reasons either in the Act or in the commission's procedures that lead to this, and what do you think can be done about it?

Ms WALTON: The first thing I would like to do is give you a snapshot of some comparisons of 1993, 1994, 1995, to just show you, I suppose, the improvements. For example, in 1993, the average time for an investigation of serious complaints was 422 days. In 1994 it was 327 days and in 1995, I am talking calendar years, it was 136 days. So it has reduced significantly. The average time to finalise other complaints other than serious, in 1993 it was 180 days, in 1994 126 days, and in 1995 69 days. So, 57 per cent of the complaints made in 1995 are getting resolved within that year compared to 44 per cent in 1993.

Now, the improvements are really nothing to do with structural changes,

they are to do with decreasing case loads and additional resources from savings being used to try to move those files along. There are impediments to having speedy investigations. The Act requires the commission to consult many times with registration authorities, and if I could just name them, we are required to consult on assessment of a complaint, we are required to consult if the complaint is assessed as appropriate for conciliation or investigation, we are required to consult at the end of an investigation, we are required to consult after any adverse comment or criticism that we may find against a person, and we are required to consult prior to going to disciplinary action.

This process is quite a bureaucratic process, and my understanding of why it was included in the legislation at the time was concerns from the medical profession that the medical board or the nurses board from the nurses association were aware of what the commission was doing. But the Act also allows the commission independently to discipline, if it wants to, or investigate if it wants to. So it seems there are a lot of steps and consulting requirements which prolong the time for an investigation. It seems to me we should consult at the beginning and the end. Those other steps add significantly to the process.

The other problems we have is there is no compulsion on any respondent to reply to the commission within a certain time frame or, indeed, to reply to the commission which can be a difficulty when you are investigating a complaint and one is not sure whether it is serious or not. You cannot close the file, so that prolongs it. We have difficulties in getting reports from subsequent treating doctors who also get advice from their defence unions, either to co-operate or not.

Some treating subsequent doctors feel uncomfortable about participating and assisting the commission in its functions. We have had significant problems in terms of getting speedy reports from our peer reviewers. Part of an our investigation relies on what peers think of a respondent's conduct or treatment and' we are required to get a written report which says how far they departed from the standard of what the quality of care was. Because peers must be practising practitioners in the area of the respondent, they are busy people and sometimes we have had 6 months to a year, not without prompting of our peers, to get reports back.

We do have coercive powers in terms of search warrant powers but we can only use those if the complaint is serious and would constitute professional misconduct if proved and the offender deregistered. We have exercised search warrant powers. It would not be appropriate to execute warrant powers in 95 per cent of the complaints we get. We are meeting with the defence unions to try to get some agreement of their quickening the process and handing over records. For example, the Act requires statutory declarations from complainants in investigations. That significantly adds about three or four months to the investigation process, because we get a letter of complaint, we write back to the complainant to get a statutory declaration which can be intimidating to some people. We have a brochure now on how to do a statutory declaration. That adds time.

The thing we would like, for example, the medical defence union to consider is letting us use the letter of complaint as an authority to them to give us a report. At the moment we have to get separate authorities from complainants to give to the

respondent to enable them to give us a report. So there is a lot of bureaucratic and legal requirement in preparation for investigating a complaint, let alone just the normal investigative process.

Dr MACDONALD: The Ombudsman's report in 1993 would not have agreed with some of the things you were saying there because it basically said the Complaints Unit was mismanaged and there was quite a lot of criticism of management rather than the difficulties you were talking about. I want you to comment on that, and perhaps tell the Committee what changes have been undertaken which would address some of those issues that were highlighted. The other thing, the statistics on page 13 do not really tell us a story. It talks about the number of complaints being received and finalised year by year, but it does not tell us if there is an accumulation of complaints over the years. It would be useful for the Committee to know how many outstanding complaints there are and what sort of spread over what years. It gives us a truer story of what the delays are.

Ms WALTON: I can give you the break down over years.

Dr MACDONALD: Why is that not in the report, or is it in the annual report?

Ms WALTON: It is not in the annual report in terms of a break down by year. We do have the capacity to do that. There were 1,055 complaints open in 1995, of which 1 per cent was for 1991, 5 per cent for 1992, in 1993 it was 15 per cent, 1994 33 per cent, 46 per cent for 1995. That is now, not at the end of the reporting year.

CHAIRMAN: Would you like to make that document available to the Committee?

Ms WALTON: Yes.

Dr MACDONALD: How does that stack up with the fact that you indicate in 1994-95, 1,787 complaints were received and 1,676 finalised and yet 46 per cent of the outstanding complaints - I see, 46 per cent represents the 111, is that right?

Ms WALTON: No, I do not understand.

Dr MACDONALD: The total number of outstanding complaints is 1,055 of which you say 46 per cent, that is somewhere around 500, are from 1995, yet your figures on page 13 indicate 111 are outstanding complaints for the 1994-95.

Ms WALTON: There is a carry over of years. The 1,055 complaints would comprise every complaint made before 1995 as well.

Dr MACDONALD: I understand that, but you said to the Committee that 46 per cent are from 1995.

Ms FURNESS: Could I suggest the figures we have just provided to you

are on the basis of the calendar year of 1995, whereas the figures in the annual report are on the annual reporting year 1994-95. So the figures will not be the same.

Dr MACDONALD: Perhaps you could get back to my original question regarding the Ombudsman's report and the assertions of mismanagement.

Ms WALTON: You would be aware that there was disagreement of the findings of the Ombudsman's report at the time. The Ombudsman has written subsequently before the Unit became the commission saying they were satisfied that the commission had resolved it. We got KPMG consultants in during the Ombudsman's period and I think this Committee has that report which made a number of recommendations in terms of case loads, education and training, capping case loads, and all those recommendations were implemented.

The problems we had then were mainly put about because the complaints unit overran its budget because of disciplinary cases and not having a separate budget and eight staff had to be retrenched. Case loads went up to 180 files and now case loads are 40. It is clearly a difference in terms of management of cases when cases are capped at 50 and indeed they are 40 as to 150. We also did not have legislation determining what the commission could take on or not. That is clearly articulated in the legislation: what the commission must do. There is a better response from the system now of them handling complaints and not relying on the Complaints Unit to do it.

Dr MACDONALD: I accept that. It is not so clear in the annual report as to how you specifically address the Ombudsman's report.

Ms WALTON: It was addressed in the previous annual report.

Dr MACDONALD: I want to go back to these figures. Page 13 suggests that in the years 1993-94 there was in fact an excess of complaints finalised over those received, and in 1995 slightly less were finalised than received. So, over those years, clearly there has been a high level of handling and yet you provided figures to the Committee that 1,055 complaints are outstanding, of which 82 per cent relate to the years 1994 and 1995. Perhaps you need to take that on notice, but I have a concern that the figures are not stacking up, that is all.

Ms WALTON: The figures I gave you are the calendar year. I can get back to the Committee and convert them to the reporting year of the annual report or, indeed, any other figures you might like.

The Hon. PATRICIA STAUNTON: Page 12 of the report talks of the 1,676 complaints finalised. The commission declined to investigate 224, some 13 per cent. Investigated but could not substantiate a further 357, 21 per cent, referred another 36 per cent or 607 to other bodies, including registration boards, terminated 154, that is 9 per cent, and only ended up investigating and substantiating 16 per cent, some 268.

On a prima facie reading of that paragraph the question that goes through my mind is why is it that you are left with some 16 per cent that you only investigate and

substantiate, and I appreciate you will have some comment to make, but an enormous number of the complaints that are coming to you seem to be either declined to investigate or shuffled off to some other group. Can you explain why it is that you are left with simply 16 per cent?

Ms WALTON: It is not, it is actually investigate but could not substantiate, another 21 per cent. So that is included. We investigated that, so that is 21 plus 16, that is 37 per cent were investigated and the rest were referred to other bodies as the Act allows us to do and, indeed, we are taking on less than 37 per cent at the moment. As I explained to the Committee at the beginning, last month we only took on 12 per cent of the complaints.

The Hon. PATRICIA STAUNTON: Who makes the decision once you receive a complaint to carry on investigating it?

Ms WALTON: It is a consultative process. There is an assessment committee in the commission comprising the Deputy Commissioner, Commissioner and head of operations. We must consult with the appropriate registration board prior to finalising the assessment decision and once the assessment decision is made, whoever takes the more serious view about it, is the view that prevails. For example, if the commission wants to investigate and the medical board want to conciliate, it will be investigated. If the nurses board or medical board want it investigated and we do not, it must be investigated.

The Hon. PATRICIA STAUNTON: Is it possible for the commission to take unto itself the power to investigate complaints because of a view it might have about a practitioner?

Ms WALTON: If, whatever body, a registration board or the commission thinks a matter should be investigated, it shall be investigated, whoever takes the more serious view. Investigation is a serious view of a complaint as opposed to decline or refer elsewhere or conciliate.

The Hon. PATRICIA STAUNTON: The reason I asked that question about the number of complaints and those that seemed to end up elsewhere is that, on one hand, there seems to be a perception if you were to read those figures, even the ones you investigate and do not substantiate, perhaps a lot of complaints are coming to you that should not be coming to you, but also the other side of that is that there seems to be, at least on one glance, a decision sometimes taken by the commission to pursue complaints that are unwarranted.

Obviously, having made that statement it is up to me to at least put one matter before you and I refer, of course, to the McBride case and that is the whole question of complaints. You would be aware very much so of the decision that was seemingly a decision taken by the commission of its own motion to prosecute Dr McBride for some additional 44 cases of professional misconduct which extended over a considerable period of time and used enormous resources of the commission and, indeed, led to the President of the Court of Appeal Mr Justice Kirby saying only some month or

two ago when you lost your appeal in relation to costs of more than $1 million, that one might expect in such an extensive audit that some charges at least might not be made out, but to succeed in only one particular of one case of so many complaints and then a minor one presented against Dr McBride necessarily raises a serious question concerning the judgment of those who brought the complaints.

It is my understanding that those complaints brought against Dr McBride, quite apart from the scientific fraud case which was one raised independently, was a decision made by the commission ultimately, whether it was or was not made on advice, which caused not only enormous delays throughout the system of complaint handling but cost an enormous amount of money. I would be interested in your comments about the way in which complaints are decided to be processed, are in fact followed through, and clearly, of course, this particular matter of the McBride one must raise some concerns about the decisions taken within the commission about the prosecution of complaints. One can hardly dismiss the words of the President of the Court of Appeal.

Ms WALTON: I have two responses. The joint Committee under section 65 (2) is not able to discuss particular cases, but I am prepared to answer this. It was not the commission who independently took the decision. It was the Complaints Unit and it did it consulting the Director-General of Health and the medical board. The comments made in that judgment are in relation to costs, Dr McBride was struck off. There was an investigation. It was done appropriately. There was Queen's Counsel's advice. There was no delay caused in the investigation of the case. The delay was in the court proceedings which took two and half to three years. There was no delay in the Complaints Unit. That case particularly raised many significant issues of how to present clinical information in an adversarial context.

The whole problem in medicine is when you have clinical data, epidemiological data analysed in an adversarial situation with lawyers does not get the outcome intended. If anything, we learned a lot from that case in terms of what it said to us is that it is very difficult to win clinical cases in an adversarial context.

The Hon. PATRICIA STAUNTON: You mentioned that was a decision taken by the Complaints Unit but you were in charge of the Complaints Unit at that time.

Ms WALTON: But it was not the commission.

The Hon. PATRICIA STAUNTON: You are in fact the child of the Complaints Unit and you were its successor.

Ms WALTON: It is not the commission, that is all I am saying.

The Hon. PATRICIA STAUNTON: You were certainly in the same position that you are in now, albeit in a different type of role. You mentioned certainly in a newspaper report in defence of the decision of the McBride case, "We sought Queen's Counsel advice prior to lodging the complaints and continually during the case, and with no power to withdraw a complaint or advice that we should not continue". Are you saying that you would like power to withdraw complaints?

Ms WALTON: It has come up recently that, for example, during professional standards committee hearings there has been evidence that provides additional information which changes the whole picture. There is no power to withdraw a complaint under the Medical Practice Act.

The Hon. ELISABETH KIRKBY: If I understand it rightly, Dr McBride was struck off because of scientific fraud. He was not struck off because of his clinical practice. When you were coming to the decision to pursue the case through the courts, did you consult at all with the complainants about how they might be treated by the defence lawyers and were you aware of the humiliation that those complainants might suffer in the witness box?

Ms WALTON: Legal processes for complainants or witnesses in the medical tribunal are always very difficult and we have been conscious of that. The complaints in the obstetrics case came from a medical practitioner who worked with babies. He was a neonatologist. It was a complaint from the system itself in terms of caesarean rates. I feel uncomfortable talking about individual cases, especially when this one was so long ago and I have not got the file.

The Hon. PATRICIA STAUNTON: It is in the annual report.

Ms WALTON: The cost is in the annual report, not the case.

Dr MACDONALD: How did it affect the budget of the Health Care Complaints Commission, and I guess it is getting back to the question of investigation of complaints? What was the impact of that allocation of resources in terms of delaying investigation of other complaints?

Ms WALTON: There was no delay in investigating other complaints. Adverse costs do not come out of the commission's budget. Years ago I negotiated with the Department of Health that they would appropriately pay adverse costs if the commission lost a case. Clearly, you cannot be guided by whether you lodge a disciplinary case that if you lose it you will have no money. That has been accepted. At the moment we are under current negotiations with the Minister about removing it from the Department of Health and looking at some other mechanism to dedicate money in the advent of an adverse cost order.

The Hon. PATRICIA STAUNTON: How much was the adverse cost outcome?

Ms WALTON: It is not sorted out. It will take another 18 months in terms of taxing bills. I think around $600,000. I have no idea. I do not know, really.

Dr MACDONALD: Could I follow up on the question. How do you prioritise the matters as they come through? How do you prioritise which matters you will handle first? What sort of gatekeeper arrangement have you got and is there any room for improvement? Could there be some sort of independent body that would help you to sift through those complaints or are you happy that that process is being properly handled?

Ms WALTON: There are two bodies involved in that process, the boards and the commission. Given the fact now that we only receive - I mean we are down to bare bones. Those accepted for investigation, all those matters are identified as priority because that is the bare bones of the system. The legal section automatically takes on assault, sexual misconduct, overprescribing, serious incorrect prescribing and they are dealt with. Every case now of an investigation would be a serious matter. If there is an illness complaint, AIDS or HIV, that has a different time frame in terms of solving the complaint speedily.

Ms FICARRA: Going back to the comments you made before about the different bureaucratic hold ups along the way, how does New South Wales compare with other States in terms of those processes and any improvements that you feel are necessary would be appropriate for you to make those suggestions to the Minister?

Ms WALTON: Other States do not investigate complaints like the commission does. In Victoria and Queensland, if there is a complaint against a medical practitioner or a nurse, they must refer to the boards and the boards self-regulate and do it all themselves. New South Wales is the only State in Australia where there is the investigation and prosecution of health practitioners who have been removed from the boards, so we do not have a comparison in that sense.

In terms of improvements to the investigative procedures, removing some of the consultation requirements, setting up the patient support service to have local resolution with an advocate for consumers would be assisting us in terms of having an alternative place for consumers to go to resolve their complaints. We are always mindful of resources of the commission, obviously, in terms of expectations of the community and the Government about how quickly to resolve complaints. For example, if everyone wanted complaints resolved in six months we would probably need to double our staff.

At the moment we are satisfied that we are reducing time frames and the commission is profiling different types of complaints. At the end of the process we will get an external evaluation of that process and it might look like for sexual misconduct complaints the time frame is six months and these are the steps you must do. For a pattern of practice prescribing complaints where you are looking at schedules of drugs over years, it might be 18 months and that is the time frame. Then cases are allocated according to what type of matter you have. So, one case officer might have 15 matters, another might have 30, depending on the value we are going to attach to the type of complaint. We are trialing that process at the moment and we will get it evaluated and that may well assist in terms of getting some structure into time frames where we are accountable for that.

Ms FICARRA: You are made mention in your introductory remarks about staffing submissions. Could you elaborate for me?

Ms WALTON: We have made two staffing submissions since becoming the commission. When the commission opened, no additional resources were given. The Complaints Unit budget became the budget of the commission. The first staffing submission was made on 13 June in relation to a number of sections and it was a submission for around $600,000 for 15 staff. That was not successful. We have

subsequently made a second submission in the new budget for an enhancement package to include the setting up of a patient support office which would include creating a separate office of patient support to be located out in the districts and areas as well as an extra telephone inquiry officer, a complainant liaison officer and a legal officer.

We have been funding those positions out of our own savings, and we can continue to fund them until the end of this financial period and then we will not be in a position to continue to do so. The Minister has supported the enhancement proposals that we have made. I have not got the results of that yet.

The Hon. ELISABETH KIRKBY: In reply to a previous question you said that New South Wales was the only State where the Health Care Complaints Commission had the power also to take action through the court, and Victoria and South Australia did not have.

Ms WALTON: And Queensland.

The Hon. ELISABETH KIRKBY: Would you believe that it would be of an advantage to people in New South Wales, particularly complainants who are put through very gruelling process in the court, if that power was removed from the commission?

Ms WALTON: No, to the contrary. Prior to 1987, consumers were responsible for lodging their own complaints to the medical board and engaging their own lawyers to process their complaint. It is not the responsibility of consumers to maintain standards, it is actually the profession's responsibility. There is a public perception - it is like police investigating police - that self-regulation does not work in the sense that the perception that those who assess, receive, investigate, prosecute and adjudicate on complaints can do it independently and fairly.

The model that is in New South Wales is a separate body investigates and prosecutes where the boards adjudicate on the matter along various models and consumers do not have to pay for this service and nor should they, in my view, and it is not as if consumers have to make a complaint and go through this process. Indeed, it is my opposite experience. Most consumers want disciplinary action rather than do not want it.

The complainant liaison officer was employed to assist people through the legal process when they go through it and the person in the commission attends all conferences with barristers, sits in on all the interviews with lawyers, goes to court, provides information about the process and stays with them afterwards and makes sure they are appropriately referred.

The Hon. ELISABETH KIRKBY: Surely it is the responsibility of the commission, particularly so far as women are concerned and particularly if it is a matter that relates to a very intimate part of a woman's life, that she is not put in a situation in the witness box when, after possibly having undergone a very distressing experience, she is further humiliated by defence lawyers.

Ms WALTON: I empathise with your comments, but when someone's occupation is at stake, there are rules of natural justice and fairness. We have prosecuted a doctor where we did not have a consumer, but in that case he admitted misconduct and we were not actually going to call that consumer because she was very ill, but we were calling medical evidence as to why we were going to call her, but to date we have always been required to bring witnesses. We can close courts and apply for in camera hearings, which we have done in the past.

The Hon. ELISABETH KIRKBY: That, I think, saves the person from personal publicity because the media could not be present, but it does not save them from the humiliating and emotional experience of being gruelled and ripped to pieces by a clever defence lawyer when they may not have any ability to cope with the type of cross-examination. They are innocent victims. It is not like a court of law where they have been charged with an offence and possibly might, until proved otherwise, be considered guilty.

Ms WALTON: Certainly the commission has no powers in that area.

CHAIRMAN: The Committee has had a request from the media to obtain photographs and film footage of your attendance at this hearing. Would either of you have any objection to a photographer taking shots for the next five minutes or so or the attendance of a film crew from 10.50 to 11 a.m.?

Ms WALTON: No.

The Hon. PATRICIA STAUNTON: Page 16 of the annual report deals with assessing complaints. It states that the commission assesses each complaint received and decides how best to deal with it and it can then decide to do a number of things, decline, refer, seek the consent of the parties and so on, or the commission can investigate the complaint. Do you have criteria by which you make those decisions as to which ones you pursue and investigate and which ones you decide you will not, so if a complainant comes to you they are well aware of those criteria on which you make those decisions?

Ms WALTON: We always assess every case on a case-by-case basis. The criteria we would use is previous complaints against the respondent would be an issue. When we get a complaint, we get information from our data banks about the respondent, whether there has been a previous complaint about the respondent, the type of complaint, whether it prima facie would result in disciplinary action if found proven. Sexual and physical assaults are always investigated and public health or safety is determined by the seriousness of the complaint. Section 23 of the Act actually describes those cases we must take on.

The Hon. PATRICIA STAUNTON: But obviously there is a discretion. You appear to have a wide-ranging discretion?

Ms FURNESS: In fact section 23 does not give us a discretion. It says we must investigate complaints that fall within certain categories. Certainly we have a discretion if it falls within those, but if it does not we must investigate. Similarly, under

25 of the Act we are required to refer to the Director-General certain complaints involving breaches of named legislation, so the Act actually is the main guide as to what matters are taken on. If you also refer to section 27 it sets out the circumstances in which we can decline to deal with the complaint.

The Hon. PATRICIA STAUNTON: But that section is not definitive.

Ms FURNESS: No, but in terms of guidance --

The Hon. PATRICIA STAUNTON: It only says the ones you shall and those that you may take on board.

Ms FURNESS: Certainly, but in terms of providing guidance to us and complainants, the Act provides that.

The Hon. PATRICIA STAUNTON: You do not provide anything to the complaints over and above what the Act says by way of any decision you make to investigate or reject a complaint?

Ms WALTON: Except advice that they can request a review. Given our case loads and the concern of delays of people, we are taking on those that we must investigate and we are reluctant to take on those we shall not, except for categories of complaints. For example, we are concerned at present about admission policy for people with a mental illness in casualty hospitals and we will take on those complaints.

The Hon. PATRICIA STAUNTON: In answer to a question from the Hon. Elisabeth Kirkby you said that New South Wales is the only State that actually separates out its investigatory activities in relation to the health professionals. Queensland, I think, was the example you cited. They actually do refer the complaint and you highlighted some of the concerns. You used the police as an example of concerns that have been raised where one investigates there own. I suppose the Law Society would be another one. I am not sure what the Law Society would think about criticism of that, but could I say that on page 15 where you talk about the role and function of the commission, in many respects the commission itself has the very function of both receiving the complaint, investigating the complaint and prosecuting it. Would that not be right?

Ms WALTON: Except we do not make findings and determinations or adjudications.

The Hon. PATRICIA STAUNTON: You actually leave that to a tribunal, but what I am saying is, and if you look at page 15, you receive a complaint, assess it, investigate it and prosecute it. You then report on action that is to be taken following the investigation of complaint and, of course, you publish and distribute information to the community.

Now, do you not see even on that scenario of receiving, dealing, assessing, prosecuting and then following up, that you might sometimes be seen to have a genuine conflict or inability particularly to a respondent that you are not unbiased in your capacity

both to receive the complaint, to assess it, to investigate it and then to prosecute it? Do you not see that that could be seen in the minds of some respondents that you are not being impartial?

Ms WALTON: To respondents?

The Hon. PATRICIA STAUNTON: Yes, to the people who are complained about, rather than to the complainants?

Ms WALTON: In the sense of investigation and prosecution, there has been discussion about the appropriateness of an investigator prosecuting. Up until 1987 that was the case in New South Wales where the medical board or whoever investigated it referred it to the Crown Solicitor to prosecute and, indeed, the Complaints Unit did as well and there was a lot of criticisms about that in terms of the quality of the representation in a specialised area. We did not prosecute.

The people who investigate do not do the prosecution. We brief barristers.

The Hon. PATRICIA STAUNTON: Not all the time.

Ms WALTON: But in terms of professional standards committees, lawyers are not allowed in those processes and the investigation officer does it. It is a model. There is argument for separating prosecuting from investigating. There has been no evidence in this State that that is necessary and I have never heard it called for before.

The Hon. PATRICIA STAUNTON: You mentioned earlier about the rules of natural justice. I think you and I have had discussions about the rules of natural justice in the past. One of them is that a person should not be judged of their own course and each side has the right to be heard and so on. Do you not agree that, by having the power both to receive, to assess, investigate and prosecute, there sometimes could be this breach of natural justice in your zealous following through of certain complaints?

Ms WALTON: I do not think we are zealous in our investigation of complaints.

The Hon. PATRICIA STAUNTON: I hope you are.

Ms WALTON: Not in the sense I think you used it. We are vigorous and we are fair and we are rigorous, but I do not think we could be seen to have an agenda. I do not think that that is the case here in New South Wales. I have not had complaints voiced to me by respondents that the problem in the commission is that we receive, assess, investigate and prosecute.

The Hon. PATRICIA STAUNTON: You agree it could happen?

Ms WALTON: I know of legal argument of separating, prosecuting and investigating.

Dr MACDONALD: I return to the issue of McBride. I do not think it is beyond the scope of this Committee to discuss the issue, and I have checked on Section 65 of the Act. I know you are nervous about going into real details but I think you can talk about it. The New South Wales royal commission in to Chelmsford talked about how there was an allegation that the establishment of the Complaints Unit was in fact rather than being a response to Chelmsford and the abuses that occurred there, was in fact driven by the politicians of the day to look in to allegations of fraud and overservicing. That was a statement in the royal commission. It seemed to me that it could be argued in the case of McBride that it was driven by overservicing and possible fraud rather than medical standards and complaints. Would you like to convince me that that is not the case?

Ms WALTON: It is not the case. The two complaints the Complaints Unit received were scientific fraud, which was a complaint made and that has been shown to be proved. The other complaint was a clinical complaint that came from a doctor, a neonatologist who voiced concerns about the outcomes of some pregnancies and caesarean rates. It was a pure clinical case that led to that investigation. We engaged external reviewers and, in fact, in an attempt to be fair during the investigative process we got four or five external reviewers not from New South Wales, ranging from Western Australia and Victoria. Our reviewers are eminent gynaecologists and obstetricians who gave advice in the investigative stage of the level and standard of care and the decision that came to whether a caesarean should have been done in those clinical circumstances.

That information was given to a QC who advised the appropriateness of drafting complaints. There was no hesitation in that from the medical board or the Director-General of Health in the consultations. The issue became very evident in an adversarial situation where we had statistical rates as the basis of the complaint, epidemiological data, which each of those statistics became like a separate tribunal case. That is where the case got into real difficulty. We learned from that in terms of the appropriateness of adversarial situations, looking at clinical patterns of practice complaints.

Ms HALL: My question goes back to the complaint handling mechanism, and I hope no one has asked this question while I was out of the room. One of my mine concerns is the backlog and how long it takes to get through the complaints. I am wondering whether you have looked at stricter screening of complaints and perhaps setting different criteria for accepting complaints or more criterion so that at least you have a stronger framework and that way you can get through more complaints.

Ms FURNESS: Prior to your arriving, we discussed at some length the numbers of cases that we are currently investigating that were received in previous years. The figures for complaints received up until 18 December, we had 1 per cent, or less than 1 per cent of complaints from 1991, 5 per cent from 1992, 15 per cent from 1993, 33 per cent from 1994 and the remainder at 46 per cent from 1995. The commission is very conscious to make decisions about its investigations at an early a stage as possible so to reduce stress on providers and complainants. Certainly, in the assessment stage we take into account whether or not the matter is likely to lead to disciplinary action or, indeed, policy change, and if it is not likely to lead to that we would certainly assess it as appropriate for referral to another agency, conciliation or some other method of resolution other than investigation.

Ms WALTON: Of the 1 per cent in 1991, that concerns five disciplinary matters. The reasons for the delay in resolving these matters arising from 1991 involved other police involvement and investigation, witnesses disappearing and not leaving contact numbers, and having to locate them and delay in receiving peer reports. In relation to 1992 complaints, 5 per cent of those complaints remain outstanding out of a total of 1,762 complaints for that year, and of these 69 complaints over 60 per cent are disciplinary, so they are not matters that can be closed. The reasons for delay include non-responsiveness of practitioner, coronial inquiries current, and we are awaiting outcomes, multiple experts involved, pattern of practice complaints where the first complaint we received, say, in 1992 but we continue to receive complaints in 1993, 1994 and 1995, and we are looking at them as a totality and we are reluctant to close the old 1990 file because it relates to the same type of matter and difficulties in obtaining information from hospitals and other health organisations, for example identifying respondents, whether in terms of registrars, misplaced medical records, non-responsiveness in relation to the questions we asked. There are reasons for those 5 per cent that are unresolved.

Ms HALL: It is a major concern that it has taken 379 days as an average.

Ms FURNESS: In fact we provided additional information to the Committee this morning about the amount of time taken. As at 1995 the average time to finalise complaints other than serious matters is 69 days. The average time for investigation of serious complaints in 1995 has reduced to only 136 days.

The Hon. ELISABETH KIRKBY: You mentioned a few moments ago that one of the reasons for delays were the delays in coronial inquiries. Would you believe that it would be valuable if there were some updating of the Coroner's Act so that there would not be these lengthy delays before a final decision is made by the Coroner? Obviously, this is very distressing for complainants particularly when they have laid the complaint in 1991 and the coronial finding does not come down until 1994.

Ms WALTON: Everyone obviously should try to do things as quickly as possible. I do not have enough details about the Coroner Act to comment on how they could speed up that process, except to say there is a part of the Health Care Complaints Act which has not yet been proclaimed and that relates to the capacity of the Coroner to refer to the commission misconduct cases. He can refer at the end of an inquiry any matter that should be referred to the commission or the health department, but there is another provision there which I think relates to any misconduct and that has not yet been proclaimed.

The Hon. ELISABETH KIRKBY: Have you any idea why that has not been proclaimed?

Ms WALTON: No, I would not be able to officially say that.

CHAIRMAN: I want to ask a question relating to page 26 of the report. Under policy outcomes, one possible outcome of an investigation is that the commission will recommend to a relevant authority that new policies procedures or guidelines be introduced or modified. You then go on to say that the commission is kept informed of

and monitors progress towards the implementation of your recommendations. Can you tell us what are the rates of implementation, how do you go about monitoring these things, and what options do you have if the relevant health authority does not carry out the recommendations you make?

Ms WALTON: To this month, 1995, we have made a total of 42 policy recommendations. We are awaiting a substantive response to seven of these. We have had 31 recommendations accepted in full and four have been accepted in part and are acceptable to the commission in terms of what steps they have taken. The method by which we monitor this is the policy section is responsible for monitoring recommendations made. When the investigative file is complete, a new file is opened in the policy section. We write to the Director-General or the college, whoever is the person responsible, we have a re-submit system in terms of follow up, and our computer data base records the details of the complaint and the policy issues that it makes.

In the event of an organisation not following a recommendation, the commission can make recommendations or comments concerning health organisations to the Director-General under section 42(2). In this report we must include the reason for its conclusions and the reasons for any action recommended to be taken. Section 44 of the Act allows the commission to request the Director-General of Health to notify it of any action taken or proposed to be taken as a consequence of report under section 42(2).

If we are not satisfied that sufficient steps are being taken within a reasonable time as a consequence of the report, after consultation with the Director-General, we can make a report to the Minister under section 44(2). If the commission is not satisfied that sufficient steps have been taken within a reasonable time after consulting with the Minister and reporting to the Minister, the commission can make a special report to the Presiding Officer of each House of Parliament under section 44(4). Clearly, to date all of them have been accepted in full or in part.

CHAIRMAN: You have not made any special report to Parliament?

Ms WALTON: No, that has not been necessary.

Dr MACDONALD: I notice you have got the New South Wales AMA off side, which probably is not a bad thing, regarding your comments or recommendations regarding competency tests. Where in the power of the Health Care Complaints Act or where does it give you the power to make that sort of recommendation? It seems to me there may be something in what the AMA was saying if one has regard for section 92 of the Act, which basically says nothing in this Act gives the commission power to determine or recommend general standards of clinical practice.

Perhaps that is what Dr Eggleton is making reference to. Is it within your power?

Ms WALTON: I think it is in the commission's role to raise the issue for public debate. One of the objects of the commission is to improve health standards. There is a substantive body of complaints where substandard practice is evident, where we have

examined those doctors who have appeared before disciplinary tribunals, we have found they are in isolated practice, they do not engage in continuing practice, they are out of touch with current procedures and medications, there is no requirement on registration annually that a person has to prove competence and it was my view that this should be discussed publicly and since then the medical board has agreed, the Australian Medical Council agrees it is an issue and two of the colleges came out publicly in the press and said they agreed. I do not think it is the commission's role to do it but I think it is the commission's role to raise the issue.

CHAIRMAN: I refer to some of the issues of concern that you raised in the annual report and also in the press release that you issued at the time of the tabling of the annual report. In part the press release states,"Ms Walton was particularly concerned about deregistered health practitioners working as therapists, especially when they have been found guilty of sexual professional misconduct". Given the previous question and comments on that, what can be done about that process? Is it something where the commission can only raise the issue, is it up to the other boards or some one else to do something about it?

Ms WALTON: Given that there is no responsible board in existence any more because all of these people have been struck off from the psychologists, medical and nurses boards, and given that if the public interest demanded their removal in terms of potential harm to clients, that does not automatically go just because they are not registered anywhere. So the commission, because we are also responsible under the Act for alternative health practitioners, even though they are not registered, we see we have a clear responsibility to advise the government of the day whether there might be the necessity for legislation or not.

What we are doing at the moment is, because sexual misconduct is continuing to be a not insignificant body of complaint, there are more and more struck off people practising as therapists or counsellors, in 10 years you may well have quite a significant body of people out there. We are going to issue a discussion document by the end of the year or certainly over the next month for public comment. As a result we will prepare a report for the Minister and that might be an appropriate one for Parliament, I am not sure. That certainly need to be progressed and examined in more detail.

The Hon. PATRICIA STAUNTON: In the forward to your report you make mention on at least three occasions to this whole process of consultation. You talk about the Health Care Complaints Act, ensure that the appropriate professional registration boards are consulted at various stages throughout the investigation. Further down the page you talk about networking with the community and health professions. You also talk about, on the opposing page, consumers having increasing expectations of what the medical profession can achieve. At the back of the report you mention the number of organisations that you addressed at various periods throughout the year. Quite apart from those formal addressing, what processes do you have in place not just for consumers but for those who actually work within the health care system for the purposes of consultation with them?

Ms WALTON: Our consultation process with the professions is mainly

through the registration boards, the professional groups and our peers in terms of we have conducted twilight seminars for our peer reviewers in terms of their views of the commission's investigations and how they prepare their reports, what are the problems with the questions asked by the commission. So we consult with peers on our panel. We have an expert reviewer panel.

The Hon. PATRICIA STAUNTON: That was one of my questions. How do you go about drawing up your expert peer review Committee?

Ms WALTON: We write to the colleges with word of mouth because years ago it was very difficult for the Complaints Unit to get people to be willing to participate and assist the Complaints Unit. We grew from word of mouth of who is good. The expert review committee consults with the appropriate professional bodies to get people. We consult with the boards in terms of appropriate people. If it is a very specialised area, we will ourselves approach people to go on the register. We vet reports when they come in as to their fairness and objectivity. People are removed from the expert panel. It is a fairly dynamic panel. We train them, provide guidelines for our reviewers and apart from putting ads in papers which we have not done, we go to the professional bodies.

Ms ANDREWS: On page 26 you have responsibility to promote the commission's work in the public interest and inform the community about their rights in the complaints process. In view of the large number of cases that are outstanding or the large number of cases that come to you that should not be investigated by the commission, as part of that promotion would it be possible to inform the public of what cases should come before the commission and what cases should be referred to, say, the local area health service? As a newcomer into the political arena I would be great benefit greatly from guidelines as to what cases the commission will and will not investigate.

Ms WALTON: The commission has prepared guidelines for parliamentarians on appropriateness of referring locally or to the commission and we distributed that a couple of months ago to members. Our brochures do say that a complaint is best resolved locally if at all possible or appropriate. In relation to the health system, we are preparing guidelines in conjunction with the Department of Health as to the appropriateness of the areas and hospitals in referring to the commission and what matters we will refer back to them to get agreed protocols on those types of complaints.

At the moment we have agreed protocols with the public health unit, pharmaceutical services benefit and private health branch. In relation to consumers, it is very confusing for consumers of where to go. I do not have a problem with them coming to the commission in the first place to get the appropriate advice for resolving it, being mindful that we probably only see 10 per cent of them anyway and most complaints probably do go to the hospitals and district. What we are concerned about is we do not know the complaint landscape in this State.

The Minister has agreed that every area health service and district is to report to the commission on a quarterly basis all the complaints they receive, types of matters they receive, how they dealt with it and the outcomes and for the first time ever when that occurs we will have a statewide complaint profile and we will be able to identify

problem areas and look at trends, but we have never had that capacity in the past.

CHAIRMAN: That is in the Act in Victoria is it not, the area health services need to report to the commission?

Ms WALTON: Yes.

Ms HALL: This will give you a better idea to see whether or not the local area health services are handling the complaints or just passing it on and not fulfilling their responsibilities?

Ms WALTON: We probably will not know the quality of it but you can tell that from outcomes. If they are dismissing 90 per cent of the complaints that will say something.

Ms HALL: Is it possible at this stage to pick up whether things are being handled appropriately at the local level, and if so, could you give us some feedback on that?

Ms WALTON: Yes. We evaluated all those complaints since we became the commission, that we referred to the area health services and we have done a report on that evaluation. I do not have the exact figures, but the evidence is that it was pleasing to see that with a lot of the complaints there was face-to-face interviews, investigations and substantiation and changes made. That gave us some confidence. Being mindful that we are now only going to take on up to 15 per cent of all complaints, we have to be sure that the rest of the system deals with them appropriately, and one of the safety nets, I suppose, is we always tell complainants they can come back to us if they are unhappy with how their complaint was dealt with locally by whoever.

Ms HALL: Is it possible to get a copy of that report?

Ms WALTON: Yes.

The Hon. PATRICIA STAUNTON: I wanted to make a comment and then I would be interested in your views. You mentioned that throughout the history of the Complaints Unit which is now the commission there has been a degree of, I suppose, difficulty in getting co-operation, not only from the health professional groups, particularly the medical boards and on occasions nurses, because an adversarial climate sometimes develops when complaints are made. I wonder whether part of the reason for that, certainly it is a perception that I have, instead of looking at what we are trying to do here in this notion of the health care system is looking at people's rights rather than looking at it as complaints.

I have a view that we would go a lot further towards a more conciliatory process within the health care system if we got rid of this nature of complaint and in fact talked about people's rights, not only the rights of the consumers but, as you know, the rights of the people who work in the system. Rightly or wrongly, I have a view that part of the reason some of the problems come to your attention is not just because of

substandard clinical practice but because of things like lack of staff, lack of educational support, people in remote and isolated circumstances who, for better or for worse do the best they can in difficult situations and so on. Rather than talk about complaints and invoke a climate of adversarial confrontation, would it not be that if in any future review of the Act we talk about people's rights and health care rights rather than complaints and try to foster a climate more attuned to that than an adversarial complaint based mechanism?

Ms WALTON: I agree. I think patients have rights and I do not have a problem with examining that. The only conflict I see is that as a prosecutor, because the commission has a function of being the prosecutor for the registration boards, it actually is part of the regulatory system.

The Hon. PATRICIA STAUNTON: That brings me to my earlier point about prosecution.

Ms WALTON: If you separate out the regulatory systems from a patient's rights advocate area, the commission cannot be an advocate for patients or respondents. It is part of the regulatory function. I personally do not have a problem with the word, rights, because I think that is the language of the consumer movement. When there was discussion about the commission having the name 'complaints' in the title, consumers wanted to keep the word complaints in it because it tells people what it does. It actually looks at complaints. But in reviewing the Act I certainly do not have a problem with the word "rights" being incorporated in to the legislation or looking at it in those terms, except to say that we are a regulatory body and there may well be some conflict with that.

I have never had to my knowledge difficulties with the nurses board or the medical board. The political problem was with the AMA and I think that is a natural tension as a regulator. I do not think that will ever go away because we are the people who prosecute them. You would not be friends with them.

The Hon. PATRICIA STAUNTON: Let me put it this way, from previous experience it is not a question of being friends, it is a question of neither the AMA nor the Nurses Association or any other health professional organisation or board, you would agree, is in the business of condoning unsafe practice, so therefore if we are going to talk about health care rights, we have rights on both sides of the equation.

Ms WALTON: I agree with that. I think we cannot look at what happens out of any historic context. There is major social change going on in health in terms of power relationships, doctor patient relationships and so forth. Today, I have to say, I have met with the MDUs and I invited the Nurses Association to the first meeting we had in trying to get a more co-operative attitude, so it may be that historically we are now at a place of having weathered the storms to get to some agreement of what we are all on about, which is good health standards.

Mr NEILLY: In relation to arrears of complaints, I think it would be advantageous to incorporate in the report an age analysis, where there is a capacity for the public to identify where things may be going wrong. Two other matters relate to page 54 of the report, one being associated with consumer satisfaction surveys and specifically the

comment that both these aspects of the process are bound by legislation that requires certain procedures and notification to take place. You made mention of what the commission may do in the future but you believe there is a flaw in the legislation?

Ms WALTON: I do not think complainants should be required to do statutory declarations at the beginning.

Mr NEILLY: Only when there is identification of a serious matter which ought to be substantiated?

Ms WALTON: A consumers's letter should be accepted as a basis to proceed to investigate or assess.

Mr NEILLY: The other one is under the section headed Consumer Advisory Committee. Basically it says what it is but it does not say whether they are happy, sad or otherwise. It is fairly negative to state only that they exist. I do not know to whom they report.

Ms WALTON: It is an advisory board. It is not in the legislation, but we have continued to use them because I think they are a valuable group. They meet quarterly. They advise the commission in terms of they are a group of consumers in health. They advise on the review of the Act. They will be heavily involved in that. They advise on policy matters. We can expand on that. They are appearing before this Committee next.

Mr NEILLY: I understand that, but if they are going to be incorporated in the annual report, you make some comment about consumer survey about happiness or unhappiness but no comment under Consumer Advisory Committee.

Ms WALTON: They are an advisory board but we can put in more details in the next annual report.

Mr ANDERSON: What is your difficulty with people putting in a statutory declaration?

Ms WALTON: I think some people find it legally intimidating. Once we write back to people saying could you convert it a statutory declaration they drop out because they are fearful of the process. The investigation will disclose the treatment. If there is going to be disciplinary action I think we require a statutory declaration down the track, but immediately we get a complaint and ask for it to be put in to a statutory declaration, get a JP, I am concerned there would be people who would drop out.

Mr ANDERSON: Surely it is a serious thing to make a complaint, so some justification, some qualification needs to be incorporated, even at the very outset, to make people think that what they are doing is a very serious matter and the complaint that they are lodging before you and everything else puts resources into investigating them, people must appreciate that what they are doing is a serious thing.

Ms WALTON: I think most people do appreciate it. It is the delays that are causing it.

(The witnesses withdrew)

IRENE ELSE HANCOCK, Chair, Consumer Advisory Committee to the Health Care Complaints Commission, of [redacted], sworn and examined:

CHAIRMAN: Did you receive a summons issued under my hand to attend before this Committee?

Ms HANCOCK: I did.

CHAIRMAN: The Health Care Complaints Act requires the joint parliamentary committee to examine each annual and other report made by the commission and presented to Parliament under this or any other Act and to report to both Houses of Parliament on any matter appearing in or arising out of any such report. The first annual report of the Health Care Complaints Commission was tabled in Parliament on 14 November. Today's hearing is part of the Committee's process of examination of that first annual report, and as part of that process the Committee has determined to hear from other parties involved in the commission so that we might assess how the commission is carrying out its functions under the Act. Do you wish to make an opening statement?

Ms HANCOCK: Yes, thank you, Mr Chairman. I would like to start by thanking you for inviting me to speak to the Committee and I would like to commence with a compliment to the Commissioner, Merrilyn Walton and her staff on an excellent first year of operation of the commission. Our committee has acted in an advisory capacity during the first year. We have met quarterly and participated on interview panels for the appointment of staff.

The independent Complaints Review Committee has been established during 1995. This Committee is chaired by a member of the Consumer Advisory Committee. The first annual report of the commission is comprehensive and well presented. The legislation covering the Health Care Complaints Commission, the Health Care Complaints Act 1993 is due for review at the end of 1996. There are a number of areas that the Consumer Advisory Committee would like to see addressed in this review and I would only highlight about three main ones, but there are other things that will probably need to be looked at the end of 1996.

The independent Complaints Review Committee be incorporated in the legislation. The setting up of this independent review committee is another way of ensuring that complaints are dealt with totally in an independent way and that people do have a chance of redress. It is the current Commissioner's position to set this up and she did that this year. However, it plays such an important role that we on Committee consider that it is actually incorporated in the legislation, so it is something we would very much like to look at at the end of 1996.

Another thing that we have noted at our meetings and with the reports from the Commissioner is that the current method of investigating complaints contains a very laborious and possibly unnecessary requirement to consult quite so frequently with the professions throughout the investigation of a complaint. The requirement to consult is probably something that we consider needs to be looked at and perhaps twice at the

beginning and end of the investigation may be quite sufficient.

We are aware that when the Act was first set up, of course, we were very conscious that this is the first of its type in Australia and possibly the world, and so therefore a lot of very cautious things were put in place. Also, when a consumer makes a complaint, by the time they have got to that stage it is a very fairly onerous thing to do. We consider that in itself the complaint should be sufficient. To have to come back and write out a statutory declaration can be often quite intimidating to someone. It has often taken them a lot to get to the stage where they actually complain in the first place.

The other thing I am sure the Committee would be pleased to note is the gradual turn around by the medical profession in the acceptance of the role of the complaints commission. I only heard a little bit of what was said earlier, despite that, I believe the bridges have been mended quite considerably and I am sure that is due to the work of the Commissioner and her staff and members of the medical and other health professions.

Another matter I wish to draw to the Committee's attention is the proposed New South Wales health consumer network initiated and developed by members of the Consumer Advisory Committee. By virtue of our representative nature, our committee was the unofficial adviser to the Minister for health and the Department of Health on policy matters, documents et cetera. As at 1 July, 1995, the Health Care Complaints Commission severed all ties with the Department of Health, thus resulting in the loss of any formal or informal communication with the Consumer Advisory Committee. Therefore, currently the Minister or the department have no formal channels of communication with consumers. The New South Wales health consumer network proposal is currently before the Minister and the Department of Health and we are awaiting their reply.

CHAIRMAN: Thank you.

Dr MACDONALD: I would like to ask Ms Hancock more about the independent Complaints Review Committee. I am trying to work out where that fits into the Act.

Ms HANCOCK: It is not in the act.

Dr MACDONALD: So, this is basically another level of appeal?

Ms HANCOCK: Yes.

Dr MACDONALD: If you are unhappy with a decision that is taken under section 39, for instance, you would have this body review --

Ms HANCOCK: What happens, if complainants are not happy with the outcome, they can go back to the commission. The commission will undertake, under the current system, to reinvestigate. If, at the end of that outcome they are still not happy with the result, it then goes to the Independent Review Committee. The Independent Review

Committee is chaired by someone from the Consumer Advisory Committee. There is a member of the medical or nursing board, whichever it is, and a member of the commission, so those three people then review it.

Dr MACDONALD: They essentially have the file, reopen it, examine it and make a recommendation as to whether it should be discontinued or whether they uphold the outcome?

Ms HANCOCK: Yes. The full workings of it you would probably need to go back to the commission of how it actually functions because it was only set up this year and the member from the Consumer Advisory Committee, Jeanette Moss chairs it and I think they have reviewed some half dozen cases this year.

Dr MACDONALD: Does this suggest you have a lack of confidence in the Health Care Complaints Commission?

Ms HANCOCK: No, I think it is another mechanism of ensuring that justice is really seen to be done, that people feel if they have another avenue and they are not happy with the outcome there is this independent review.

Dr MACDONALD: The Consumer Advisory Committee is of a view that it needs to have that additional role. Currently, if you did not have that particular opportunity for reviewing the outcome of a complaint, what other role do you have in terms of influencing the commission?

Ms HANCOCK: Well, just in our advisory role per se. This initiative did not come from the advisory committee. The initiative came from the Commissioner as another form of ensuring independent review.

Ms HALL: Would it be fair to say you are another peak body that has input in to what is happening in the commission?

Ms HANCOCK: Well, we actually are a group of people. There are 16 peak consumer groups represented on the Committee.

Ms ANDREWS: From the cases that come before you, do you then make an assessment of that and give feedback to the Minister or to the department?

Ms HANCOCK: Cases do not come before us as such.

Ms ANDREWS: But people who are not satisfied --

Ms HANCOCK: You are talking about the Independent Review Committee?

Ms ANDREWS: Yes. Do you make an assessment of the types of things that are coming before you and do you then give that feedback to the Minister?

Ms HANCOCK: No, it goes through the process that the commission has already reinvestigated it. If they are not happy, then it is forwarded by the Commissioner to the Independent Review Committee.

Ms ANDREWS: And where does it go from there, after you have looked at it?

Ms HANCOCK: I think that is probably the end of it. Naturally there are recommendations, whether that is reinvestigated or certain sections of it are that they consider the outcome has been adequate.

Ms FICARRA: According to the annual report, this Independent Complaints Review Committee actually did not review any decisions made by the commission in the proceeding year?

Ms HANCOCK: Not in that financial year. They have since then. I think about half a dozen cases.

Mr RIXON: You talked about these additional appeal channels. About how many cases are you talking about on the average each year?

Ms HANCOCK: Again, I do not know. We have not had a full year. It was only set up in the first half of this financial year, so the statistics we have is the half dozen or so. The reason we would like to see it in the legislation is the fact that it is something that the current Commissioner is committed to but if we have a change of commissioner, then if it is not in the legislation they might decide they do not want an independent review. We just consider that an independent review mechanism is an essential thing in a group like this.

Mr NEILLY: In relation to the role of the consumer committee, you made mention of the advisory capacity and also the review capacity of the committee. Is there any other role that the committee has and are they designated by the commission itself?

Ms HANCOCK: It is always a member of the Consumer Advisory Committee on the interviewing panels for the employment of staff at the commission. Other than that, that is about it. We advise the Commissioner and staff on things they bring to us. We meet quarterly. We get a report from the Commissioner at that quarterly meeting and any other issues that other members of the Consumer Advisory Committee may bring to the actual meeting. They may be things that we would comment on by virtue of our representative group.

Mr NEILLY: What would be typical of some of the matters you advise the committee on?

Ms HANCOCK: This year has been relatively quiet. Prior to that there was a large amount of activity, as you could imagine, prior to the Act, when the bill was going through and we envisage that 1996 is going to be a fairly busy year coming up to the review. We have prepared a comment paper on the natural death legislation. We do

a variety of things. It varies and the actual amount of material we do varies from time to time.

Mr NEILLY: Do you have any resources or access to resources?

Ms HANCOCK: We are resourced by the commission. The senior policy adviser is our executive officer and she works in that capacity. She takes the minutes and distributes any information to members.

Mr NEILLY: In your opening statement you made mention towards the end of the ties with the Department of Health being severed. Do you mean that in the sense of the independence of the commission itself?

Ms HANCOCK: The independence. Up until then they still looked after things like salaries and that sort of thing, so there was still a tenuous link between the department and the commission. Now there is none and as that has happened there are no formal links to the consumers. In the past, just about every document that went through the department, copies went out because they knew they had a pool of consumers who would comment and that is one of the reasons we put forward this proposal.

Mr NEILLY: If there were something that the Committee wanted to communicate to the Department of Health, that is still possible or is it possible via the commission?

Ms HANCOCK: No, we have to do that independently. It is not possible via the commission.

Mr NEILLY: Do you do that independently at all?

Ms HANCOCK: Yes, individual groups do, but not as a committee.

Mr NEILLY: The concluding comment that the proposed consumers network proposal that is currently before the Minister and the Department of Health and you are awaiting a response, was that presented by the various consumers per se or by the committee itself?

Ms HANCOCK: It was by a subcommittee of the Committee. Five of us acted on behalf of the large body of the committee, but the actual drawing up of the proposal was done by a member, distributed, commented on and refined to the actual document that is now before them.

Mr NEILLY: How long back was that?

Ms HANCOCK: We started in the time of the previous Government because we knew that this was going to happen, so we were setting it up then and we then followed it up with Minister Refshauge.

Mr NEILLY: How long back did you formally initiate that with the

Minister?

Ms HANCOCK: Within the first few weeks of his taking office.

Mr NEILLY: So you have been holding your breath for a long time.

Ms HANCOCK: We are persistent.

The Hon. PATRICIA STAUNTON: I was not sure at what point you came in to the discussion I was having with Ms Walton.

Ms HANCOCK: Probably about the last 15 minutes.

The Hon. PATRICIA STAUNTON: You would, I presume, have heard my comment where I asked Ms Walton to comment on the notion of health rights rather than complaints?

Ms HANCOCK: Yes.

The Hon. PATRICIA STAUNTON: You heard that?

Ms HANCOCK: Yes, I did.

The Hon. PATRICIA STAUNTON: I note that page 54 of the annual report it states that, the commission consults widely as part of its role in maintaining and improving the quality of health care services in New South Wales. To facilitate, I presume is meant to be the word, this process, the commission has established a Consumer Advisory Committee with a membership that includes peak organisations in the health and consumer areas. Further down it lists the organisations that are on the committee.

Ms HANCOCK: Yes.

The Hon. PATRICIA STAUNTON: Given the statement that it is there to include peak organisations in the health and consumer areas, would you see merit in having on that committee representation from the AMA, the Nurses Association and any other health organisation that would clearly be interested in the work? I say this quite sincerely, because if you accepted the notion and this is why I am seeking your comment on the notion of health rights rather than complaints.

Given that both the people who use the system and the people who work in it have an interest in rights and rights within the health care system, and given the need to try to conciliate which has already been said to us as much as possible that is the preferred way to try to solve these problems because at the back of a lot of problems that arises is the potential for litigation and the adversarial process, so would you not see that, instead of having a committee made up of groups who may use the system, the committee may well also comprise people who work within the system which may help facilitate this conciliation process of health rights rather than looking at it as an adversarial system of complaints?

Ms HANCOCK: I do not see any problems with individual health professionals being involved because I myself am a health professional. But to actually have bodies like that on a consumer advisory committee I think you would need to be looking at a totally different structure of the commission and of the advisory body.

The Hon. PATRICIA STAUNTON: I agree with you totally, which is why I was interested in your comments about health rights.

Ms HANCOCK: If you are looking at a rights commission as opposed to what we have now, yes, I could see that body working together. In the present climate, no, I cannot and that might lead me, if I may, to my second statement because that may highlight some of the things you are asking. I wish to raise an area of concern at this forum regarding the imbalance of power between the medical professions and --

The Hon. PATRICIA STAUNTON: I still have some questions to ask you. Is this the statement that is attached about the anaesthetists?

Ms HANCOCK: That is the one, yes.

The Hon. PATRICIA STAUNTON: I have had a look at that statement, but if you want to read it on to the record I am sure Mr Chairman will be happy to deal with that.

CHAIRMAN: I suggest we do not need to read it on to the report because the members have it. If you are happy we can table this for the record.

Ms HANCOCK: That would be nice.

CHAIRMAN: If you want to comment on it, perhaps start with the last paragraph.

The Hon. PATRICIA STAUNTON: I come back to the questions that were asked of you by Dr Macdonald about the need, as you have said in your statement, to incorporate into the Act the Independent Complaints Review Committee which currently is an informal structure, if I could use that term, rather than being provided for by legislation. The reason you said you particularly wanted it was you wanted some form of independent review - they were the words you used - of the nature of complaints.

The impression that I am gathering and I think the question posed to you by Dr Macdonald is do you not have any faith in what the complaints commission is doing, if you then want a further independent review body to come in over the top of the work that is being done. It comes back in part also to my point about rights rather than complaints and that the complaints commission, as it is the at the moment, has the power to receive, assess, prosecute and deal with complaints.

One of the rationales behind setting up the complaints commission or the Complaints Unit as it was first known was to put in place an independent body and to take away from the health professional registration boards, particularly that power of

investigating complaints and ultimately prosecuting. The comment you may have heard me make when I spoke with Ms Walton was this difficulty, that people would perceive in a body that has all of that power to assess, investigate, prosecute and follow through on that, that its genuine capacity to be seen as independent or not free from being a judge of its own quarters might well arise in the minds of those who are being complained about. Now you are saying you want another body to come in over the top of that role.

Ms HANCOCK: I do not think it is actually coming in over the top in that way. If the outcome is not to the satisfaction of people and they ask the commission to review it, there is still that doubt then, "Well they are only investigating their own staff", whereas if you have an independent one over and above - I mean not many cases are likely to get to that stage, but it was just another mechanism to make people feel that this genuinely does happen.

The Hon. PATRICIA STAUNTON: Do you think it would be more logical if you were to put that into legislation at the same time and constitute within a new framework of health rights, to take away from the health rights commission the power to prosecute if you are going to give them an overriding role to come in over the top of decisions of which they have already been part of?

Ms HANCOCK: Quite frankly I do not think I am in a situation to be able to answer that right now.

The Hon. PATRICIA STAUNTON: The Consumer Advisory Committee has made certain comments about what they want and--

CHAIRMAN: I am not ruling the question out of order but it has been answered.

Ms HANCOCK: I would not like it answer that without conferring with the committee. I think at this stage I might be going off on left field and get my nose chopped off over it.

Dr MACDONALD: A question on the Australian Association Welfare of Child Health of which you are the President, you are a member of the Consumer Advisory Committee which is a committee set up to provide a rigorous consumer advocacy role. Are you compromised in any way by the fact that you are funded fully by the New South Wales Department of Health?

Ms HANCOCK: No.

Dr MACDONALD: Does that apply to--

Ms HANCOCK: No, I could categorically say no, we are not compromised by that because we are probably some of the hardest people on the Department of Health when it comes to child health issues.

Dr MACDONALD: Of the members of the Consumer Advisory

Committee, what percentage of them are funded by the Government?

Ms HANCOCK: That, I could not tell you, I am sorry, I have not got that information with me.

Dr MACDONALD: Do you feel you are sufficiently separated from establishment and government and the commission to play a rigorous role in terms of consumer advocacy?

Ms HANCOCK: I think so. This group when it was first established was the Association Welfare of Children in Hospital back in the 1970s and they were funded for 10 years by the Federal Government. When the Federal Government phased out the funding, we tried to become self-funded but when you are trying to raise money for a philosophical ideal it is very difficult. If you are trying to raise money for a bus or something like that, people can see something tangible and in reality we were unable.

The University of Western Sydney picked up our rent. We actually have rent free accommodation on the campus of the University of Western Sydney. The audio visual reference library, which is one of the largest in the world, on non-medical needs of children, is also housed and funded by the university and the department picked up the funding. The New South Wales Department of Health actually funds the national body, which is quite a unique thing and quite a compliment to our organisation. Yes, we are independent.

Dr MACDONALD: You are not independent.

Ms HANCOCK: Well, not independent but certainly we are not compromised.

The Hon. ELISABETH KIRKBY: I must apologise for being out of the room when you first arrived. Can you tell me whether or not you believe you should have more of a- dictatorial is the wrong word - but more teeth than simply being an advisory committee? Does it not hamper your work if you can only advise and know that your advice can be totally disregarded?

Ms HANCOCK: No, I think if you have too many teeth people will not come to you for advice. I think that is the role we play in being an advisory group. On that committee are some fairly strong people who are fairly good at lobbying, so if they really set their sights on a particular issue, usually unless it is way out of whack - on that committee there are a lot of very articulate people - some of them would leave me for dead. No, I would not like to see it with teeth. I think it is much better in the capacity it is in.

The Hon. ELISABETH KIRKBY: With reference to your statement and your problem over the Australian Society of Anaesthetists, are you suggesting to this Committee that you have members of your association who have not been able to be with children during the induction procedure of the anaesthetic?

Ms HANCOCK: Not members of our society but members of the public, families, yes. That still happens today. This is the reason behind developing the educational video and to dispel some of the myths that parent are not going to grab things out of the doctor's hands.

The Hon. ELISABETH KIRKBY: Have they also been denied access to the child when the child was recovering from r anaesthetic?

Ms HANCOCK: No, recovery wards are very good. It is during the induction procedure, yes. We have an enormous amount of anaesthetists who support the parents being present.

The Hon. ELISABETH KIRKBY: I would think it would be of enormous assistance to them, particularly if the child was very nervous. I would have thought it was to their advantage.

Ms HANCOCK: That is the philosophy behind the video.

Mr ANDERSON: What was the reason for the objection then? It seems to have been pretty nasty at one stage.

Ms HANCOCK: It was.

Mr ANDERSON: What was the reason for it?

Ms HANCOCK: Well, there was a lot of - it was a bit hard to understand what the objection was. Predominantly one of the first things was, because we are in the State of New South Wales we actually went out of the State of New South Wales and it was made in Adelaide for us and the fact that we have not consulted in New South Wales. But being a national body we did not see that as a problem and their unit made it for us for minimal cost, which was another reason we went there.

I was told by one member that if parents saw that video without a professional with them they might think they have a right to be there and every fibre in my body almost said yes they do but I did not. It is questioning practice. There is nothing more to it. Unfortunately, I guess people feel threatened by that. It is the same sort of thing when our organisation in the 70s got the 24-hour visiting for parents, the importance of play, the fact that parents need to stay with their children in hospital and should be accommodated. It was like going back 20 years. It was quite a shock.

The Hon. ELISABETH KIRKBY: It has nothing to do with the parents' ability to enter an area that might be described as surgically sterile or anything like that?

Ms HANCOCK: No, in fact those myths are dispelled in the video.

Ms FICARRA: I am slightly confused. If you are appearing this morning as chair of the Consumer Advisory Committee, what does this statement that you make in terms of you being the National President for the Welfare of Child Health got to do with

your appearing as the chair for the Consumer Advisory Committee? It seems to be like two bites of the cherry but perhaps there is a logical explanation for this, and could you explain also what you mean by the concluding paragraph in an attempt to address that?

Ms HANCOCK: That was is the reason why I put it there. We are looking at the end of 1996 reviewing the role of the commission and the Act and one of the things that we are looking at is, is there any way that the powers of the commission can be broadened to involve this sort of thing. I am not sure if it can and that is why I have raised it at this Committee. It is more a question.

CHAIRMAN: It is the kind of question I want to suggest to members of the Committee we should leave until a later hearing if we have any hearing about changes to the Act. It is a long way away from the question of the annual report.

The Hon. ELISABETH KIRKBY: Could we just ask whether or not any of the consumers, the parents who wish to be with their children made a formal complaint to the Health Care Complaints Commission?

Ms HANCOCK: No, they made them to our association.

The Hon. ELISABETH KIRKBY: And not to the commission?

Ms HANCOCK: No, not that I am aware of. There may be the odd case, but I am not sure.

Ms HALL: The groups that are involved or represented in your organisation, can that be expanded?

Ms HANCOCK: They are at the invitation of the commission so it can be expanded.

Ms HALL: Would you expand on your points 2 and 3 in your opening statement about the frequency of consulting with professionals and also the need for the statutory declaration?

Ms HANCOCK: Mainly to speed up the process because it does take a long time. When we received our reports on the amount of cases that are dealt with, the length of time, that sort of thing, it was something we said perhaps we need to look at this in the legislation when it is reviewed as to whether it is necessary to consult quite that many times and also the fact that, as I said to you before, this was a new venture, a new type of legislation and people were making sure that they were very cautious of how it was worded.

Ms HALL: With the statutory declaration has any one ever complained to the Committee about finding that --

Ms HANCOCK: Not to us but they have talked to the investigating officers.

Ms HALL: Or any of the peak bodies?

Ms HANCOCK: They may well talked to the peak bodies. You may talk to the MCA this afternoon and they may be able to answer that.

(The witness withdrew)

JOAN LILLIAN ENGLERT, Area Director, Nursing Services, Central Sydney Area Health Service, Missenden Road, Camperdown, Sydney, sworn and examined:

CHAIRMAN: Did you receive a summons issued under my hand to attend before this Committee?

Ms ENGLERT: Yes, I did.

CHAIRMAN: The Health Care Complaints Act requires the Joint Parliamentary Committee to examine each annual report and other reports made by the commission and presented to Parliament under this Act or any other Act and to report to both Houses of Parliament on any matter appearing in or arising out of any such report. The first annual report of the Health Care Complaints Commission was tabled in Parliament on 14 November 1995. Today's hearing is part of the Committee's process of examination of that first annual report. As part of that process, the Committee has determined to hear from other parties involved and the commission so that the Committee might assess how the commission is carrying out its functions under the Act. Do you wish to make an opening statement?

Ms ENGLERT: No.

CHAIRMAN: Then I will ask members of the Committee if they have any questions.

Ms FICARRA: As to the rapid response team and criticisms by the Nursing Association on its operations, I believe there is now a special projects team that has taken over that role in specific circumstances. Could you give the Committee some feedback on that?

Ms ENGLERT: No, I could not. We on the board really do not have anything to do with the rapid response team.

Ms FICARRA: Are there any complaints to the Nurses Association?

Ms ENGLERT: No.

CHAIRMAN: What is the relationship between the board and the other two bodies to which complaints are referred - that is, the Nursing Professional Standards Committee and the Nurses Tribunal?

Ms ENGLERT: The New South Wales Nurses Registration Board, under the provisions of the Act, of course has quite a large disciplinary role. We have a screening committee of that board. We have the Health Care Complaints Commissioner as an observer on that committee. Complaints come into that committee from everywhere really - from individuals, the courts, the Health Department, from area health services, and from the Health Care Complaints Committee. That screening committee is a review

committee to decide where that complaint should go. The Professional Standards Committee, which you mentioned before, have have that matter referred to it, which is a much more informal committee; but the Nurses Tribunal, of course, is set up under legislation and is different altogether.

CHAIRMAN: Does the board nominate the people on the Nursing Tribunal as well as on the Professional Standards Committee?

Ms ENGLERT: No. The Nursing Tribunal chair and deputy chair are appointed by the Minister. As to the Professional Standards Committee, the president of the board can appoint the chair and the deputy chair. There are two nurses, but there are also lay people as well on that committee who are appointed by the Minister.

Ms HALL: What is the board's reaction to the annual report? How does the board feel about the Health Care Complaints Committee's role as a prosecutor as well as an investigative body?

Ms ENGLERT: The annual report of the Health Care Complaints Committee outlines all its functions during the -----

Ms HALL: I mean the current one, not generally.

Ms ENGLERT: The annual report sets out the functions of that body. As far as the board is concerned, when our report goes out we feel exactly the same. We have not been critical of it, if that is what you mean.

Ms HALL: I was seeking your reaction to the annual report 1994-95, not just reports generally.

Ms ENGLERT: We have accepted that report. We have had a look at what is in the report. We do not have any criticisms of it.

Ms HALL: No comment?

Ms ENGLERT: No comments.

Ms HALL: What about the board's reaction to the commission's role as a prosecutor?

Ms ENGLERT: The Health Care Complaints Committee has that role.

Ms HALL: What is your board's reaction to it having that role?

Ms ENGLERT: Because we are set up under legislation we have not criticised that role of prosecutor.

Ms HALL: You have got no problem with it?

Ms ENGLERT: No, because each of the cases is reviewed and monitored very carefully. Some of the cases which are complex in law take a great deal of time, and the board is very mindful of that fact. We work very well together, I feel, with that screening committee.

Ms HALL: In other words, you believe that it is a function that the committee should have?

Ms ENGLERT: Yes.

Mr NEILLY: Page 21 of the report sets out some of the types of matters that were before the Nurses Registration Board. I noted that in relation to those matters there are none in respect of which the board has, of its own volition, terminated registration. As there been a situation where the board has referred matters to the Tribunal independently of the commission?

Ms ENGLERT: No.

Mr NEILLY: It is a big curiosity of mine, given my past experience.

Ms ENGLERT: The Nurses Act 1991 as amended allowed the board to look again at how it was going to deal with disciplinary matters. The board wanted to create a space between the board members and the prosecuting of nurses. This was in our history. We have been very pleased with the new disciplinary procedures that have been set up.

Mr NEILLY: My curiosity was aroused by the fact that a few years ago a fellow was incarcerated for an armed hold-up and his registration was terminated. That had nothing to do with his medical capacity; perhaps it was due to the ethics of the situation. Would that be the case?

Ms ENGLERT: It could have been character. The board's review committee looks at any persons wishing to register, and if they disclose anything like that we actually look at each case as far as the character goes.

Mr NEILLY: So it becomes a question of character rather than professional capacity?

Ms ENGLERT: If the person was already a registered nurse, that is in quite a different category.

The Hon. PATRICIA STAUNTON: The rule of the Nurses Registration Board is, of course, clearly defined by legislation. It is a bit like the Medical Board. Would that be right?

Ms ENGLERT: Yes.

The Hon. PATRICIA STAUNTON: Indeed, its major role is to be

concerned about the registration of both registered and enrolled nurses as far as their educational competency is concerned, to approve curricula of the various universities and TAFE colleges for enrolled nurses, and to be involved with the procedural mechanisms for deregistration if that is necessary.

Ms ENGLERT: Yes.

The Hon. PATRICIA STAUNTON: It would be fair to say that, like the Medical Board, the Nurses Registration Board does not involve itself in the actual prosecution of matters in relation to professional misconduct?

Ms ENGLERT: That is correct.

The Hon. PATRICIA STAUNTON: And that that is in fact done in relation to nurses primarily by the New South Wales Nurses Association and maybe other legal bodies that may act for individual nurses. Would that be right?

Ms ENGLERT: That is right.

The Hon. PATRICIA STAUNTON: Similar to the Medical Defence Union acting for doctors who may be called to appear before the Medical Board.

Ms ENGLERT: That is right.

The Hon. PATRICIA STAUNTON: It would be fair to say, would it not, that you, in your professional capacity having worked throughout the New South Wales public health system for many years, would be aware of concerns that have been raised in relation to some matters that have been prosecuted in relation to professional misconduct of nurses. Would that be right?

Ms ENGLERT: Yes.

The Hon. PATRICIA STAUNTON: You would be aware that some of those concerns raised would relate to the manner and way in which those complaints were prosecuted by what was the Health Complaints Unit, which is now the Health Care Complaints Commission. Would that be right?

Ms ENGLERT: What case are you referring to?

The Hon. PATRICIA STAUNTON: I could refer to Sophie Heathcote.

Ms ENGLERT: Yes. Well, that, of course, was when the Act was changed.

The Hon. PATRICIA STAUNTON: Yes. But you asked me for an example. You would be very much aware of the enormous disquiet at that time about that matter, without going through other laborious matters with you.

Ms ENGLERT: Yes. If I might say so, that was one of the main reasons why we were looking at the whole of the procedures, and we really took on the Medical Board model as far as disciplinary procedures went. So there was a separation of the board - which there was not for that case - so that natural justice could be achieved.

The Hon. PATRICIA STAUNTON: So, if one wanted to know more details about any concerns that might be raised about the way in which the Health Care Complaints Commission investigates matters of professional misconduct in relation to nurses, one would be better advised to talk to, say, the New South Wales Nursing Association. Would that be right?

Ms ENGLERT: Probably, but I am not sure because it is not my field.

The Hon. PATRICIA STAUNTON: I would be interested in your comments on a matter. You may not have heard all of the evidence about the notion of looking at this whole question of matters that arise within the health care system as health care rights rather than complaints.

Ms ENGLERT: That was the first time I had heard that suggestion, at the last session. I am not up with that.

The Hon. PATRICIA STAUNTON: You might have heard me mention it.

Ms ENGLERT: Yes, I heard it mentioned.

The Hon. PATRICIA STAUNTON: I would be interested in your comment.

Ms ENGLERT: Well, certainly, that was the first time that I had heard that expression. I would need to take that on notice, think about it and consider what it means. I did not quite hear the whole of the explanation.

The Hon. PATRICIA STAUNTON: The notion is that we have within the health care system a mechanism that now focuses on the word "complaint", which of itself raises an adversarial context. Rather than see the problems that the health care system clearly does from time to time throw up as complaints within an adversarial mechanism, perhaps we should talk about health care rights and work towards a more conciliatory framework of health care rights, recognising the rights of consumers as well as those who work within the industry - getting away from this concentration on the word "complaint", but not in any way removing the disciplinary procedures, which are clearly necessary from time to time. That is really what the notion related to.

Ms ENGLERT: Coming at it from a different viewpoint, and removing the adversarial aspect, which is really very worrying for people. I am going back to where a complaint starts, say in a health care institution, and you are investigating it at that level, which we are not really talking about, but you cannot help but put someone in that adversarial position as soon as you say to them, "You write a report about that incident,"

or whatever it might be. So that you are saying that under your proposal we would still have to go through the procedure of investigating the health rights, rather than the health complaint.

The Hon. PATRICIA STAUNTON: There would have to be a different process, certainly, but not an adversarial process.

Ms ENGLERT: No.

The Hon. PATRICIA STAUNTON: Given the focus that is now in the Health Care Complaints Act, which I assume you are familiar with, which deals with conciliation.

Ms ENGLERT: That is where we should be going towards - conciliation.

Dr MACDONALD: How have the actions or decisions of the Health Care Complaints Commission impacted on the Nurses Registration Board, particularly in terms of any policy decisions or recommendations that have been made by the Health Care Complaints Commission, and has that in any way altered the way in which you manage the registration of nurses or resulted in you making certain recommendations to the nursing profession in terms of disciplinary issues, et cetera? What are the beneficial outcomes? Have there been disadvantages as a result of the activities of the Health Care Complaints Commission?

Ms ENGLERT: I think that the consultative process that we have between the board and the Health Care Complaints Commission has been very good. I have noticed quite an improvement - and I have been on the board now since 1989, and so I have watched what has been happening as far as discipline is concerned. We are now getting a formal activity report. It comes to the board with comparative figures for the previous year - and they are all in fiscal years - and that has allowed us to see the progress that we are making.

If we are introducing something like quality improvement, it allows us to judge just exactly where we are going with that. Certainly, there are still delays - and these could be attributable to the complexity of cases - and we are mindful of that, but we have seen a gradual improvement in the way that we are dealing with our screening committee and with referrals to the Professional Standards Committee, the tribunal or to the board counselling committees and to the board's review committee itself. So we have a good relationship at that boundary. It is not part of the board as such, but we have a good relationship as far as the screening committee goes and in consulting on any changes that might be occurring with the Health Care Complaints Commission and how that could affect complaints coming to the board. I mean, they are not part of that board.

Dr MACDONALD: What I would like you to comment on is one of the roles of the Health Care Complaints Commission, which is to look at and make recommendations on systemic changes to the conduct of various professions. Are there matters that have come to your attention through the work of the Health Care Complaints Commission which have resulted in the board making recommendations as to how a

profession is dealt with differently?

Ms ENGLERT: No.

Dr MACDONALD: Which, otherwise, you would not have recommended; in other words, they have brought up some new issues?

Ms ENGLERT: No. We have not got that kind of relationship where we are going together and discussing that type of mutual change to legislation or anything like that. We definitely function under the Nurses Act, and that is prescribed. If that had to be considered, it would have to come back to the board and be looked at. It would also probably take a special committee to review and decide what was the right thing to do. We have not had that presented to us.

Dr MACDONALD: For instance, the protocol and procedures for the nursing profession in terms of double checking of injections given in certain situations, and so on, are the sorts of things that might be noticed by the Health Care Complaints Commission as a recommendation for the commission that the protocol should be changed within the profession. Can you draw to the Committee's attention any matters that might show some benefits that have flowed from the Health Care Complaints Commission?

Ms ENGLERT: The board has professional liaison committees with the profession; and, if there any issues like that, they are discussed with all the main professional bodies with a view to seeking their advice. We bring in the professional liaison committees, which are the heads of all the bodies, the New South Wales Nurses Association, the College of Nursing, and all the other main bodies; or we bring in the clinical professional committees, such as midwifery or psychiatry. Those decisions are made through our professions, to discuss what should be done, should there be a standard looked at by the professions themselves, and so on. The board is all about professional nursing standards and the nurses themselves are the ones to advise on that.

Dr MACDONALD: Nothing has been initiated by the Health Care Complaints Commission?

Ms ENGLERT: No.

The Hon. ELISABETH KIRKBY: There have been anecdotes that nurses have had complaints laid against them with the Health Care Complaints Commission, and they have felt very uneasy and concerned about what their futures might be when those complaints took a long time to resolve. Can you inform us of any ways in which you think the process could be speeded up? The end result might be that that complaint is dismissed, but that could take years in some cases, and in the meantime people might feel that they and their futures are threatened. Can you tell us any ways you think the processes could be speeded up?

Ms ENGLERT: These are legal processes. We get a full report on each of the cases that are with the Health Care Complaints Commission. We review the action that has been taken. Quite often it appears that statutory declarations can hold things up,

and so on. But the board's screening committee is delegated the review and monitoring of that. This is what I mean. We are mindful that the delays in any case could be painful to the nurse.

The Hon. ELISABETH KIRKBY: You said a moment ago that statutory declarations could hold matters up. Would it not be possible, when the complain was first received, that it came in in the form of a statutory declaration?

Ms ENGLERT: That would be very helpful, I should imagine.

The Hon. ELISABETH KIRKBY: Surely that would be a simply administrative thing to do. Can you see any barrier to initiating that purely administrative change?

Ms ENGLERT: It is not my role on the board to actually know whether there is a barrier or not. Our committees deal with the reviewing of the process of dealing with complaints. I would not imagine that there would be a barrier, but I do not know.

The Hon. PATRICIA STAUNTON: On page 19 the report deals with expert and peer reviewers. You mentioned earlier your concern about standards. The report says:

> " The Commission cannot determine accepted standards as that is a matter for the professions. The reviewers' opinions assist the Commission's conclusions on whether practitioners have failed to deliver an appropriate standard of care. "

Does the Nurses Registration Board recommend people to the Health Care Complaints Commission for the purposes of those expert or peer review reports?

Ms ENGLERT: I have not been asked for any. Are you talking about the professional standards?

The Hon. PATRICIA STAUNTON: I am talking about the Nurses Registration Board.

Ms ENGLERT: Yes. But we have not been asked to nominate anyone.

The Hon. PATRICIA STAUNTON: Where does the commission go then for its views about what are accepted standards for the profession?

Ms ENGLERT: I have no idea.

The Hon. PATRICIA STAUNTON: So they do not use you at all?

Ms ENGLERT: No. Wouldn't they be using expert witnesses?

The Hon. PATRICIA STAUNTON: Well, yes. But my understanding

is - and I could be wrong - that it is the Nurses Registration Board that recommended people to them for the purpose of such expert review.

Ms ENGLERT: That would be for the professional standards committees.

The Hon. PATRICIA STAUNTON: But that is part of the board, is it not?

Ms ENGLERT: Yes.

The Hon. PATRICIA STAUNTON: To the best of your knowledge, the board has not submitted, for instance, a list of people to the Health Care Complaints Commission for the purpose of using those people for expert advice?

Ms ENGLERT: Not in that way. It is only for the various cases.

The Hon. PATRICIA STAUNTON: I think you mentioned earlier that the Health Care Complaints Commissioner sits on the screening committee.

Ms ENGLERT: As an observer.

The Hon. PATRICIA STAUNTON: Does that observer status give that person some intervention rights in terms of proffering views?

Ms ENGLERT: Advising.

The Hon. PATRICIA STAUNTON: Which could, of course, be quite instrumental in decisions to be made about whether to pursue matters or not?

Ms ENGLERT: I have not been on that committee, so I do not know whether there is any problem with that. But no-one on that committee has said that there is any problem in the relationship.

The Hon. PATRICIA STAUNTON: No, I was not suggesting that. I am just saying that they are certainly present - and I could not put it any higher than that, because neither you nor I is present at meetings - but that person could be influential in the making of decisions whether to pursue matters or not?

Ms ENGLERT: I guess anyone on the committee has that opportunity.

(The witness withdrew)

ANDREW JOHN ALLAN, Secretary, Medical Consumers Association, P.O. Box 230, Balgowlah, New South Wales, sworn and examined:

CHAIRMAN: In what capacity are you appearing before the Committee?

Mr ALLAN: I appear here as Secretary of the Medical Consumers Association. I am a professional electronics engineer and manager currently doing general consulting.

CHAIRMAN: Did you receive a summons issued under my hand to attend before this Committee?

Mr ALLAN: Yes, I did.

CHAIRMAN: The Medical Consumers Association has made a written submission which we have received only late yesterday afternoon. Members of the Committee now have a copy of that, but regrettably none of us would have had time to read it. But I thank you for your submission. Is it your wish that the submission be tendered as evidence to the Committee?

Mr ALLAN: Yes, it is, Mr Chairman. I have also been requested by our committee to read the statement, if that is not disruptive.

CHAIRMAN: Is the statement contained within the submission?

Mr ALLAN: Yes.

CHAIRMAN: We have allocated only half an hour for your evidence, and I am concerned about the time constraints.

Mr ALLAN: Could I make two corrections then?

CHAIRMAN: On which pages are those corrections?

Mr ALLAN: They are clearly marked as a statement. I would just read out the sections where there were changes. The actual wording should be as follows:

> " I have been required to report here that other consumer complainants have in letters called for the dismissal of the Commissioner, and that MCA is told by persons in two quite separate fatality cases that they would like to get criminal charges initiated against the Commissioner"

Ms HALL: Could you please indicate where you are reading?

CHAIRMAN: Andrew, the Committee members are having trouble working out where you are reading.

Mr ALLAN: This is the section that starts "The annual report falsely makes complaints management look trivial."

CHAIRMAN: At which page is that?

Mr ALLAN: This is the section on "Consumer Satisfaction", towards the end of that second paragraph. The word should be "required": I have been required to report here ...

Ms ANDREWS: Instead of "asked"?

Mr ALLAN: Yes.

CHAIRMAN: You want that correction made.

Mr ALLAN: And the other thing is that, at the end, the last but one paragraph:

> " At the recent Federal Task Force meeting in Sydney Mr George Rubin of New South Wales Health expressed his concern to MCA ...."

We decided that we would leave it as "George Rubin" and not Mr George Rubin.

CHAIRMAN: Andrew, I suggest it may not be appropriate to read out the entire statement, but if you want to highlight matters in it, this is the opportunity to do it.

Mr ALLAN: Thank you very much. What we are concerned about is that the report does not really tell us much. We have got aggregated figures, which have been noted. I think we have got problems in that if you look at the task force figures - and I refer here to the quality in Australian health care study. You cannot get a logical link between what they have found and complaints management in New South Wales. So we have made that point.

Customer satisfaction, we think, has been left out. We did not see any hard statistics. We don't know how these figures were arrived at. I said that:

> " The annual report false makes complaints management look trivial.
> "

We have nine anonymous letters of praise, and a few words on page 54 painting a rosy picture of satisfied medical complainants. I note that we received a letter out of the blue, unsolicited, this month - and we get these from time to time - which describes the commission as "redundant, a dinosaur of inefficiency" and which makes comment on commission staff as follows:

> "..... our staff called my report a communication breakdown or vindictive ... your staff were not interested."

We think the new conciliation function is a fraud and say:

> " A recent case shows the Registry to be a device for uncontrollable covert counselling and a problem cover-up system. Conciliation [in one case] has meant that a medical victim who has been nearly killed due to hopelessly wrong diagnosis, abuse, cuts, bruising, and sexual molestation, from various medical professionals, followed by insults and implied threats when bounced back by the Commission to the local level for complaints interviews, is then offered the spuriously named 'conciliation' to help her accept the hard reality that no investigation will be done, the Commission having determined her complaint to be about communication problems. "

If it was not for the ability of Standards Australia to state that their standard could be overridden by statute, this commission and the registry would not meet the standard for complaints handling that Standards Australia put out. We also think that we have a lot of evidence on how this sort of structure works, because this commission is a linear development of the unit, and to that end we have provided information about this year's operation, but we think that the history is important.

Just in conclusion, there was a comment made about the Consumer Advisory Committee. I would draw the Committee's attention to some letters. There is a letter from New South Wales Health of 8 July 1993 addressed to myself.

CHAIRMAN: That is in your submission?

Mr ALLAN: That is in the submission. I would say that if you give the CAC more teeth they will eat consumers.

Ms HALL: I see you have picked up a number of my concerns, one of which was with the advisory committee. I am just disappointed that we did not have your submission earlier, because I think it would have been very beneficial if I could have read it before the Committee took your evidence today. I thank you for what you have presented in the submission, because we really need to have genuine consumer input.

Mr ALLAN: Could I comment on that?

CHAIRMAN: Certainly.

Mr ALLAN: I am very concerned because we received the letter on 12 December, and I personally and some other people worked very hard to put this together. We physically could not get the submission to you before yesterday; it was just physically impossible.

CHAIRMAN: I regret that that was taken as a criticism. I do not think it was intended to be.

Ms ANDREWS: No, it definitely was not.

CHAIRMAN: The Committee as a whole will not be making any criticism at all about that. Please do not take that as a criticism.

Mr ANDERSON: In your submission, on the first page and third paragraph, it says:

> " These figures would indicate the Commission is structured to cover up the extent of medical malpractice. "

Then you start quoting figures. Where do you get those figures from?

Mr ALLAN: They are explained in the report. The thing I am trying to explain here is that the commission just is not a comprehensive complaints handling system. Merrilyn said as much; she has problems with staffing and that. But I think it goes deeper than that. We are saying that the Act itself does not address the problem it was supposed to address. We think, basically - and I comment here on this independent complaints review committee - that so much of this essentially ended up to be government of the bureaucrats, by the bureaucrats, for the bureaucrats. We do not think there has been proper consumer consultation.

Mr ANDERSON: Where did you get these figures from?

Mr ALLAN: The note on it is No. 6. If you look in the section, you will find -----

Ms FICARRA: It is a fairly sweeping statement. One would hope that you can explain it.

Mr ALLAN: I can explain it. It is in the material that you have been provided with. What we did was look at the national figures. The trouble is that there are no figures for Australia in terms of consumer response, so I had to use some US figures. So I then had to make some sort of guess as to what the difference is between an American and an Australian and how they respond to a complaints process. I have suggested that to come up with those figures, I believe, is like trying to predict what probability there is of life elsewhere in the universe. It is about that reliable.

The thing I question here is that what this is about is the lives of medical consumers. The fact that those figures do not exist, and that we cannot sensibly do that calculation, I have to question whether there is intelligent life in this building.

Mr RIXON: Very simply, you are saying consumers are not getting enough protection and are not getting their complaints checked out well enough?

Mr ALLAN: Yes, that is right. That is not happening.

The Hon. PATRICIA STAUNTON: Mr Chairman, to do justice to a statement like this, which I only got about an hour ago, it would require an enormous amount of time on my part to read. I would have to say that at first glance the first three

pages leave me very concerned about the sweeping generalisations within them. Much as I might have my concerns about what I consider to be the focus of the Health Care Complaints Commission, it is a body that I believe has gone about its job in a way that is in accordance with the legislation that drives it, whilst I might have some criticism about the process and approach. So, on a first glance view of your submission, my impression is that I cannot agree with the sweeping generality of it. I would like to refrain from any other comment until I have had the opportunity to read it in detail. I presume we will have the benefit of hearing from you in detail in relation to this statement when the Committee comes to review the Act later next year.

CHAIRMAN: Do you have any response to that?

Mr ALLAN: Yes, a comment. I sincerely hope that we do have a chance. The problem for consumers is that we just do not get an opportunity to have our say. The Chelmsford people, who are affiliated with our group, as are a lot of other groups, constantly complain that consumers just don't get a say. I would thoroughly agree with sitting on a committee with members of the AMA, if the people there were from the people's medical association and people on the consumer side had the same funding base and the same relative situation as the AMA does. It is a question of balance of representation.

The Hon. ELISABETH KIRKBY: As correspondence with me is mentioned in this report, can you explain something to us. You stated a few moments ago that you could not get any figures from Australia, and therefore it was necessary for you to extrapolate figures from America. When they have a totally different demographic mix, they have a totally different racial problems, and they have a totally different medical service from the one that we get here in Australia, how can you possibly correlate the figures that you have taken from American documents and transform those figures to Australian medical practice?

Mr ALLAN: I don't think you can. I have explained that clearly in this report. The point I was making in the statement was that what I was talking about was the management of a complaints system. I was not talking about the absolute figures. When I wrote to you I only had the Harvard medical practice study, and I only suggested an order of magnitude on the figures. That was for that very reason. Since then, of course, I estimated about 5,000 deaths or something like that, and the Herald said 18,000 recently. So I was almost an order of magnitude out, but I had a stab at it. I thought that thousands of deaths were important, and it was worth making a stab at it rather than saying nothing, that is all.

Mr NEILLY: The MCA is certainly not in the Health Care Complaints Commission's fan club. On pages 120, 121 and 122 of the submission you have a heading "The MCA mug punter's guide to using the proposed New South Wales Health Care Complaints Commission 1993 Bill." Was this written recently?

Mr ALLAN: No. This was all done and issued at a public meeting to people prior to the Act. This is part of the lobbying to try and get sensible provisions in

that Act. We failed.

Mr NEILLY: Now the views remain consistent?

Mr ALLAN: Yes.

Mr NEILLY: As requested earlier, basically you have sought to provide a submission in respect of updating or upgrading the legislation in the latter part of 1996. Are the submissions reflective of the concerns raised in those pages?

Mr ALLAN: Yes. I don't think anything has happened to change opinions. The only problem I have is that prior to the bill going before the Parliament there was considerable community interest. We had a lot of affiliate groups - with a total membership of 500,000. Since then I have not had the means to consult with them. So, in saying things now, all I can speak for basically is the Medical Consumers Association, the Chelmsford Victims Action Group and part of Combined Pensioners. We have some representation on other groups, but I cannot say that I have got feedback. So I am speaking for the MCA and other immediate groups that feel they have an advocacy role for.

Mr NEILLY: In essence, you would extrapolate the comments in your submission on the foibles of the bill into positive improvements?

Mr ALLAN: We have tried to be positive. We have tried to hang in there and do what we can. A good example is the Consumer Advisory Committee. I used to serve on that, and I found I was facing a conflict of interest. I felt I was a disruptive element because of the issues that I was having to bring up, and I stepped back. In fact, we wrote to the commission. We now supply a nominee. We want to contribute, but at the same time we have a responsibility to our constituency. So it is a balance. I appreciate that other people have a responsibility to their groups. The consumers have rights and providers have rights. We don't disagree with any of that.

The Hon. PATRICIA STAUNTON: I presume that the bulk of this submission will be relied upon, together with anything else that you might want to add, when we hear from you concerning the review of the Act, which seems to be your biggest concern.

Mr ALLAN: That is right. There are structural problems. I mean, it is no good giving bureaucrats an impossible piece of legislation to administer.

(The witness withdrew)

ALBERTJE GURLEY, Registrar, Health Conciliation Registry, [redacted] affirmed and examined:

CHAIRMAN: Did you receive a summons issued under my hand to attend before this Committee?

Ms GURLEY: I did.

CHAIRMAN: The Health Care Complaints Act requires the Joint Parliamentary Committee to examine each annual and other report made by the commission and present to Parliament under this or any other Act and to report to both Houses of Parliament on any matter appearing in or arising out of any such report. The first annual report of the commission was tabled in Parliament on 14 November. Today's hearing is part of the Committee's process of examination of that first annual report of the Health Care Complaints Commission. Because conciliation is something new in the procedures since the new Act of the commission was passed, we had considerable discussion earlier today with the commissioner about this. Can you describe to the Committee how the Health Conciliation Registry operates? What are the steps in the process, how many people are involved, and roughly how long does the conciliation process take?

Ms GURLEY: Matters are referred to us by the Health Care Complaints Commission. That is generally the first we see of it, although occasionally people ring up before they give their consent to the commission and want to know more about the process. Once we have received the referral - which consists of a letter telling us who the parties to the complaint are - we arrange for a conciliation to take place.

The lead time for most doctors means that they are generally set about a month after we receive the referral. I could give the Committee an idea of how long it generally takes by referring to this graph. You will see that the vast majority of the complaints received to 19 December were dealt with within 60 days; in fact, quite a large proportion are dealt with between 1 to 30 days. I might say that any delay at that stage is because one or other of the parties to the dispute is unavailable for conciliation.

Once they walk in the door it is a matter of half a day, at the end of which the whole matter is over. I have a panel of conciliators, who are appointed by the Minister, and they come in on a fee-for-service basis. I try to match them as well as possible with the kind of complaint and the kind of matter we have as well as the parties involved so that people will feel as comfortable as possible. It is of great importance to us that the whole of the process takes place in a pleasant atmosphere and as unbureaucratically as possible. It is on the basis that whatever agreement is reached between the parties is their agreement.

The legislation makes it quite clear, and the principles of mediation or conciliation are very much that the role of the conciliator is entirely neutral. We do not make awards, we do not make decisions, we do not cast blame, and we do not make any comment. What goes on in the conciliation is entirely confidential. There is a privacy clause for both the Ombudsman Act and the freedom of information legislation and defamation legislation,

which means that people are able to be completely frank and this facilitates the process to the extent that we are running at about a 75 percent success rate.

I might say that the administrative end of it is done by myself and the Assistant Registrar, and that is all there is at the moment. If you like, I could tender a copy of this graph, which is to do with the number of matters referred. We deal with only matters referred. You will note that at the top there are an extra four conciliations. These are matters which were split into two at the request of the parties. So we may occasionally have conciliations where there is more than one respondent present. In fact, that is not unusual. If someone makes a complaint about what happened to them in a hospital, we may have the medical director and/or the director of nursing and/or one of the doctors, and sometimes two doctors, such as the radiologist and the clinician.

You will see that first column is up to the end of June 1995, and the second column has complete totals up to 19 December 1995. You will see that at the bottom we had 16 matters pending, and at this stage we have six matters pending. All of the others are cumulative totals.

CHAIRMAN: If I could follow up on some information in the annual report of the Health Care Complaints Commission. It states that 15 cases referred to conciliation were not successful last year. Could you give us some reasons as to why conciliation fails?

Ms GURLEY: I can, but I would like to say that our numbers do not actually add up like that. But, as I say, we count differently; we take them in terms of referrals.

CHAIRMAN: The number is not important to the question.

Ms GURLEY: There are frequently quite a lot of issues dealt with at the one conciliation because they are so interwoven. As to the reason that they fail, I might say that when I started this we started with nothing - not even the space to do it in. The most important thing we did not have was any kind of precedent. I have set up an evaluation system, but our data base is not completed so I cannot do a lot of cross-tabulations, but I am getting quite a good idea about what happens.

The reasons for which no agreement can be found are globally because people have not come with the intention of resolving the dispute. If they come to prove that they are right, or to make somebody listen, or tell how much they care about their child, then it is virtually impossible to get them to walk away from that and see what lies in their future, because that is what they are interested in doing and conciliation is not a forum for that; it does not work.

Other than that, there are areas where, if a matter has gone on for long enough and people are now so committed to the need to justify themselves, again it is impossible to push them past that. We had one case where the patient had lived with this for such a long time that, although he was swept along with the process or by the process, when we had an agreement typed out for him to sign, when it came to signing it he realised that this

would be the end of his interest in the matter and he then demanded something that was impossible, and so the conciliation failed at that stage, after the agreement had been drawn up. But those are the main difficulties we see.

The Hon. ELISABETH KIRKBY: Would you like to give some opinion on this. Do you agree with some academic opinion that conciliation is not possible with the types of cases that the Health Care Complaints Commission has to deal with?

Ms GURLEY: No, I do not. One of the questions that we ask in the exit questionnaire is: Would you return to conciliation with a similar problem in the future? As you see, I have split this into two categories. The one on the left is for the people who have made the complaint; and on the right are the respondents to the complaint. You will see that 80 percent of them see it as a sensible process which they would come back to. I might say that among the people who said no was one who felt that he did not need conciliation and that it could have been fixed beforehand, and the issue was too small. The fact is that it had not been fixed. The conciliation resolved the complaint. We get quite a few people who feel it should have been dealt with more quickly than it had been.

The Hon. PATRICIA STAUNTON: At page 19 of the report it is said, under the heading of "Conciliation", "If the Commission is of the view that a complaint would best be resolved through conciliation, and the appropriate consultations have taken place, it will make this recommendation to both the complainant and respondent." Are you involved in any liaison or discussion with the commission about referring matters to you for conciliation?

Ms GURLEY: Never.

The Hon. PATRICIA STAUNTON: Do you have a view about the types of matters that do come to you for conciliation as to whether some may be appropriate or inappropriate or whether you think there is wider scope for conciliation, from your own knowledge of matters?

Ms GURLEY: I can only look at what comes to me. I am unable to comment on what the commission gets, but in terms of raw numbers I would think that a third of complaints would be a very conservative estimate of what should go to conciliation. I say this from a background of complaints management before I came to this particular position: there is an awful lot of unhappiness which can be resolved by conciliation and where the conciliation can have an educative value as well.

I am extremely enthusiastic about the process, because it is in fact quite moving to see people who are so angry and so distraught that they have to be separated at the beginning into physically separate spaces because they cannot bear to be in the same room, to almost invariably three and a half hours later - and it takes three and a half hours, it is just one of those things - walking out talking to each other and laughing. It is quite moving in some ways.

The Hon. PATRICIA STAUNTON: If you do not have any liaison at all with the Health Care Complaints Commission about what comes to you, even by way of

feedback, how is it possible to perhaps improve the role of conciliation or to enhance the role of conciliation if you are not providing and are not getting feedback about those matters that are directed to you?

Ms GURLEY: The feedback I get is from my own evaluation process.

The Hon. PATRICIA STAUNTON: What about the ones you do not see?

Ms GURLEY: They are not in my purview. If I do not get to see them, I cannot have a view on them.

The Hon. PATRICIA STAUNTON: Do you think that it would help if you had any sort of liaison with the commission about the matters that come to you or do not come to you for conciliation? Are you aware of the criteria that are used to send matters to conciliation?

Ms GURLEY: As the Registrar of the Conciliation Registry, and as somebody who has a very strong and positive view of conciliation, of course I am going to say that any kind of consultation is worthwhile; that is part of the package, I guess.

The Hon. PATRICIA STAUNTON: But you are not aware, or are you, of the criteria that are used by the commission to send matters to you?

Ms GURLEY: To some extent, yes. I know that there are some matters that do not come to me, and I can see exactly why, and I agree with that. They are those matters which are sufficiently serious to probably lead to prosecution or what in fact would be called criminal matters. Clearly, they are out of my arena. The basis upon which matters are sent to the health areas or to me, I do not know. I do not understand the distinction. In fact, I am not sure how area health services deal with complaints when they get them.

The Hon. PATRICIA STAUNTON: Have you ever asked the area health services?

Ms GURLEY: No, because it is not my place. I cannot very well ask the area health services, "How do you deal with matters that are sent to you by the Health Care Complaints Commission?"

The Hon. PATRICIA STAUNTON: I am sorry, I misunderstood what you said to start with.

Mr NEILLY: You have indicated two areas from which referrals would not be made, such criminal prosecution cases. I would imagine where professional standards are involved those cases would be diverted elsewhere. Is there a typical type of case that you get? Could you give me one or two illustrations of matters that come to the Health Conciliation Registry so that I will have some idea of what you are dealing with?

Ms GURLEY: Illustrations are difficult.

Mr NEILLY: Give me two matters you have dealt with.

Ms GURLEY: Perhaps I can do it without breaching confidentiality. I have a difficulty with confidentiality, which is so crucial. There are two things that are absolutely crucial to conciliation: one is neutrality - the registry and the conciliator must not only be neutral but be seen to be neutral. That is absolutely crucial. It is the foundation and the cornerstone of conciliation, and the legislation reflects that.

Mr NEILLY: I do not need that detail. There are community justice centres that conciliate problems between neighbours. We know what neighbourhood problems, and we know they are a typical situation. There has got to be something typical about matters referred to you. What are they?

Ms GURLEY: It is called bad outcomes. A bad outcome can be anything in a category which is a statistical expectation. For instance, about 2 percent of appendectomy wounds become infected. If that is how a hospital runs, apparently that is good enough; that is what you would expect. But it is no comfort to the person with the infected wound. So the cases of people who fall into that category of statistical expectation are very good for conciliation.

There is a second category of bad outcome which is really the result of an error in judgment. Why people spend money on doctors is because they are buying their judgment. Unfortunately, everybody makes mistakes, including doctors, and that error becomes obvious with 20/20 hindsight; if we had done the caesarean a bit earlier, or left it a bit later. They are very good for conciliation.

I might say that, looking at the question that Miss Staunton asked earlier was, why would doctors come? One of the reasons I am finding now is that they come out of a sense of professionalism. It could be to prove that they had done nothing wrong, and the conciliation leads them along to an agreement with the patient and, as I say, it is quite educative because they can see how the patient feels at the loss. Quite frequently they come because they believe they are responsible for resolving the issue with the patient. Now, there are also people who see it as a soft option, I am sure of that. But, in itself, it is an educative process.

Ms FICARRA: A question on the number of mediators you use and where they come from. They are experienced, obviously, in health matters. If you offered conciliation all along the way along the line of the complaints process, how would your unit be able to cope?

Ms GURLEY: Our conciliators are very experienced, and they are appointed by the Minister on the basis of their training and experience. They are not necessarily experienced in health matters, because the important thing is the neutrality. I agree with the commissioner's statement that conciliation should be able to be offered at any stage through the process, and I would say even after the process because there are often residual matters that have not been resolved at the end of an investigation and the prosecution.

Thirdly, would we be able to cope? At the moment, I think we could easily handle double the number that we are getting without adding to our resources. Beyond that, I think we may need more staff.

Ms FICARRA: A supplementary question. Where complaints are dealt with by the area health services, and properly so, could you see a case where, if there was more conciliation at that level, it would make the whole process a lot more acceptable?

Ms GURLEY: The thing about conciliation is that it needs to be done by somebody who is trained in the process. I have no idea what the area health services have available to them by way of trained conciliators.

Ms FICARRA: But you would see no problem with the area health services resourcing those mediators that you do at the moment to help you in the job? In other words, I am saying, if it works for you and your unit, why wouldn't it work for an area health service?

Ms GURLEY: It would. It would be a question of having properly trained conciliators. That is the crucial element. One other aspect of it is that the conciliation process would have to be entirely neutral. Without the neutrality, it will not work. Therefore, it is better if it is seen to be quite clearly out of the hierarchical structure of the health service.

Ms ANDREWS: I am a great believer in conciliation, and I feel that a number of health care complaints could be resolved through conciliation, if the problem at the beginning is a lack of communication between some medical practitioners and consumers, for want of a better word. When it comes to the conciliation process, because in other industrial areas people go into the conciliation with an advocate, I am wondering whether some people might steer away from conciliation thinking that it is a case of David versus Goliath. I am concerned about that. Most people coming to see a State member are people looking for assistance, and if they are thrown into this conciliation process I am concerned about that aspect.

Ms GURLEY: I know exactly what you are saying. A lot of people feel hesitant about throwing themselves into it. As you can see from this document, occasionally the issue is raised. We had one person who finally decided that she would not come. I might say there are a number of issues here. The first is that unless the process is entirely voluntary it is contaminated, really. At the same time people who make their attendance conditional on some specific thing that they want, are not really coming to resolve the dispute.

We can generally reassure people - and, with the exception of that one, we always have - but part of the training and the skill of the conciliator is to make sure that people are empowered to reach their own agreement. That empowerment is really what the conciliation is about - that people feel comfortable, because it is a process where they can be listened to without being interrupted. A conciliation is to make sure that happens.

Because there is no other role than conciliation, there is no investigative or

prosecutorial powers, that conciliation is a completely independent and neutral function, the whole question of having legal representation becomes superfluous. We help them to find an agreement which is about what they both want. That is why the agreement holds. It is very important that the agreement holds after the parties leave, because the piece of paper that they sign at the conciliation registry is not worth the paper the agreement is written on; it is just their own agreement which they can review, and to remind them about what it was that the other person is going to do if they uphold what their part of the bargain is.

I should also say that people can, and have, reached agreements which include damages or compensation. We have what we call our breakout rooms, which give people an opportunity to consult with somebody they have brought with them who does not come into the conciliation room or to make a private telephone call to whomever they like. They can leave the conciliation at any time to do exactly that. As soon as they feel uncomfortable, they can go and do that. If they want to bring somebody that person cannot be part of the conciliation unless it facilitates the conciliation. That is always what I look at: Is this going to facilitate this conciliation?

The fewer people we have, the easier it is to find what it is that the parties want. So, if they feel that it will make them feel better to have somebody there, we will give them a cup of tea, give them somewhere comfortable to wait, and the party to the dispute can come out of the conciliation room and consult with that person at any time.

Ms ANDREWS: Is it like a conciliator and the client on a one-on-one basis?

Ms GURLEY: Not necessarily.

Ms ANDREWS: But only one complainant?

Ms GURLEY: Not necessarily. For instance, we have had several instances where we have had a complaint made about the treatment of a child, and both parents will be there.

Ms ANDREWS: Would there ever be a case where you have got a single adult who feels he has been wronged by the medical profession and, say, three from the medical side? Would there ever be a situation like that?

Ms GURLEY: I don't think we have had three. We have certainly had a couple, especially if the complaint is against the hospital. But they are amongst the 80 percent of people who say they would come back. I think that is the crucial thing as far as I am concerned. I should say something else, and that is that everybody has a sort of an idea about conciliation. I think that one of the things that I can do, and that I am planning for February, is to have a simulated mediation/conciliation. This came out of discussions with the Medical Board. The Medical Board and the defences organisations and the AMA will come. If you would like me to let you know, Mr Chairman, I would be happy to have anyone from here attend, because it is quite an interesting process.

CHAIRMAN: Thank you very much for the offer.

Mr ANDERSON: Where you have got a support person during a conciliation, are you referring to legal representation?

Ms GURLEY: Never.

Mr ANDERSON: What do you mean by support person?

Ms GURLEY: I will give you an example. We had a patient who had, on a previous visit that had nothing to do with conciliation, was severely handicapped and was very difficult to understand, and was also blind, which meant that there was no eye contact possible either. The carer came in to assist, because it was very difficult to understand this person. I think the other case involved an interpreter.

(The witness withdrew)

(Luncheon adjournment)

JOHN STEPHEN HORVATH, Medical Practitioner, President of the New South Wales Medical Board, [redacted], sworn and examined, and

ANDREW EDWARD DIX, Solicitor, Registrar, New South Wales Medical Board, Off Punt Road, Gladesville, affirmed and examined:

CHAIRMAN: Did each of you receive a summons issued under my hand to attend before this Committee?

Prof. HORVATH: I did.

Mr DIX: I did.

CHAIRMAN: The Health Care Complaints Act 1993, section 65 (1)(d) requires the Joint Parliamentary Committee to examine each annual and other report made by the commission and presented to Parliament under this and any other Act and to report to both Houses of Parliament on any matter appearing in or arising out of any such report. The first annual report of the Health Care Complaints Commission was tabled in Parliament on 14 November 1995. Today's hearing is part of the Committee's process of examination of that first annual report of the Health Care Complaints Commission. As part of that process the Committee determined to hear from the Health Care Complaints Commission and other parties involved with the commission so that the Committee may assess how the commission is carrying out its functions under the Act. Professor Horvath, do you wish to make any kind of a general or opening statement?

Prof. HORVATH: I would thank you, Chairman. Just for the record, the New South Wales Medical Board operates under its own Act, which is separate from but has some correlation with the Health Care Complaints Act. It is generally regarded that the whole process of discipline and impairment in New South Wales, and the way it operates, are the benchmark for the rest of Australia. Two other States have formed their Acts to be as close to ours as possible. I am also President of the Australian Medical Council, which is representative of all medical boards and councils. It is generally regarded that ours is one of the better systems.

I think the board recognises that it is not a static system, that it continues to change. From 1987-88, when I first went to the board, up to the present time there has been a new Act. And in 1992 we were very fortunate to be given impairment provisions, so that sick doctors are not dealt with under a disciplinary structure. The board and the profession, as well as the Health Care Complaints Commission, are regularly looking at and reviewing the various issues to try to continue to improve the structure.

At the moment, the potential problems are the perennial one of balancing the very important consumers' rights - because the Medical Board's interests is only one of public safety and interest - and at the same time balancing the rights of doctors in the process. This is a very difficult middle road to run. Secondly, the board recognises the issue of delays in completion of complaints. We regard that as an ongoing challenge to us, as well as to the commission, and we are constantly reviewing - and are in the process of review -

to try to address these issues. I would regard those as the potential current problems that continue to beset us.

CHAIRMAN: The annual report shows that 35 complaints investigated by the commission were referred to the Medical Board for determination. Could you outline to the Committee how the Medical Board deals with those complaints, in a general way? Could you give us any idea, either quantitatively or qualitatively, of the outcomes of the cases?

Prof. HORVATH: I could not give you any outcomes, but generally speaking there is a monthly meeting of a subcommittee of the board called the screening committee. This is a subcommittee of the board on which the Health Care Complaints Commission also sits. All complaints are reviewed at this time. It is jointly determined what is the fate of these complaints, with as much material before us as possible.

At that particular committee there may be a decision to send the matter to another place for resolution, or dismiss it altogether, at one end of the spectrum, right up to referring it to a tribunal for a potentially serious case that may lead to deregistration.

At that committee, under both our Acts, either the commissioner or the board can override the other and take it to a higher order. Therefore, if either the commissioner or the board believes that the option is not sufficiently serious, it can go a step or two higher. But it is done in concert at that time and with as much material available as is possible. If there is not sufficient material, it will be referred back for further investigation and to be referred to the screening committee.

Mr RIXON: You mentioned you were looking at ways and means of reducing the time it takes for investigations and that sort of thing. I notice at page 26 of the report that there was at least one policy recommendation that came across to you. What I am looking at is how you work with the group to improve the situation, and could you indicate whether these policy recommendations are welcomed by yourselves, and so on?

Prof. HORVATH: Policy recommendations move in both directions, and they are always welcome in both directions. At the present time we are looking at a whole series of policy recommendations to continue to move this forward. The two groups, very importantly, work separately but with interlinking circles. There are important checks and balances there; either the Medical Board or the commissioner can proceed on as far as a complaint if they believe that is in the public interest. I do not know the precise recommendation that you refer to, so that I cannot tell you its fate, and I will take that on notice, but I cannot remember a serious recommendation being ignored.

Ms ANDREWS: Professor Horvath, do you feel there is any way in which the Health Care Complaints Commission could improve its operations or how it works?

Prof. HORVATH: At the present time we are looking at some of the delays that are inherent in the system. The commission is distressed by the delays, and consumers are stressed by the delays. The board's philosophy is that it is distressed by

delays because delays clearly are a cause of major concern to patients who do not believe their complaints have been resolved. There is a review of the legislation next year, and we are currently looking at what sort of legislative issues are slowing things up. For example, the amount of consultation required between the commission and ourselves, if we took it to the letter of the law - and Mr Dix might like to comment on it because he is a lawyer - really slows things up. We are looking at that as an option.

We are looking at whether some of the steps in the early assessment in that 60-day period could not in fact be speeded up, without losing the rights of the public, which are terribly important, but at the same time not putting in place draconian measures that would totally turn the profession away from cooperation. I think one of the important things that have happened since 1988 - and I do not think the profession will ever like the disciplinary system imposed upon itself by self-regulation; in fact, I think it would be too much to ask - but there is a very high level of cooperation, and most of the time the profession feels it is getting a fair go.

If an Act was to be draconian - let us hypothesise that a doctor had to reply within seven days or be referred to a tribunal, or something crazy like that - we would spend an inordinate amount of time in legal proceedings. At the moment, we have a reasonable level most of the time of cooperation from the profession in dealing with patient complaints. Sure, there are the outliers - the really serious matters that clearly will go to a tribunal, with potentially serious outcomes - and people have the right to defend themselves under those circumstances.

So we are looking at our role. We are liaising with the commission and with other players to see how we can improve that early system whilst maintaining the cooperation of the professions, which I believe we have got in the last little while.

Mr ANDERSON: Mr Dix might be best placed to answer this question. Is there any way in which the Health Care Complaints Act could be amended so as to improve the way the commission works?

Mr DIX: I think Professor Horvath has referred to this. When the Act first came in one of the important issues in all the debate and discussion leading up to it was to ensure that there was reflected what had happened in practice - of a high degree of consultation back and forth between the board and the commission, but also that the doctor or the professional people and/or the complainant had an opportunity to comment at various stages. That has all been put in. But the way in which it has operated, particularly when you link it with the provision of the other Acts which also have their procedural provisions, such as the Medical Practice Act, there are a number of areas where they just conflict. Whilst we can resolve those, it is difficult and it is very time-consuming.

There is another issue which relates to statutory declarations, where the two Acts have a different approach as to when and how a statutory declaration ought to be obtained. That has proved to be a major problem in obtaining statutory declarations. So those are two specific issues. But I think the philosophy of the board behind the Health Care Complaints Act, which really reflected what had been happening up to that point but put it on a much more solid basis, is right. But the Act probably needs a major overhaul as

far as procedures are concerned.

Ms HALL: The report listed a number of matters of concern. One was that deregistered medical practitioners were operating as alternative therapists. Do you see that as a problem? If so, how do you think we can get around it?

Prof. HORVATH: We see it is a huge, but once doctors are deregistered they pass out of our Act and we really have to pass the matter on to another jurisdiction. I am not a lawyer, but I think one of the Acts of the New South Wales House has to be strengthened to provide serious penalties.

Ms HALL: I understand that Ms Staunton will pick up her health rights issue. When Ms Staunton asks her question, could you answer for me whether you have any problem with the fact that the Health Care Complaints Commission actually investigates and prosecutes.

CHAIRMAN: That question is on notice, because I think that question will be asked when Ms Staunton asks her questions.

Ms HALL: When you answer it, would you look at it from the way I am asking it as well as the way Pat Staunton asks it as well.

The Hon. ELISABETH KIRKBY: Doctor Horvath, a few moments ago you said that you believe the medical profession believed that it was treated fairly. However that may be, there are many consumers who believe that doctors get off too lightly, and they are very concerned - and this comes particularly from the Chelmsford group - that there are still people practising who were involved in that matter. Can you tell us what you believe could be done to strengthen sanctions against people who have in fact been found guilty of professional misconduct but who still continue to practice?

Prof. HORVATH: The actual sanctions are not the realm of the board; they are the realm of the tribunal, which is a function of the District Court. The board does not decide sanctions. Once the board, or the director general or the Health Care Complaints Commissioner has decided that a process leading to deregistration should occur, it is entirely out of our hands. We cannot comment on it, and we have no further input whatsoever. The tribunal, which is set up under the auspice of the District Court, decides what the penalties will be, and then it goes through the appeals court. We have seen the processes. Even if the board on one occasion was not happy with the outcome - and I think Andrew may have appealed against an appeals court decision.

Mr DIX: We sought advice about it.

Prof. HORVATH: It is then out of our hands.

The Hon. ELISABETH KIRKBY: Surely as the Medical Registration Board for this State you are in a position to influence the ethics committees of the various royal colleges, for example, and to try to strengthen what the public believes the registration board is all about - that a person who is practising is a fit and proper person.

Prof. HORVATH: We do not have links with college ethics committees. We talk from time to time about various issues. That is something I will take on notice - whether we should have links with college ethics committees. I think that is an interesting approach to look at matters more globally. But, once it is in the judicial process before the tribunal, we do not have a role.

The Hon. ELISABETH KIRKBY: Even if you are a board set up by statute?

Prof. HORVATH: We do not have a role. It becomes a judicial matter. In some other States the board sits as the judicial functionary. That is sort of foreshadowing Ms Staunton's question. We think that is wrong because then you become judge and jury, investigator and prosecutor.

The Hon. PATRICIA STAUNTON: You do not know the question, obviously.

Prof. HORVATH: We believe that that is really out of our hands.

The Hon. PATRICIA STAUNTON: You actually touched on my point in your opening statement when you spoke about some of the problems that continue to beset the commission - the need to balance the rights of the consumers with the rights of the providers. That is something that I have had some experience with, coming from the perception of health care providers. I will make a statement and then ask for your comment. We have a focus at the moment on this whole issue of heal care complaints, which by its very title and the way in which the Act is focused, brings to the arena an adversarial approach.

It seems to be that we should be more focused on the issues of rights - the rights of the consumers and the rights of providers - and to try to move away from the adversarial approaching in this Act. This, in part, of course is supported in my view by the move towards conciliation mechanisms within the Health Care Complaints Commission itself as the best way to try to resolve problems. Whilst the Health Care Complaints Commission, or, as it was earlier known, the Health Care Complaints Unit, had been charged with the task of prosecuting complaints and taking that task away from the registration boards, in fact it has almost become that in itself in that it assesses, investigates, prosecutes and follows through on the nature of complaints.

There is some suggestion now coming from the Health Care Complaints Commission itself that we should put in place, through legislation, and independent review commission with overriding power to independently review the work of the commission, which rather seems to be defeating its purpose. I would be very interested in your view on this notion of what we are trying to do in that respect. You are quite right: we want the providers to cooperate, and they will not cooperate totally within a climate of adversarial confrontation. They will cooperate more if there is this recognition of mutual rights and responsibilities that are contained within a framework of conciliation rather than adversarial arrangements, and we should try to focus on that in our legislative structure rather on the structure that we have at the moment.

Prof. HORVATH: I think there is a mixture there. Certainly the board and the commission have moved towards a non-adversarial approach to dealing with a number of issues. I think the best example there is the impairment. The whole area of impairment which used to be dealt with prior to the 1992 Act was adversarial, dealt with by complaint. It is now non-adversarial, dealt with by conciliation and consensually.

At the other end, if doctors have done something that should result in them being struck off, and the public safety interests are that the doctors be struck off, I do not believe that there is any other way except in an adversarial situation to deal with the matter, because the doctor, very correctly, will hire whatever legal support he needs to defend his situation, and the commission has to match it to protect the public. I personally cannot see the adversarial situation being resolved there.

Then we move into that vast middle ground, where we are all looking at reducing the adversarial content. Whether it needs some legislative changes in both our Acts, certainly the professional standards committees deal with matters of professional competence, et cetera, that will not lead to deregistration, we and the commission have been conducting those matters in a non-adversarial style rather than dealing with them adversarially. But the closer you get to the matter being serious, with serious sanctions, the more adversarial it will be.

The Hon. PATRICIA STAUNTON: Do you think we should separate those processes - the rights as opposed to the adversarial - instead of trying to merge them, as is being done at the moment?

Prof. HORVATH: I do not follow you. How would you separate them?

Ms HALL: Perhaps it might be appropriate to ask my question at this point. It relates to the role of the Health Care Complaints Commission as a prosecutor as well as having the other functions to perform. Do you think that is appropriate?

Prof. HORVATH: I do not believe the board has ever felt it was inappropriate. Certainly, the board, in looking at its legislation and recommendations to the Minister, has thought it entirely appropriate. I would think it inappropriate to go the Victorian route, where the board takes a step further and sits as the tribunal. But I believe what we are doing at the moment is appropriate. Andrew might comment from the judicial point of view.

Mr DIX: Our system has worked well and, by and large, the board is comfortable with it, and it makes sense. It would add another layer to try to introduce a further body to deal with that.

The Hon. PATRICIA STAUNTON: I was not thinking of adding another body. I was actually saying that I see difficulties in bringing a degree of impartiality to an adversarial process in a body that has investigatory, assessment and prosecutorial roles, which is the current system we have, when that does nothing to engender this notion of rights. I think there has been at least some acknowledgment that there have to be rights on both sides in the one organisation.

Mr DIX: Can I comment on that from the point of view of the professional standards committees, which Professor Horvath spoke about, dealing with the lower level hearings - if you like, matters that are not likely on the face of them to lead to suspension or deregistration. The way those matters are being conducted, the commission is there, the doctor is there, and the doctor has no right of legal representation, although he or she may have a legal person present with him or her. The commission has a standing rule that it will not use a legally qualified person, so that the doctor is not disadvantaged by that situation.

The actual proceedings are conducted on an inquisitorial line, so that essentially the commission is not there in an adversarial role. The material is pre-circulated. So we have developed a range of procedural rules to try to maintain that sort of focus. But I have to say that it seems to be inherent that the system is always being cranked up and tightened up, and we have to constantly monitor it to see that it is not slipping into the adversarial mode.

Prof. HORVATH: If I could add to that. The further up the line is the seriousness, the closer you get to confrontationist and adversarial. If health professionals are going to have conditions put on their registration and their colleges, we do tell colleges that we have taken action. We tell a college that Doctor Suchandsuch has been found guilty of unprofessional conduct which could have serious impact on the professional and the employer for years thereafter. That is going to increase the heat. You cannot get a non-adversarial situation in those circumstances.

The Hon. PATRICIA STAUNTON: It is the organisation that does most of the work in terms of dealing with these matters on behalf of the doctors, the Medical Defence Union.

Prof. HORVATH: That is correct.

The Hon. PATRICIA STAUNTON: It would have a completely different view to the one that you are propounding at the moment.

Prof. HORVATH: Correct.

Mr NEILLY: Professor, on page 23 of the Health Care Complaints Commission's report reference is made in the latter part of the first column to the fact that the complainant or affected practitioner may lodge an appeal against a professional standards committee decision to the Registrar of the Medical Board who refers it to the Medical Tribunal. Basically, my question is, why the middle man?

Prof. HORVATH: It is a procedural thing. He is a letter box. He does not look like a letter box. It is just a procedural thing. He has no option but to pass it on to the tribunal and set it up.

Mr NEILLY: There is no "may" about his referral?

Prof. HORVATH: Absolutely none whatsoever. An appeal is an automatic right.

Mr NEILLY: Another matter is that under the heading of "Counselling" is this statement, "The Medical Board's policy on counselling is currently under review." Is that to verve it up, or is to make it fit a bit more snugly into the new arrangements in the advent of a new structure?

Prof. HORVATH: The counselling role is one that we have not been comfortable with. Our current policy is that we do not counsel unless the medical practitioner has conceded the fact. So it is not a debate about what happened; it is really then us telling the medical practitioner that we do not believe that his actions were appropriate. We are looking at whether or not we should broaden the use of counselling, so we do not have any firm views on that at present.

We are looking again at how the board would use its counselling powers. The board does not believe it should use its counselling powers to intervene when there is not enough evidence to proceed. It only uses those powers when the doctor has said, "I agree I did that, but I don't think it was terribly bad," and we say, "You have agreed you have done it, and we think it was pretty rotten, and if you do it again then it is going to be pretty serious." But we are looking at that whole area of whether the board has a bigger role in counselling, and this perhaps comes back to your original comment as to whether we cannot have a broader influence on general behaviour.

CHAIRMAN: I have a question about conciliation, which is new to the commission under the Act. It seems to many of us that there are not many cases that go to conciliation. I know that is not within the board's direct area of operation, but do you have a general view on whether enough cases are being conciliated?

Prof. HORVATH: I think it is too early to make any comment. The process is really new. We totally support conciliation. We put it in our original submission to the Minister as something we desired to see happen. I think that a little further down the line we have to review the outcomes of conciliations, whether everybody has been happy with the outcomes, and whether conciliation has worked, and whether there has or has not been under-referral. I think it would be premature for us to comment on it now.

CHAIRMAN: I think you, Professor Horvath and Mr Dix, for your clear and concise evidence to the Committee.

(The witnesses withdrew)

(The Committee adjourned at 2.45 p.m.)

APPENDIX 1

Proceedings of the
Joint Committee on the Health Care Complaints Commission
held Wednesday 20 December, at 9.30am
in Room 814-815, Parliament House, Sydney

MEMBERS PRESENT

Mr Mills (Chairman)

Legislative Assembly	Legislative Council
Mr Anderson	Ms Kirkby
Ms Andrews	Dr Pezzutti
Ms Ficarra	Ms Staunton
Ms Hall	
Dr Macdonald	
Mr Neilly	
Mr Rixon	

In attendance: Catherine Watson, Project Officer, Hilary Parker, Assistant Committee Officer.

The Chairman opened the meeting, welcomed the witnesses and made an opening address.

Ms Merrilyn Margaret Walton, Health Care Complaints Commissioner, and Ms Gail Barton Furness, Deputy Commissioner, of 28 Foveaux Street, Surry Hills, both affirmed and acknowledged receipt of summons.

The Commissioner addressed the Committee.

The members of the Committee questioned the Commissioner on matters in the Annual Report.

Evidence concluded the witnesses withdrew.

Ms Irene Else Hancock, Consumer Advisory Committee, took the oath and acknowledged receipt of summons. Ms Hancock made an opening statement. The Committee questioned the witness.

Evidence concluded, the witness withdrew.

Mrs Joan Lillian Englert, Nurses Registration Board, took the oath and acknowledged receipt of summons. The Committee questioned the witness.

Evidence concluded, the witness withdrew.

Mr Andrew John Allan, Secretary, Medical Consumers Association, took the oath and acknowledged receipt of summons. The Committee questioned the witness.

Evidence concluded, the witness withdrew.

Ms Albertje Gurley, Registrar, Health Conciliation Registry, affirmed and acknowledged receipt of summons. The Committee questioned the witness.

Evidence concluded, the witness withdrew.

Dr John Stephen Horvath, President, New South Wales Medical Board, took the oath and Mr Andrew Edward Dix, Registrar, affirmed and both acknowledged receipt of summons. The Committee questioned the witnesses.

Evidence concluded, the witnesses withdrew.

At 3.55pm the Committee went in-camera for deliberations and the public left the room.

...

The Committee adjourned at 4.25pm, sine die.

Chairman

Clerk to the Committee

APPENDIX 2

OPENING STATEMENT TO THE JOINT COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION PUBLIC HEARING WEDNESDAY 20TH DECEMBER, 1995, BY CHAIR CONSUMER ADVISORY COMMITTEE TO THE HCCC IRENE HANCOCK

I would like to complement the Commissioner Merrylin Walton and her staff on an excellent first year of operation of the Commission. Our Committee has acted in an advisory capacity during this first year, we have met quarterly and participated on interview panels for the employment of staff.

The Independent Complaints Review Committee has been established during 1995. This Committee is chaired by a member of the Consumer Advisory Committee.

The first Annual Report of the Commission is comprehensive and well presented.

The Legislation covering the Health Care Complaints Commission, the Health Care Complaints Act 1993, is due for review at the end of 1996.

There are a number of areas the Consumer Advisory Committee would like to see addressed in the review, namely:

1. The Independent Complaints Review Committee be incorporated in the Legislation.

2. The current method of investigating complaints contains a laborious and unnecessary requirement to consult frequently with the professions, the requirement to consult should only be at the beginning and the end of the investigation.

3. A complaint by a consumer should in itself be the authority instead of requiring the complainant to complete a statutory declaration.

The gradual turn around by the medical profession to accepting the Health Care Complaints Commission must be pleasing to the Joint Committee.

Another matter I wish to draw to the Committee's attention is the proposed NSW Health Consumers Network which was initiated and developed by members of the Consumer Advisory Committee, by virtue of our representative nature our Committee was the unofficial advisor to the Minister for Health and the Department of Health on policy documents etc., as at July 1 1995 the Health Care Complaints Commission severed all ties with the Department of Health and thus resulting in the loss of any formal or informal communication with the Consumer Advisory Committee - therefore currently the Minister or the Department have no formal channels of communication with consumers.

The NSW Health Consumers Network proposal is currently before the Minister and the Department of Health - we are awaiting their reply.

STATEMENT TO THE JOINT COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION PUBLIC HEARING WEDNESDAY 20TH DECEMBER, 1995.

BY CHAIR CONSUMER ADVISORY COMMITTEE TO THE HCCC

(National President Association for the Welfare of Child Health)

IRENE HANCOCK

Before I conclude, I wish to raise an area of concern in this forum regarding the imbalance of power between the medical profession and consumers. The Association for the Welfare of Child Health (AWCH), of which I am National President, is a recognised national peak consumer group.

Recently our Association produced a video aimed at educating and changing clinical practice on the issue of parental presence during the induction of a child's anaesthesia.

Following invitations to the launch of the video being issued, my staff were subjected to abuse by members of the Australian Society of Anaesthetists, a video was taken prior to the launch without our knowledge and screened in Canberra at an Anaesthetists meeting.

AWCH has experienced ongoing difficulties in dealing with these parties, due to the fact that their vocal and vehement opposition to the video and its philosophy, expressed to my staff and other health professionals, was totally denied while the media were present. It is impossible to resolve issues with individuals who so easily present diametrically opposing private and public persona's.

As a result, on the 19th of October I wrote to the President of the NSW Branch of the Australian Society of Anaesthetists seeking a formal apology and return of the video. To this date there has been no acknowledgment of the letter - copies of which I table for your information.

The issue of concern is that if a peak consumer body such as AWCH is dealt with in this manner, what hope has an individual consumer got in this type of situation.

In an attempt to address this imbalance of power, I would like to raise the possibility of broadening the terms of reference in which the Health Care Complaints Commission could use their power - in dealing with attitudinal issues on behalf of consumers.

Australian Association for the Welfare of Child Health Inc.

Formerly Australian Association for the Welfare of Children in Hospital

(Wholly funded by the NSW Department of Health)

University of Western Sydney, Nepean
Building D, Moree Ave, Westmead 2145
(P.O. Box 113)
Tel: (02) 633 1988
Fax: (02) 633 1180

19th October 1995

Dr J N Matheson
President NSW Branch
Australian Society of Anaesthetists
604 East Point Tower
235 New South Head Road
EDGECLIFF NSW 2027

Dear Dr Matheson,

Following the successful launch of the video "Parental Involvement in their Child's Anaesthetic", I write on behalf of the Association for the Welfare of Child Health (AWCH) to formally register our protest in the strongest possible terms at the appalling behaviour of a member of your Society. The taking without permission of a copy of the video, and subsequent screening at a meeting in Canberra is a breach of copyright. We expect your Society to take appropriate action and to notify us of the outcome. In an attempt to address this problem we would anticipate a formal apology from both the Society and the member concerned.

This type of behaviour reinforces the patriarchal nature of some members of the medical profession, in which they do not even observe normal common courtesy, reinforcing the need for groups such as AWCH to develop educational resources to further the debate, and work towards a meaningful partnership between health professionals and health consumers. We were also distressed at the treatment received by Dr Johan van der Walt by some of his colleagues.

As a mark of our Association's desire to develop a more harmonious relationship between anaesthetists, parents and AWCH we have undertaken to add a couple of riders to the video - re the practices portrayed in the video and that there may be occasions when it is not possible for parents to be present - prior to its release for sale. To avoid any mix up with the video I request you return the copy we couriered to your office within the next few days.

I appreciated your rational approach when we discussed the issues by telephone on the 19th September 1995, and look forward to a satisfactory resolution of this matter and a future congenial relationship between your Society and AWCH.

Yours sincerely,

[redacted]

IRENE HANCOCK
NATIONAL PRESIDENT

APPENDIX 3

Submission to the Joint Committee on the Health Care Complaints Commission.

Hearing held on 20 December 1995 at Parliament House

Contents

M C A MEDICAL CONSUMERS ASSOCIATION OF N.S.W.

P.O. Box 230 Balgowlah N.S.W. 2093

SECTION 1

Statement from The Medical Consumers Association of NSW

on The HCCC's First Year Of Operation and 1994-5 Annual Report

presented by Andrew Allan MCA Hon. Secretary

The Commission's annual report reveals a limited amount, but even so contradicts what members of the public have told MCA directly about their dealings with the Commission this past year. [1] Medical consumers are concerned by pain, suffering, and death at the hands of a very powerful industry, that appears quite able to control NSW governments when it needs to. [2] An eminent medical industry figure saw the role of the Commission as allowing patients to *vent their spleen.* [3] Another such worthy sees any supporter of the complaining patient viewpoint as *sly, underhand, a mischievous crook, the enemy of science and downgrader of excellence.* [4] So as MCA secretary I suppose I risk being "shot as the messenger of unwelcome news" in presenting heretical material that will offend those who have close connections with what medical victims have described as the religion of medical services supply.

However some common ground should exist here today. MCA expects all those present here have a strong desire to improve, and make safer, health care in NSW. But we have a long way to go. The recent Quality in Australian Health Care Study showed that each year about 18,000 Australians are killed by hospital errors and that about 330,000 suffer disability for the same reason. [5]

These figures must indicate the Commission is structured to cover up the extent of medical malpractice. [6] On theoretical grounds MCA would currently expect a very good complaints system in NSW to hope to get over 10,000 complaints per year, and certainly around 3,000 complaints, not just 1,787. [7] The Commission and Registry appear to be prime examples of what an eminent jurist called "The New Despotism" , they are administrative "black holes". [8] Under the HCC Act it is inherently legally impossible for the public and almost certainly also for the NSW Parliament or Ombudsman to verify how the Commission and Registry actually perform, or to discern what their practical function is in individual service responses to medical consumer complainants. [9]

MCA repeats the 1993 call from the over half million strong Coalition of Concerned Community Groups for a public inquiry into the wider issues associated with what is now unfortunately the 1993 HCC Act. [10]

In the few remaining minutes allowed I consider Client Satisfaction, Complaints Management, the Consumer Advisory Committee, and Communication.

Consumer Satisfaction

This should be a most important outcome indicator but gets just one line in the annual report, plus in the appendix the associated note *'Consumer Feedback'* shows most time and money was probably expended on talking to medical professionals, not medical consumers. The limited financial data (pages 46-52) are aggregated amounts and so totally useless for determining where the Commission actually applied its funds. [11]

Complaints Management

The annual report falsely makes complaints management look trivial. The 9 anonymous letters of praise point this way, and the few words at page 54 paint a rosy picture of satisfied medical consumer complainants. But significantly the report totally fails to give any quantitative data or details of how claimed satisfaction was objectively measured. In stark contrast are the unsolicited letters that MCA receives from time to time about the Commission's operation. Typical is one this month that describes the Commission as "... *redundant, a dinosaur of inefficiency"* and which also makes comment on Commission staff as follows: *" ... your staff called my report a communication breakdown or vindictive ... your staff were not interested."*. [17] I have been asked to report here that other consumer complainants have in letters called for the dismissal of the Commissioner, and that MCA is told by persons in two quite separate fatality cases that they would like to get criminal charges initiated against the Commissioner.

The new conciliation function appears revealed as a fraud practiced on the public. A recent case shows the Registry to be a device for uncontrollable covert counselling and a problem cover-up system. Conciliation has meant that a medical victim who has been nearly killed due to hopelessly wrong diagnosis, abuse, cuts, bruising, and sexual molestation, from various medical professionals, followed by insults and implied threats when bounced back by the Commission to the local level for complaints interviews, is then offered the spuriously named "conciliation" to help her accept the hard reality that no investigation will done, the Commission having determined her complaint to be about communication problems . [18]

If the Standards Australia 'Complaints Handling' standard was not designed to allow statutory limits to be applied the Commission and Registry would hopelessly fail to meet this Australian Standard. [12] As the Commission is but a linear development of the former Complaints Unit with the same CEO, and most senior staff, it can be safely assumed that the organisational culture is unchanged. In the light of the findings of the December 1993 Ombudsman's report, and the then Health Minister's highly questionable action in suppressing 7 consumer complaints in order to cover up mismanagement and bodgie figures in his Department [13] , why should medical consumers trust the accuracy of this annual report from the Commission ? Following the High Court's finding last

month a further doubt in the mind of consumer tax-payers must be, is the extra $1 million or more from the so called "McBride witch-hunt" to be a "off-budget item" next financial year ? [14] It is not clear that consumer complaints are to be the true driving force for the Commission. The informed consumer expectation must be that the medical industry will be even more able to call the shots under the secrecy cloak conferred by "independence". After all this "independent" Commission is a legislative captive, locked solidly into a self regulation structure of an industry that acts to insult consumers who dare to complain. [15] However the Commission is given total freedom under this anti-consumer Act to be fully independent of a complainants evidence and wishes. [16]

The Consumer Advisory Committee, CAC

This is presented as the Commission's major organ of community contact. Such a committee existed prior to the Commission. [19] MCA's direct experience on the former CAC saw it evolve into a device whereby consumers could be told what it was allowable for them to say publicly, and to allow government to falsely claim they had popular support for measures without actually having to do any expensive community consultation. The CAC was used to muzzle consumer discussion over the introduction of the anti-consumer HCC Act in 1992-3. [20] The new CAC allows even greater control of consumers. It has (or soon will have) a signed code of conduct that MCA feels must lock any consumer body represented into effective control by the Commission's machinery. MCA now only supplies a nominee (not a representative) to the CAC for this reason. [21] The new CAC cannot discuss individual cases. The CAC is now also used in conjunction with a quite spuriously named Independent Complaints Review Committee. [22] The HCC Act failed to define any consumer consultation machinery and thus the CAC operates at the whim of the Commissioner, who can disband it. It consists overwhelmingly of NGO providers, not medical consumers, and includes some medical professionals and departmental officials.

Finally it is not clear to MCA that this type of complaints Commission can ever hope to address the serious communications problems that exist. It is more likely to act as yet a further structural impediment. We note that senior management within Health have made serious attempts, in vain it would seem, to cut through the mass of professional groups and NGO quasi-professionals who all claim to speak for that almost mythical entity, the patient. At the recent Federal Task Force meeting in Sydney Mr George Rubin of NSW Health expressed his concern to MCA representatives that the NSW Medical Board had found it all but impossible to make contact with actual patients and so to be able to find out what they wanted done. [23]

MCA thanks the Joint Committee for this opportunity to provide this submission which includes the associated notes and reports as sworn evidence to extend this statement.

SECTION 2 : Explanatory Notes

These notes provide background information on views expressed in the MCA Statement to the Joint Committee (Section 1) As notice of his hearing was only received just over a week before the hearing date, material 'at hand' and printouts of letters held on disk has had to be used to represent MCA's views on the first year of operation of the HCCC and Registry. Thus some parts of segments included do not bear directly on the first year of operation; and also the presentation standard is less than MCA would have wished. MCA apologises for this. However it is felt that all of the material supplied is useful in providing a better overview of the general context for and background to the operation of the Commission in its first year of complaints management from MCA's perspective.

(Note: To find the note associated with superscript 6, for example, in the Statement look at 2.6 below.)

2.1 Annual Reporting by the Commission

Annual reports by organisations are in practical terms much more of an 'art form' than a communication medium. Even when strictly quantitative data has to be presented expert professionals are today employed to present data in such a way that vital commercial secrets are not disclosed to competitors. Such professionals also dominate public enterprises and so the technology of disinformation is unfortunately standard in governmental bodies. Problems that exist are covered up. The private sector convention is that annual reports must read like sales literature and be full of 'apple pie and motherhood statements', or the CEO and others get fired. Thus it is quite normal for the public as the government's "shareholders" not to have a clue as to the truth after reading government reports. The HCCC's annual report is no exception.

But due credit must be given to the HCCC for the case studies section which should represent a very useful training resource for medical professionals, and a warning of things to be wary of for consumers. For consumers the other key pages in the report are 26 and 37 which are in effect the only detailed outcomes statement.

However medical consumers would be also interested to know more about how the hours of the staff were actually spent. Of problems encountered. To have a score card and list of doctors names and addresses that have substantiated complaints against them. To know what the kill rate and golden-staph cross infection league tables etc. are for NSW hospital units. If such data were available the HCCC could charge money for its annual report and get lots of buyers. It would be a best seller up there with the Sydney Street directory.

But this is all wishful thinking. (Apart from the statistical problem that the HCCC is probably incapable of addressing such a task with any certainty because it cannot manage

the data flows needed to get a sufficient sample size.) We live in a "free democracy" and in NSW ("The Defamation Capital of the World") so such data must be kept top secret from the public anyway. So all the average NSW medical consumer can do is pray to whatever God (s)he follows when illness hits and make a totally uninformed 'choice of doctor' and hospital etc., depending just on divine providence to prevent ending up as fodder for the rapacious medical services industry.

2.2 Medical Services Industry: Control of Government

This industry trades on keeping knowledge of its craft obscure from the wider community and makes claims to self regulation and primacy of opinion that virtually no other industry does. Thus self regulation of the industry and market control extends without limit. Much has been written about this effect. The Joint Committee is directed in particular to the paper by Tony Dugdale "Restructuring legal and health services: the challenge to the professions", in the Journal Professional Negligence for May/June 1989. It is perhaps worth noting that the votes in the NSW Parliament of MPs who are also qualified doctors were decisive in getting the HCC Act passed in 1993, and that debate in the upper house was also associated with those close to the industry.

Also long prior to the Bill ever appearing the ***Australian Dr Weekly*** for 22 June 1990 in *"Complaints unit under fire from doctors"* Reported a longstanding campaign by the AMA mounted against the Unit that apparently was having effects and that the NSW Medical Board had recently recommended changes proposing that two separate bodies be established:

> "An independent health services Commissioner would conciliate complaints in one and the other would prosecute complaints in formal proceedings against medical practitioners.
> Complaints unit director Merrilyn Walton has argued strongly against the proposal, saying it is against the public interest and would weaken the unit's powers. Ms Walton said the comments made at the AMA's conference were "nonsense".
> She said the AMA represented only a minority of doctors and that most of the medical profession supported the unit, as did patients and other health consumers. The unit had good working relations with the MDU until the union recently lost a case which arose out of a complaint investigated by the unit, she said. The attack had arisen because the unit challenged the medical profession's right to operate behind "closed doors", she said. "

So some five years down the track it is clear very clear who won. The score-card reads.

The Public Interest	0
The shadowy medical "forces of darkness"	10
Medical system victims	-10

Doctors do not like to lose. The "forces of darkness" got just about all they could have wished for in an Act that is a minefield to operate and probably has the potential to denude a number of forests due to the mountains of paperwork that progressing complaints takes. The 'king hit' against consumers is Section 27 which allows the Commission to reject any complaint. (See also ***The Democratic Process ?***)

But as they say : It doesn't end there. The AMA have just withdrawn support for the Commission and are moving again to now oppose their new Commission, presumably they want not only a non-functional legislative monstrosity but wish to reduce even this to a 'smoking wreck' with their new expected wave of attacks, just to make doubly sure that doctors are not prosecuted.

2.3-4 Views expressed about medical consumers making complaints

A view of the complaints management system and the move to include conciliation was reported in 1993. Dr Craig Lilienthal of the MDU was quoted in The Australian Dr Weekly 28th May 1993 as saying that unsatisfied consumers could *vent their spleen* via the complaints management system and thus doctor and patient would be able to get together and come to some agreement through the system.

In 1993 *Australian Private Doctor* ran the line "Consumerism is like maggots in the meat". It quoted the president of the Private Doctors Association Dr John MacKellar as seeing 'consumerism' as something insidiously conceived in the United States and now the calling card of the evil Left and of arguing that *"the consumer advocate is very often a sly, underhand and mischievous crook. He is the enemy of science, the destroyer of elitism and the downgrader of excellence."*
However some hope clearly does exist for medical consumers. There are a lot of ethical doctors out there and so this outburst by Dr MacKellar was questioned in an editorial by The *Medical Observer* of 20th August.

2.5 The Quality in Australian Health Care Study

The death and injury figures are taken from the Sydney Morning Herald for Monday November 6, 1995 Page 2 ***"Hospital errors kill 18,000 a year: Study"*** The Joint Committee are referred to material in Section 4: The MCA Briefing Note on QAHCS correspondence and also the MCA newsletters ***Medi-tation*** for July-Sept. 1995 and Oct-Dec. 1995 for more information.

2.6 Structure of the Commission

MCA opposed the form of linkage inherent in the HCC Act. The Joint Committee are referred to the 1993 MCA documents in Section 4 ***The Democratic Process ?*** and to

the MCA document ***Indemnity Insurance: the Case for Change*** for MCA's related views.

2.7 Complaints management theory

From the QAHCS data it would not be at all unreasonable to assume that major failures in the provision of services nationwide could give rise to at least 400,000 complaints per year. So that for NSW a figure of say around 150,000 complaints per year does not seem unreasonable. If one considers that in NSW of the order of 400 major service locations could be said to exist this translates to around one complaint per day from each site. But evidence from other industries * is that 96% of people fail to complain when they have good reason to. This suggests an expectation for a figure of around 6000 complaints per year. If in NSW consumers are say half as ready to defend their rights** as United States citizens are this gives around 3000 complaints per year as an expected figure.

MCA cannot claim that this calculation is any more reliable than the type of calculation that is used to determine what the likelihood of there being intelligent life elsewhere in the Universe. Rather the point of trying to do this calculation here is to make the Joint Committee realise that what we are talking about here is not little green men 10,000 light years away but a life and death issue here today for all NSW medical consumers. The simple absence of any reliable data to work with should cause informed medical consumers in NSW to seriously question if intelligent life exists in the NSW Health Department , or more properly in the NSW Parliament.

It is noted that MCA's correspondence with the Australian Democrats on this issue in February 1994 well before the QAHCS data became available (see the MCA report on ***The Democratic Process ?***) left the MCA Committee feeling that it was quite impossible to explain any of this to those at Macquarie Street !

What MCA very strongly suspects is actually going on is that the all pervasive medical industry culture (the well known walls of silence effect etc.) is at work and a complaints management system is converting complaints as follows.

1) Generally consumer complaints get converted into inquiries only.

2) Persistent medical consumers with complaints get classified as mad crazy people and rejected as vindictive etc. (or in Queensland end up being actually put in the "nut-house" against their will to shut them up and prevent any compensation pay out. See MCA case study **F21394**)

3) People with some medical background or better education get a bit further but find only conciliation with expert 'walls of silence' operatives offered.

4) But if the complainant has poor English , or limited verbal and written skills they get stopped much earlier in the complaints management process.

5) In contrast if the medical industry wishes to take action then millions of dollars of tax-payers funds can be spent and patients records raided to try to 'get the goods' on a particular provider. No medical consumer complaints are even needed in such cases.

* In the 1980's TARP, a research firm, carried out studies on customer behaviour for the Carter administration's Office of Consumer Affairs. The findings are summarized by Karl Albrecht and Ron Zemke in ***Service America !*** at pages 6-7 publisher Dow-Jones Irwin 1985.

** Of course Australians do not technically have any clear rights to defend. (see Hilary Charlesworth (1993) , The Australian Reluctance about Rights, Osgoode Hall law Journal Vol 31 No 1 page 197 -232.)

2.8 An Infinite Scope for Administrative Law

Entities such as the Commission are set up to be independent. Baron Gordon Hewart in ***The New Despotism*** (publisher Ernest Benn Limited 1943) identified a creed that such independent ardent bureaucrats can reflect as follows:

1) The business of the Executive is to govern.

2) The only persons fit to govern are experts.

3) The experts in the art of government are the permanent officials, who exhibiting an ancient and too much neglected virtue "think themselves worthy of great things, being worthy".

4) But the expert must deal with things as they are. The "foursquare man" makes the best of the circumstances in which he finds himself.

5) Two main obstacles hamper the beneficent work of the expert. One is the Sovereignty of Parliament, and the other is the Rule of Law.

6) A kind of fetish-worship, prevalent among an ignorant public, prevents the destruction of these obstacles. The expert, therefore, must make use of the first in order to frustrate the second.

7) To this end let him, under Parliamentary forms, clothe himself with despotic power, and then, because the forms *are* Parliamentary, defy the Law Courts.

8) This course will prove tolerably simple if he can :

(a) get legislation passed in skeleton form;

(b) fill up the gaps with his own rules, orders, and regulations;

(c) make it difficult or impossible for Parliament to check the said rules, orders, regulations;

(d) secure for them the force of statute;

(e) make his own decision final;

(f) arrange that the fact of his decision shall be conclusive proof of its legality;

(g) take power to modify the provisions of statutes;

and (h) prevent and avoid any sort of appeal to a Court of Law.

For those who have traced the evolution of the Unit (the proto-Commission) and now the Commission this concise blueprint explains what has been going on. The support of PIAC for a minimalist legislation form for the HCC Bill. Use of the PIAC "legal eagles" on such groups as ARAFMI, and PIAC's amazing insistence that just one Commissioner and full exemption from FOI was vital to "the consumer interest" all neatly fall into place. Note also the strong correlation between such a creed and that of some very eminent medical professionals when it comes to autonomy of action.

2.9 Assessment of the Commission's performance

MCA must seriously question if the Commission's annual report is anything more than a product of selective editing. Nine glowing letters of commendation and not a single upset medical consumer in sight ? Certainly the Commission staff do not seem quite as happy as in past Complaints Unit annual reports, we see less "lovely photos of smiling people". But perhaps this just connected with a report graphics publishing policy shift following the publicity surrounding the notorious E-mail of December 1993. (See page 14 of **The Democratic Process ?** in Section 4)

The real problem is how does anyone get below such froth and trivia and so find out what actually is going on when one urgently needs to ? The HCCC is largely exempt from FOI, it is set up as a high security area, The Parliamentary Joint Committee cannot get down to such a detailed level, the director-general of Health appears "locked out" (see The SUN-HERALD May 21 1995 page 22 *"Question of Priorities"*) and MCA still feels that owing to provisions in the HCCC Act so is the NSW Ombudsman. It is just not clear to MCA that when a consumer has a complaint against the HCCC that the HCCC can be said to be part of a democratic Westminster system at all. Independence can just mean unaccountablity. This even turns out to be the reality for consumers and the NSW Legal Aid Commission which is governed by legislation that actually at first sight seems to have more checks and balances than the HCC Act.

Consumers and tax-payers seem to agree that government annual reports are full of statistics and that a fuller sequence of doubtful propositions should thus read : Lies, Damned Lies, Statistics, and Annual Reports.

As the above shows it is by such material alone that the NSW public will be told just what a wonderful job the Commission and Registry are doing.

2.10 The passage of the 1993 HCC Act

The Joint Committee are referred to the 1993 MCA document in Section 4 ***The Democratic Process ?*** for more information.

2.11 The Numbers Racket: Use of aggregated amounts in the Annual report

No breakdown of staff time is shown in the accounts. When a business has annual operating costs of $3,519,000 and employee related costs are $2,330,000 uncharted except for simple statutory deductions as note 3(a), one knows virtually nothing about how the money was actually spent. Good accounting if another McBride case should pop up ?

The report contains lots of nice round figures. The reporting resolution being $1000, which must be just petty cash for these top bureaucrats, and it's only tax-payers money after all.

Users (* medical consumers directly ?) apparently paid the Commission a nice round total of $100,000 and other unnamed entities paid the Commission $198,000 for what ? The annual report is quite clear for what at page 50 where the mystery is explained as ***"Other"***.

* 268 complaints were investigated and substantiated. In the very unlikely event that at note 4 ***User Charges Services*** was in fact hard cash from injured consumers for services successfully rendered then could it be that those who did not pay $373.13 on average to get an investigation done missed out ?

The real problem for both tax-payers and medical consumers (who have actually paid for it all) is that such observations are totally pointless as M.T. Spriggins ACA has accepted the accounts as meeting the requirements of the Public Finance and Audit Act 1983.

A simple query from page 11 where do the complaints come from ? The source of 86% of complaints are explained, but who lodges the remaining 14% ?

2.12 Standards Generally

One of the features of the medical services industry is its insistence that it is totally different to all other forms of human endeavour. It always demands to be treated differently, particularly in Australia where one would think that Australians are a life form biologically very different to humans elsewhere on the planet if one accepts at face value what some medical authorities say in defence of 'their turf'. This spills over into

complaints management. Thus medical complaints management becomes more akin to management of Whistleblowing and the professional interests fight against any use of standards that could reduce the scope for exercise of their established professional autonomy and powerbase. In contrast standards have been developed in California and a Board of Quality Assurance set up so that terms like medical negligence actually have some meaning. In NSW even gross negligence (a term that is used in the HCC Act) has no meaning.

MCA does not think that the HCCC can address any issues of negligence at all. We refer the Joint Committee to an HCCC Issues Paper from 1994.

The HCCC issued an Issues Paper Investigating Allegations of Malpractice 1 Sept. 1994 in CAC agenda papers for the CAC meeting of 26-9-94. This seemed to show the problems caused by the way the Act became law and seemed to show the Commission would have problems with Section 80(1)(j) of its Act. As the agenda papers reached MCA on 22 Sept by express post and MCA had a meeting with CVAG that same day MCA did discuss these issues with CVAG and gave them a copy of the Issues paper. MCA was planning to do a newsletter item on the Issues paper to tell members about this as the difference between professional misconduct and negligence are a major problem for many victims. On Monday at the CAC meeting commented on this paper and that our members would be interested in the matter. We were told by Mr Blackmore of the HCCC not to discuss this paper at all outside the CAC as it was a draft paper only and should be treated as confidential.

We note that nowhere is this paper marked as being a draft. Once again due to sloppy procedures used by the HCCC in the CAC MCA could well have ended up being accused of breaching CAC confidentiality. In fact nothing happened we did not tell the HCCC or CAC that we had already given a copy of the Issues Paper to another consumer group. We did not run the newsletter item and told CVAG soon after the CAC meeting that the Issues paper was considered confidential by the HCCC and should not be quoted or used in any communication.

MCA feels that this type of incident shows just how difficult it has been to work with the CAC and HCCC. We also do not see really what the point is of preparing an Issues Paper 8 pages long that probably cost some thousands of dollars to produce (it is a detailed legal one) on a topic that in this case related to general matters of standards and procedure development and then to make it impossible to have general community discussion about it.

2.13 Seven Consumer Complaints discredited and suppressed by the then Health Minister in the The Sex, Lies, and E-Mail Tape Saga

The froth and bubble generators at the Health Ministry were running flat out in December 1993 over the Ombudsman's Special Report to Parliament number 07/93 issued on 13 December 1993. Thus the very serious substance of the report (that the complaints of 7 medical consumers about the complaints Unit were valid and that mismanagement was the cause) was lost in a orgy of media coverage of the subjects that sells papers best (i.e. sex, lies, and gossip) leaving a wrong impression in the public mind that the Ombudsman's report was biased and thus incorrect.

The later report of 18 January 1994, **Inquiry into matters relating to the investigation and report of the Ombudsman of the Department of Health Complaints Unit and its Director Ms Walton** by The Hon. T.R. Morling Q.C. investigating this supposed bias received no such coverage. It concluded that :

> The Ombudsman's report is very critical of the Complaint Unit's performance in the handling of complaints made to it. Whether the findings and expressions of opinion contained in the report are justified or not is not for me to say. Plainly the Department and Ms Walton believe they are not justified. They will therefore be disappointed with this report. But, in my opinion, it cannot be said that there is no basis upon which the Ombudsman could have properly reached the views expressed in his report: His critical views are not of themselves indicative of bias, and there is no evidence which could justify a finding of actual bias against him or any of his officers. Moreover, for the reasons given above, I do not think there is a reasonable apprehension that the investigation which gave rise to the report, or the report itself, were affected by bias.

But with no media coverage this had no effect on the public perception.

Minister Phillips had tabled in Parliament illegally obtained material, including the Sex-Lies E-mail, from the Ombudsman's Office that Ms Walton said later in the CAC had just arrived on her desk in mid 1993. She appeared on the TV as a wounded and upset party This TV appearance seemed in the public mind to have converted the Ombudsman's section 26 report findings of mismanagement into an unfair personal attack on her. The Sydney Morning Herald of 15-12-93 by now having shed its tradition of being a serious newspaper and glorying in its changed status as a scandal sheet ran the page 2 headline ***Landa's office faces backlash on "boffing"*** aiding the effect by wrongly reporting that a disaffected ex-Ombudsman's officer had *"poured out a diatribe against Merrilyn Walton ...."*

ICAC was said to be involved as well in an investigation into the mess, but connected events, the serious breach of the Ombudsman's Act (passing of documents, including a paper copy of the Sex-Lies E-mail quite illegally to Health Department staff) do not seem to ever have been addressed, or if they were, details of action taken never reached the mass media.

The MCA Secretary was able to talk personally to Mr Lander later about his report (on 28th February 1994 at a Social Policy Directorate Seminar at which Mr Lander presented a paper) He told our Secretary that Ms Walton had held his draft report since mid 1993 and that a copy had also been sent to Minister Phillips but that Mr Phillips was not agreeable to the report being made public. Mr Lander said to the MCA Secretary that he had been trying to get Mr Phillips to see him personally about this matter for some time and had finally managed to get a meeting time and place agreed in late 1993 but that Mr Phillips just failed to arrive for the agreed meeting and thus Mr Lander said that he felt he had to continue with the normal process and so had released his report. Mr Phillips then had rapidly made his attack in the Parliament. Thus the seven consumer complaints about the Complaints Unit that the Ombudsman's report verified as true have been effectively publicly suppressed due to Minister Phillips' actions. Some MCA members remain very upset by this.

Minister Phillips had called the Ombudsman's report biased. A review of it by The Hon. T.R. Morling Q.C. found it not to be biased, but this was not accepted by the Minister. So while publicly still rejecting the Ombudsman's report it seems that Health started to implement its key recommendation. At the end The Ombudsman's report (07/93) says:

> *11.5 On the information provided it is not possible to assess the effectiveness of the new strategies. I am not confident that the Unit will not fall back into earlier patterns of mismanagement once this investigation is completed, as occurred after the 1988 investigation of this office. Therefore, I consider that an external management review of the Unit is essential. Given that the problems have been so entrenched, it is vital that they are resolved, and resolved before the Unit becomes a Commission, as provided for in the Health Care Complaints Act.*

The Minister authorised such a review. (Ms Walton apparently discussing the scope for the review with Richard Lumley, Partner KPMG, of this management consultancy. The report was named "Complaints File Management System Post Implementation Review of Operational Enhancements Initiatives" April 1994, DOH94R/CFMS/R 1803)

This KPMG review was claimed by Ms Walton on 27th June to MCA (and other members of the Consumer Advisory Committee to the Complaints Unit) to vindicate her over the false criticisms made by the Ombudsman's section 26 report of 1993 which she said had been prepared without any personal contact with her by the Ombudsman's office.

Ms Walton specifically told CAC members on 27th June 1994 that it was ok to tell others of the existence of this KPMG report and that it vindicated the Unit over the Ombudsman's report but that no photocopies were to be made of it. The MCA rep. noted this all down in his diary at the CAC meeting. The existence of the KPMG report was noted at a public MCA meeting shortly afterwards and the meeting told of Ms

Walton's view but no details were provided. MCA was approached by the press who asked for a copy. MCA refused to supply a copy, suggesting they contact MP's (it had been issued to MP's), Ms Walton, or KPMG for a copy. They must have done this as a story appeared in the **Sun-Herald** on July 17 1994 ***Medical complaints let down*** page 19 which said *victims of negligence were putting their trust in people who lack investigative skills* and talked of a confidential KPMG report.

At the next CAC meeting on 26-9-94 MCA was attacked and accused of breaching confidentially. It was or course impossible for the MCA representative to prove that no copies had been supplied to other MCA members or the press. Also the minutes of the last CAC meeting which as usual were issued only hours before the next meeting failed to report what Ms Walton had said about the KPMG report. The minutes incorrectly just said the KPMG report was confidential and failed to report what Ms Walton had actually said.

It was not really clear to MCA at the time why Ms Walton would wish to place such restrictions on a report that she claimed to the CAC vindicated her. The report does not contain any material that relates to personal files of complainants, and is not marked confidential anywhere. As the title makes clear it relates to a review of management changes made in the Complaints Unit and was carried out in 1994 over a full year after the investigations by the Ombudsman that led to his office issuing his draft section 26 report in mid 1993 to Ms Walton for comment. The KPMG review does not even mention the Ombudsman's investigation of the Unit. But it did seem to MCA to confirm that at the time the Ombudsman did his investigation the Unit must have been in a mess and still in 1994 had not solved all its problems, but it reported that the Unit was on the path to doing so. How this KPMG report can really be said to vindicate Ms Walton or really contradict the Ombudsman's findings MCA still does not understand.

MCA now has to feel that Ms Walton was playing politics with the CAC and so fully involved with the Minister's face saving manoeuvres. Thus the KPMG report must have been introduced in this way in agenda papers just prior the 27th June 1994 CAC meeting so that the other members of the CAC, who did not seem to have bothered to even read it when asked by the MCA rep. , would be informed clearly as to Ms Walton's view of its content.

A questions that haunt the minds of medical consumers whose complaints were squashed by the Minister for Health include: Did Ms Walton get any promises over future employment from the Minister following the Minister's stunt to save face for Health by making use, very publicly, of the offensive material that Ms Walton seems to have held for months and that was tabled in Parliament to produce distraction as the Sex Lies and E-Mail tapes media event of December 1993 ? And just how and when did Mr Phillips become aware that this illegally obtained material even existed ? A member of an MCA

affiliate did some searching and got details of material tabled. MCA is informed that the 'deep throat' from the Ombudsman's office met with officers from Health and the illegal document hand-over was conducted, in the best traditions for such events, in an underground car park somewhere in the Sydney CBD.

MCA attempts to understand what some may see as 'this old matter' now as we remain very concerned at the manner of treatment of the seven consumer complainants that initiated the Ombudsmans report. MCA feels they were very badly treated by what the Health Minister did in Parliament to discredit their complaints, clearly purely to save his Department's face. This matter demonstrates that even when medical consumers could get access to the Ombudsman over complaints against the complaints system, before the complaints system became protected by statute, they still lost out due to what MCA must see as illegal and disgusting actions. What chance do poor forgotten aggrieved medical consumers stand when public administration in NSW gets up to such games ?

Also MCA does not think that the Ombudsman could, due to the structure of the 1993 HCC Act, now even carry out this type of investigation.

2.14 The McBride case

The Ombudsmans Report (07/93) of 13 Dec 1993 made the general point that:
It is not acceptable to spend scarce resources on a handful of high profile cases and leave hundreds of ordinary files to languish.

Some estimates of the cost of the McBride investigation put it as greater than the current budget for the Commission. Thanks to bodgie figures the public may never know the full cost. No consumer complaints were made against Dr McBride so apparently The Complaints Unit set out to generate some. The fact that such massive funding could be used to "investigate" a matter that is of virtually no immediate importance to any medical consumers in NSW at a time when hundreds of medical consumers are being killed by various medical malpractices MCA feels shows that the medical complaints management systems in NSW really have had very little to do historically with responding to the wishes and complaints of medical consumers.

MCA notes that the Court of Appeal's President's very recent comments are scathing about the way the matter was conducted. Justice Kirby is reported as saying
"One might expect, in such an extensive audit, that some charges at least might not be made out. But to succeed in only one particular of one case of so many complaints (and then a minor one) presented against Dr McBride necessarily raises a serious question concerning the judgement of these who brought the complaints". (SMH 30-11-95)

As the new Commission is in reality only the old Complaints Unit Mark2 MCA suggests that the new Commission has a very long way to go before medical consumers will see claims made by the Commission to be Independent and impartial as other than pure fantasy.

The Commission may well be allowed to function as the investigative branch of the various medical registration boards and shadowy industry interests that are the ugly face of self regulation of the medical services industry. Thus it will be allowed to investigate professional misconduct but that will be its effective limit most of the time.

2.15 How Registration Boards Actually Operate

Those who wish to see demonstrated the utter futility of the medical registration board system, as it relates to the needs of medical consumers, need look no further than the NSW Ombudsman's Report of 3 July 1995 **Investigation of complaints about the conduct of the Psychologists Registration Board in relation to its registration and complaints handling procedures**. This shows how complaints from the public are treated with utter contempt.

This Board that was set up five years ago because the public were then told they were at risk from substandard practices existing because registration of psychologists was not available to set standards now writes to MCA (letter of 4-12-95) rejecting the Ombudsman's key recommendation saying it does not believe it *"necessary or practical"* for the Board to be satisfied that applicants for registration have demonstrated professional competence !

MCA has to feel that the only reality of registration and interest in it by specialities who wish to be seen as 'professionals' is that it gets the registered persons on the professional schedule fee gravy train.

The Ombudsman in effect ordered (by making a recommendation) the Psychologists Registration Board to write letters of apology to the two complainants. One complainant was Mr Barry Hart who has had well over 20 years of his life destroyed due to worthless psychological practices that directly caused false diagnosis and led to false imprisonment and assault by doctors that left him with permanent brain damage and unemployable. Mr Hart finds his so called letter of apology from the Board offensive, showing that the Board has learnt nothing and he calls for the dismissal of the board. MCA feels that all medical consumers will feel the same as Mr Hart when they read the Report and the letter. But it's no good writing to the Board for a copy of the letter. They claim its not the policy of the Board to provide copies of its correspondence to a third party* and

refused to send a copy to MCA. Mr Hart is only too pleased to supply a copy so if The Joint Committee want a copy write to Mr Hart or CVAG.

(*but MCA notes that they did just this with correspondence from the other complainant. If persons are found to be not of good character they can be de-registered by a Board. So a question that needs to be asked is can a Board de-register Board members?)

Discussion within MCA on these matters led to the lateral thinking suggestion that some psychology should be used directly on the Board members and that the Ombudsman's office should recommend that when these shonky registration boards have to supply letters of apology to members of the public, as well all that the particular board should all be "recommended" to stand in the Pitt Street Mall in a special 'sin bin' **(a new public official penance zone)** for a week (9am to 5pm) with copies of letters attached to their front and back so that the public can see that their apology is real. The deterrence effect of this could have a very positive effect on all such Boards that are supposed to exist in order to protect the public but seem to have lost the plot totally and only have dollar signs in their eyes.

2.16 The situation of being an unworthy victim

MCA cannot seriously recommend that large classes of medical consumers with certain types of complaint go anywhere near the Commission. They risk being classified as an unworthy complainant if their complaint is not a 'politically correct one' or is made against a 'protected class' of person. See also the Mug Punters Guide in Section 4.

2.17 A recent letter

The text of most * of this is reproduced below. (* As MCA has not had time to contact the medical consumer involved yet, we only got 8 days notice of this hearing of the Joint Committee, we felt it was only proper to blank out the names etc.)

2.18 Recent cases where conciliation was offered

F21294a Condensed Case Account, derived from documents provided by the medical consumer to MCA. All identifying features have been excluded.

Over 4 months I was given antibiotics for bouts of a urinary tract infection. **Saturday** I developed severe abdominal pain. The GP sent me as an emergency to hospital X where appendicitis and urinary tract infection were ruled out. I was referred to see a gynaecologist on Monday. I was told to go home and take 2 Panadol.

Sunday, as still in unbearable pain plus loss of muscular control, took a taxi to hospital Z. Was admitted. Blood pressure 200/100. Given series of pethidine injections to ease pain. Cleared of gynaecological problems. Given various tests, results all normal. Told symptoms were due to stress. Fell over striking head on floor when attempting to carry out doctor's orders to walk. By Tuesday quite unable to walk. Told to go home and that I would be fine in a few days time. Carried home by a close friend. Spent Wednesday bedridden at home. Thursday back at hospital Z to get results. Asked to do coordination tests again collapsed. Then the psychiatrist ordered me to walk refusing my request for a wheel chair. I tried to walk as ordered but collapsed off the bed, striking my head on the floor again. He quizzed me on my past and my sexual history. I chose to go home, again assisted by the friend, when told that I could only be admitted to a psychiatric ward.

Saturday saw the GP again who felt the infection had progressed. Immediately sent for a CT brain scan at hospital X because of paralysis. At hospital X was told that I had to see a psychiatrist before being allowed to see the neurologist. He carried out coordination tests and informed me that I had mental problems. His comments and actions were unusual and disturbing (things like "take your pants off now" "Oh ! you've got knickers on ") His touching was different and he found it necessary to touch and push my breasts. I felt he actually sexually molested me. 5 hours later I got to see the neurologist who told me that hospital Z said my problems were stress related and that I must be admitted now and be seen by another psychiatrist, social worker and physiotherapist. I was thus admitted, it seems as a mental case, without being given any real choice in the matter. Thanks to the assistance of my close friend I was able to get mobility assistance soon after and so was able to discharge myself at 7pm that same day.

Tuesday attended the GP who confirmed that I now had chronic infection. Urgent tests done and saw a physician and urologist. Blood test showed hypothyroidism. My immune system had turned against itself, the condition was a fatal one if not treated fast. By the time I received the correct medication I had lost my vision and was paralysed. Fortunately the condition was caught just in time and the lost faculties appear to have returned.

Over the next few months the consumer obtained hospital records. These show that the hospitals ignored what they were told by the patient, and lied to her as to what they had written in reports. All symptoms, actions, falls etc, were ascribed to serious psychiatric illness. Thyroid problems had been negligently ruled out by the hospitals and no blood test for this done. The consumer wrote letters which were not replied to by the medical bodies involved. The Medical Board just passed a letter on to the HCCC. Thus the consumer requested that MCA attend an initial complaints meeting at hospital Z. MCA found this meeting was unstructured and run in a way that was unacceptable as a complaints process interview.

The stance of the hospital at interview was most dishonest and both the hospital and area board members tried to discredit what the consumer said and treated her as mentally ill. (MCA was present at this interview). Owing to the consumer's type of career her professional employment is almost certainly at an end if the record of psychiatric illness stands. MCA asked how the false diagnosis of mental illness could be expunged from the personal records. The 'offended and abrupt' response from the senior medical officer was that medical records were legal documents and thus could not be changed in any way. When MCA pressed the sexual assault issue the medical officer warned MCA of defamation. The medical officer ended by saying that some form of apology could be due to the consumer. Later the hospital apparently told the HCCC that they just did not know what the consumer wanted done.

Hospital X took a more aggressive stance and objecting strongly to the allegation of sexual assault, insisting the consumer had serious mental problems. Via the GP the consumer found out that the hospital was attempting to carry out searches into the consumer's history and background trying without success to find anything that might be shown to be connected with mental or psychological illness. After further letters asking for action from the HCCC and asking that the false records of mental illness generated be removed from the medical records the problems were said by the HCCC to be ones of communication and the medical consumer was thus offered conciliation not with the doctors involved but with the most aggressive of the hospital administrators encountered earlier. The consumer did not feel that sexual assault, or misdiagnosis that could well have been fatal, were suitable for conciliation, but asked about what would happen in conciliation. The consumer was clearly told by letter that it was in effect counselling for her. Then her case file was closed by the HCCC because the hospital was not willing to take part. She is disgusted with the system.

A very complex and long running case is that of Dr Ooi who has a very disabled son, thanks to negligence overseas by a hospital back in 1973.

The background to the case

MCA has been told by the plaintiff that the court case overseas was conducted as follows.

1) The defence was controlled by the Sydney office of the MDU.
2) The only medical expert called was the defendant doctor.
3) The evidence given by this doctor as to what constitutes correct medical practice was a contradiction of established medical practice.

(The plaintiff has since obtained medical expert opinion based on the hospital records of the case that shows the medical treatment in question at the original trial to be negligent and that the testimony of the defendant doctor in the original court action was clearly not correct.)

4) A medical report, relating to hospital treatment, was presented as complete to the court by the defence, when in fact sections had been removed in order to suppress medical opinion that would have been in favour of the plaintiff.
5) The Judge was deceived due to the way the case was run by the defence and the plaintiff lost the case and was threatened with a defamation action if an appeal action was made. No appeal was made, the costs and threats being the reasons.

Dr Ooi contacted MCA in 1989 about this matter. Soon after the MDU phoned up MCA offering to show details of the case and interested to know what MCA had been told. MCA outlined by letter what the plaintiff had said. The defence organisation replied to MCA by letter that MCA had only heard one side of the story, was biased and MDU refused to have further correspondence with MCA. MCA can only assume that the MDU was on a fishing expedition because of the way that this manoeuvre was conducted. The defense organisation found out all that MCA had been told but revealed nothing .

In 1993 another doctor was found willing to act as a mediator in face to face discussion between Dr Ooi and Dr Lilienthal of the MDU. MCA took this opportunity to restart correspondence with the defence organisation in the hope of assisting the resolution of this long outstanding matter by mediation. However by late 1994 and a series of nine letters with Dr Lilienthal of the MDU the MDU had failed to explain itself, or put its side of the case. MCA's conclusion is that this defence organisation as represented by Dr Lilienthal was not sensible to any appeal to moral or ethical values. The mediation got nowhere either.

This defense organisation appears effectively above the law because of the way that they operated by subcontract and employ medical opinion. MCA feels that probably no medico-legal experts exist in Australia who can counter the medical opinion and legal forces that the large defence unions can muster. They certainly have the potential to win cases by use of methods which would have to fall well outside the law, but secrecy and use of medical opinion, plus shear financial muscle, makes it very easy for them to operate in such a manner with impunity.

How HCCC conciliation became offered

By January 1989, now living in Sydney Dr Ooi started legal action in the NSW small claims tribunal, seeking replies, refund of fees (because MDU had breached its contract over the way that it acted over the trial it had breached its ethical code that forms part of its undertakings to members) and his sons medical reports held from the trial.
Dr Ooi lost. Because of not understanding procedure his documents were not lodged prior to the hearing and so the magistrate in effect only took verbal evidence and just did not seem to understand issues in the case at all. Dr Ooi clearly knew that the MDU's verbal evidence involved perjury and false swearing by Dr Vallentine of the MDU but Dr Ooi could do nothing about this.

Dr Ooi had been complaining since March 1988 to the Complaints Unit about the conduct of Dr Vallentine but an evaluation of 11-4-88 , a letter from Ms Walton read in part as follows
" I am satisfied from your account that Dr Valentine's (sic) actions and those of the Medical Defence Union were not other than could be reasonably expected of them in those circumstances and accordingly I do not accept I do not accept your complaint against Dr Vallentine as one requiring further investigation. ..... Accordingly, I am now closing the file."

Dr Ooi obtained the opinion of an experienced barrister which was that MDU/Vallentine had indulged in "misrepresentation, deceit and conspiracy"

The matter simmered on Dr Ooi sought further legal advice The Unit would not accept Dr Ooi's further documents. Dr Ooi sought Police opinion and was told that one of MUD's early letters could well constitute blackmail.

On 12 June 1992 Australian Dr Weekly contained an attack by Dr Lilienthal of the MDU which painted Dr Ooi as beating up a cause which was ill-founded for a decade. This put pressure on Dr Ooi's practice and caused Dr Ooi various other problems. Dr Ooi sought legal advice about if he had a case in defamation against Dr Lilienthal.

In extreme summary by 1994 Dr Ooi's practice had fallen apart he had got legal advice from a barrister that MDU's conduct could be legally considered as "misrepresentation, deceit and/or conspiracy to pervert the course of justice" and from a senior Police Officer that "blackmail" as well could be present but the Unit/Commission would not consider new documentary evidence and in their files the matter remained that the MDU officers conduct was "reasonable".

Very recently indeed Dr Ooi has apparently got an offer from the Commission or Registry for conciliation on these matters. The question he is asking is does this amount to anything useful ? MCA is at a loss to know as well.

What makes this case so unusual is that Dr Ooi as a medical doctor was in the best position to know just what had actually happened to his son and why, and started out with the simple aim of getting reasonable compensation for the matter, so as to be able to provide for his son. What Dr Ooi actually found was that the MDU set out to deceive the court and later to destroy him financially. In recent years Dr Ooi has been writing papers for medical conferences that relate to the case of his brain damaged son, and how his son get that way, in order to warn others about MDO's and has thus become visible in medical circles. He has just told the MCA secretariate that now cannot get professional medical indemnity insurance from the defence unions. This case shows clearly just how powerful the MDO's are when it comes to controlling doctors and how useless regulatory systems such as the Unit/Commission prove to be. Presumably Dr Ooi has to be made an example of, to keep the rest of the sheep safely in the pen and paying their increasingly large membership payments for exactly what, they are not supposed know, or to ask.

2.19 History of the Consumer Advisory Committee

The Joint Committee are referred to the 1993 MCA document in Section 4 ***The Democratic Process ?*** and the briefing notes in the same section.

2.20 Nature of the 1993 HCC Act

The Joint Committee are referred to the 1993 MCA document in Section 4 ***The Democratic Process ?*** for more information. It is also noted that the Ombudsman's report of December 1993 said :

8.17 ..... It may be that the Unit not be responsible for conducting prosecutions in the Tribunals and before Professional Standards Committees. It may be that government policy on this issue needs to be changed. However such examination is beyond the scope of this investigation.

2.21 Nominee or representative to the CAC

MCA has been represented on the CAC to the Unit since its establishment. After some 4 to 5 years, by about 1990, MCA was finding communication problems existed and critical comment about specific cases was becoming unacceptable to the Unit. MCA was seen as very disruptive by 1991 over a heart attack case and an alleged rape case.

On 12 May 1993 MCA with many other community groups saw Bob Carr and Andrew Refshauge and later that day issued a joint press statement with others in opposition to the Health Care Complaints Bill. MCA was then attacked individually by some members of the CAC and by letter of 8 July 1993 by the CAC. Mr Allan responded with a letter just seeking more information. His letter was returned marked not known Return to Sender. At the next CAC meeting Mr Allan sought to defuse the situation but explained that MCA felt it had a perfect right to act in joint matters with other community groups and that representative membership on the CAC should not prevent this.
Over the next year it become clear that the views of the new Commission was that a formal code of conduct was needed and MCA the terms imposed by this led to MCA finding this made it impossible to still supply a representative, because of the difficult position the MCA representative had been placed in several times. The solution MCA adopted was to supply a non MCA committee member as just a nominee to the CAC. This has the effect of clearly dissociating the MCA nominee from the policy of MCA in talking to third parties, policy etc. and removed any need for the nominee to report what was said in the CAC back to MCA.

It should be realised that the CAC papers and Minutes are now formally defined as being confidential. The Commission who supply all support services to the CAC are to prepare public versions of all CAC meeting minutes as well as to continue to produce the real minutes which will remain confidential. See also Section 4 material and MCA newsletter abstract page 2 of April-June 1995.

It must be said that MCA feels such devices should have no place for a committee that is a consumer committee. However it must also be said that this is the way that NSW seems to operate, being based on United Kingdom ways of representative democracy rather than more participatory forms used in the USA where more legislative provision exists for "government in the sunshine". *
(* Birkinshaw P, (1985) Grievances, Remedies and the State, Sweet & Maxwell see particularly Chapter 4)

2.22 Independent , the Magic word

In the CAC on 26-9-94 more details of a new committee (The Independent Complaints Review Committee) were produced by the Commission. Having read the agenda papers

just issued the MCA representative asked what the committee was defined as being independent of and was told by the Commission's executive officer to the CAC along the lines of that was a silly question to ask. As relations with the CAC were not good at all and the MCA committee had determined that a policy of conflict avoidance was to be used when at CAC meetings the matter was not pursued further by the MCA representative.

The problem that the Commission was attempting to fix informally was the fact that no appeals system exists in the 1993 Act. MCA does not feel that such a "quick fix" is at all safely possible and that forming such a defectively named committee would in the long term act against the best interests of consumers who wished to press issues of dissatisfaction with the HCCC decisions over the path of a complaint. The composition of the so called ICRC does not allow for an independent review as the senior legal officer of the Commission is used plus a member of the registration Board that is already concerned with the particular complaint as well as a member of the CAC (which in practice has been a Health Department employed or funded person).

2.23 Consumer Communication: The writing's on the wall ?

Freedom of speech norms appear to go something like this:

USA : Under the Constitution I claim a right to speak
UK: We don't have a constitution and I don't agree with what you are saying but I will defend your right to say it.
NSW: I don't agree with what you say and I will use all powers available under the Constitution and the NSW civil law of defamation* to stop you saying it.

(* MCA has just been told that the Psychologists Registration Board has threatened to sue the academic Dr Wayne Hall (who appeared on the ABC programme ***Background Briefing*** some months back) over the critical things he said on radio about the Board.)

A friend of a medical victim who emigrated from the old Eastern Block some years ago expressed a somewhat different view saying :
In my country of origin you were not allowed to speak about problems with State services and nothing was ever done correct the problems
But here in NSW it is quite different. You are allowed to speak about such problems and nothing is ever done to correct the problems.

There is clearly considerable consumer frustration with the way NSW fails to operate for you once you become a system victim.

Very mixed messages were sent out to medical consumers by the government abandonment of Customer Focus. MCA notes that the resistance from the professionals was massive and the Conference held in October 1993 by Health represented a major slap in the face for upper management as the professionals and NGO semi-professionals present appeared to nearly all vote against the motion put by the Senior Management "That the customer is always right". In the CAC the NGO reps. just made mirth of the initiative saying its a joke, 4 people (the Customer focus Unit) against the rest, some 90,000.

While the various powerful medical professionals (mainly of the Right) fight the semi-professionals and social worker mafia (mainly of the Left) for their slice of a shrinking case-mix cake the medical consumer somewhere underneath and in the middle of the mess needs to be capable of nimble footwork to avoid being trampled underfoot.

MCA notes that some medical consumers clearly have developed their own "freedom walls". For a few days last year a Wynyard Park tree and other locations warned passers by (by means of pieces of paper and drawing pins) of a killer urologist at Concord hospital who was to be avoided at all cost. A much longer standing comment on the situation is the large white lettering (in the vicinity of Central Station) that proclaims:

A bullet a day takes a doctor away.

Should graffiti perhaps be a prime mode of communication for medical consumers who have complaints about health services in NSW in 1995 ?

This concept was brainstormed some time back with the aid of some drinks. It seemed like a real winner after about the third round or so ! It would have quite incredible economic effectiveness but needs two components NSW just does not seem to possess.
1) A defamation exempt surface. 2) Some good investigative journalists.

We have to find a large wall that lots of warnings, cases and details such as doctors names can be put up on. It's a sort of consumer's underground communication system (so the tunnel from Central Station to Broadway seems to fit the bill) plus a team of good investigative journalists who will be able to fill up the "scandal sheets" that pass for newspapers now with lots of stories (checked with the lawyers). This will generate so much revenue due to the endless public demand for scandal that it may generate $3,500,000 in value rather than like the Commission using up this much. medical complaints management by embarrassment and consumers able to vote with their feet !

Or perhaps the surface could be a virtual one ? an electronic one ..... Now just how does one use one's numbered Swiss bank account to get a numbered Internet account operating from Guatamala ?

Once upon a time there used to be a concept called the Westminster system of representative government. Under this system as a voter you elected someone who worked for you to represent you. Sure you delegated a lot of decisions to this person and took no part in the work at all, but you still had a path to get help if you hit problems with things that your government was responsible for providing or regulating, for example health services. But then government got more complex and MP's got too busy and handed over such day to day matters to an army of Sir Humpfreys who in time collected a bigger army of lesser mortals around them who you had to deal with if you hit problems. First of all you had to go many miles to get to their big offices in the city but the problem was that then if one of these minions said "nick off" over some matter there was not much you could do about it. Of course by now your MP was even more busy with matters of "national importance" and also now tied into a collective for the "important" decision making called "a party". So a popular perception grew up that these MP's were really not good value at all, in fact in public opinion polls they just about scored the same as drug dealers and other low-life. Of course this did not really matter as thanks to a compulsory voting system and the party system the pre-selected "appropriate people" got elected with what looked like reasonable percentages of the population supporting them.

Now how nice it would be to wind back the clock just a bit by providing not yet more Sir Humpfreys with yet more minions in say all hospitals, but instead resourcing MP's electorate offices (which happen to be all over the State and so close to you) so your MP or someone that reported to him personally each day was able to get action if you hit problems with a doctor or hospital. If the doctor, the minions or the remaining fewer Sir Humpfreys were stubborn over a matter then they could be exposed, as your MP has access to a "freedom wall", but rather strangely its called "the floor of the house".

MCA feels that the situation that victims of "the system" can be placed in by NSW health politics is a human rights abuse. MCA does not see a Health Care Complaints Commission as ever being able to be structured to even start to address such issues.

Discussion within MCA over contributing to this hearing also included the view that we should not make a written submission at all because firstly we did not have any time to poll our members and thus could not be democratic as to what we should say, and also because either:

1) As is normal in NSW the net effect of our submission would be to die a "death in the draw", filling up further some already bulging government filing cabinet.

or 2) To give rise to some limited cosmetic changes that would actually enable a stumbling abortion of an Act be made to look more presentable to the public while doing nothing to actually help victims or reduce the death and injury rates.

Whereas if we did nothing the HCCC might actually just implode sooner under the weight of its own legislative inefficiency.

In the end it was decided to put in a submission, in a hurry, warts and all, with as many views as possible gathered from one small group meeting plus some phone calls and to try to collect and include as much data as possible in the limited time available in the hope someone would actually read at least some of it.

Number of matters referred to the Health Conciliation Registry for conciliation

	1994/5 reporting year	Total to 19.12.95
Files Referred	40 (44 conciliations)[1]	89 (93 conciliations)[1]
Conciliations conducted	26	76
Agreement Reached	18	57
No Agreement Reached	8	19
Consent Withdrawn	2	11[2]
Pending	16	6

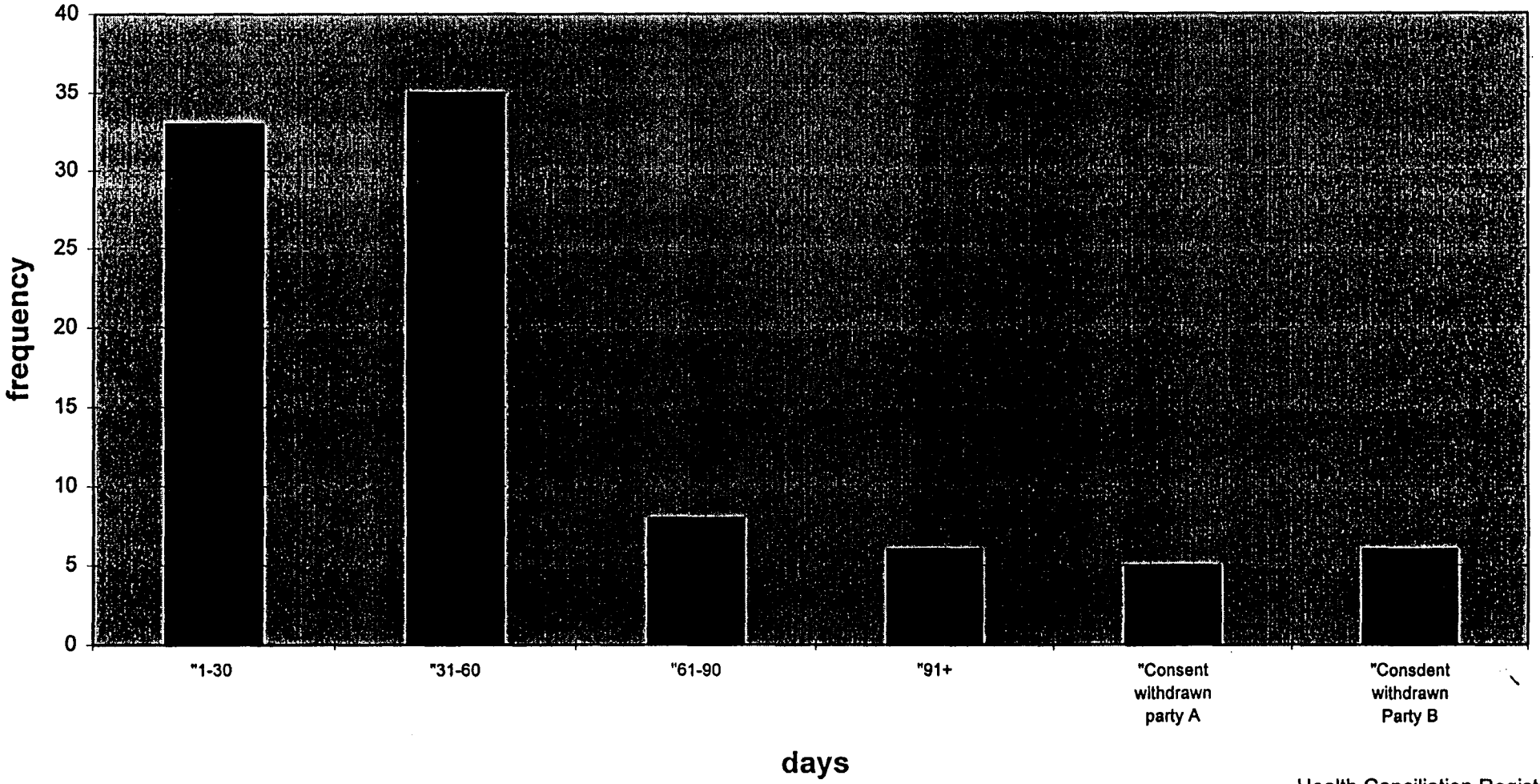
There have been seven instances where the complainant has requested the assistance of a partner or support person during conciliation. The Registrar has a discretion under s.53 of the Act to allow such assistance in certain circumstances. In two matters the discretion was exercised so as to admit the support person to conciliation. In one of the remaining five matters consent was withdrawn by the complainant when the attendance of the partner was refused, in the remaining four matters the conciliation was conducted without the support person and the parties reached agreement in three of those matters (the same proportion as in matters where the help of a support person is not raised).

---

[1] 4 files were split into two separate conciliations at the request of the parties.

[2]
- Consent was withdrawn in 2 matters as an earlier conciliation, in which the complainant was involved, had resolved the complaint.
- Consent was withdrawn in a further 2 matters when one of the parties informed the Registry that the matter had been resolved independently.
- Consent was withdrawn in one matter when the Registrar had no grounds to exercise her discretion to allow the complainant's partner to assist during conciliation.

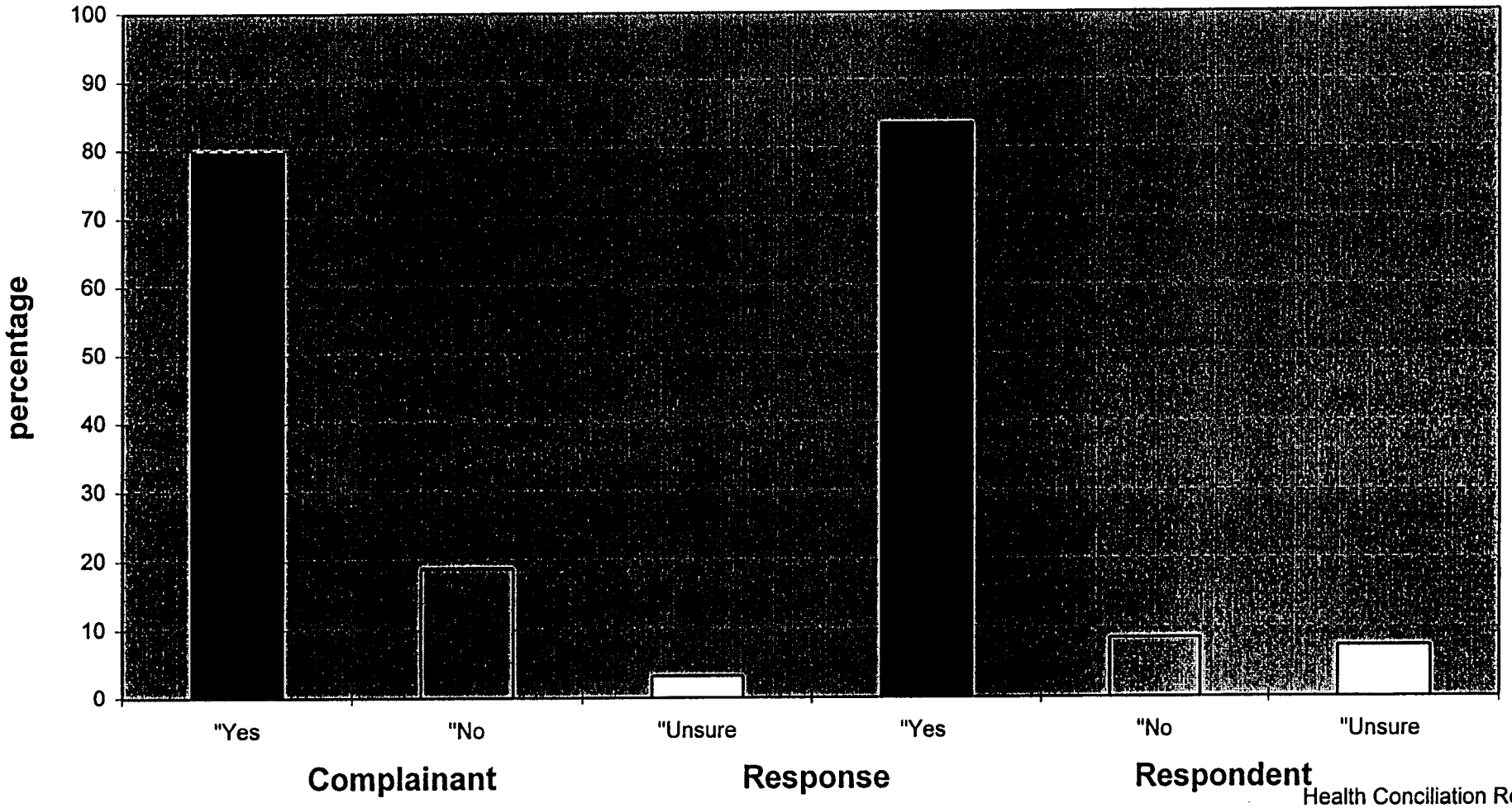
Time taken to conciliate matters from the date of receipt by the HCR



Health Conciliation Registry

12/19/95
3:15 PM

Responses to question 7 of exit questionnaire 'I would return to conciliation if I have a similar problem in the future.'



Health Conciliation Registry

12/19/95
5:21 PM

Our Ref: GFLETT/I.5
File No: HCCC58

APPENDIX 5

HEALTH CARE COMPLAINTS COMMISSION

Mr J Mills MP
Chairman
Committee on the
Health Care Complaints Commission
Room 813
Parliament House
SYDNEY NSW 2000

RECEIVED 19/1/96

Dear Mr Mills

Thank you for providing a copy of the transcript of my and the Deputy Commissioner's evidence. I enclose a corrected copy (Attachment 1).

The Committee requested the Commission's statistics on complaints currently under investigation according to the annual reporting year in which they were received. I attach the statistics for your information (Attachment 2).

In addition the Committee sought a copy of the evaluation undertaken by the Commission of those complaints referred to Area Health Services. I attach that for your information (Attachment 3).

I note your advice that I will receive a copy of the complete transcript of evidence given before the Committee and I advise that I will provide additional comments to the Committee after reviewing that transcript.

However, it maybe of benefit to the Committee to be provided with information concerning the operation of the Commission's Independent Complaints Review Committee. The Health Care Complaints Act 1993 provides that complainants dissatisfied with an assessment decision of the Commission or the outcome of an investigation can seek a review of that decision or outcome. This review is undertaken by a senior officer of the Commission.

I was concerned that there be an independent review mechanism whereby complainants could have decisions reviewed independently of the Commission. Accordingly, in June 1995 I established an Independent Complaints Review Committee. The Committee compromises a nominee of the relevant health registration authority, for example if the complaint was against a doctor, the Medical Board would be the relevant authority, the Commission's senior policy advisor and it is chaired by a member of the Consumer Advisory Committee.

../2

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The legislation does not require the Commission to establish such a Committee however, I was of the view that it would assist complainants to have a mechanism whereby the Commission's decisions were reviewed by an independent body.

I attach the terms of reference for the Independent Complaint Review Committee for the information of your Committee (Attachment 4). I advise that the Committee has met on four occasions and considered seven complaints.

I refer to one aspect of the submission made to the Committee by the Medical Consumers Association of NSW. On Page 2, the Association refers to a letter commenting on the Commission's handling of a complaint. I attach a copy of the Committee's response to that letter for your information, and draw your attention to the inaccuracies in that letter (Attachment 5). I note that that matter had concluded in 1993 and yet the complainant did not correspond with the Commission until December 1995, shortly before the hearing by your Committee.

Thank you for the opportunity of giving evidence before the Committee. It is noted above, I will provide further information and comments on review of the transcript of all of the evidence given before the Committee.

Yours sincerely

[redacted]

Merrilyn Walton
Commissioner

16 JAN 1996

ATTACHMENT 2

OPEN COMPLAINTS BY FINANCIAL YEAR @ 10 JANUARY 1996

	90/91	91/92	92/93	93/94	94/95	95/96*	Total
Preliminary	0	0	0	12	191	239	442
Main	1	40	140	267	301	159	908
Reviews #	0	0	0	0	0	4	4
Disciplinary ##	0	0	0	0	42	30	72
Total	1	40	140	279	534	432	1426
% of complaints still open	0.1	2.8	9.8	19.6	37.4	30.3	100

* from 1 July 1995 to 10 January 1996

OPEN FILES BY YEAR @ 10 JANUARY 1996

	90/91	91/92	92/93	93/94	94/95	95/96*	Total
Preliminary	0	0	0	10	138	203	351
Main	1	24	78	160	217	126	606
Reviews #	0	0	0	0	0	4	4
Disciplinary ##	0	0	0	0	36	25	61
Total	1	24	78	170	391	358	1022
% of files still open	0.1	2.3	7.6	16.6	38.3	35.1	100

* from 1 July 1995 to 10 January 1996

\# Reviews include files which have been closed and then re-opened following a request by the complainant for a review of the decision to close the file.

Disciplinary includes all files in which complaints have been lodged with registration boards initiating disciplinary action following the completion of a investigation.

HEALTH CARE COMPLAINTS COMMISSION
Survey of Area and District Health Services with regard to complaints management

In April 1995, the Health Care Complaints Commission conducted a pilot survey of Area and District Health Services, requesting information about the actions that had been taken to resolve complaints which had been referred to them for direct resolution. Areas/Districts responded with regard to 140 complaints.

Question	% positive responses
1. Did the service contact the complainant by telephone?	28.6%
2. Did the service interview the complainant?	22.14%
3. Did the service seek information from the health professionals involved?	97.40%
4. Did the service seek independent/expert opinion as to the medical issues involved?	13.9%
5. Was one or more of the complaints accepted?	55.72%
6. Was an explanation provided to the complainant following the investigation?	90.72%
7. Did any changes in policies or procedures result from the investigation?	25.72%
8. Was an apology provided to the complainant?	55.72%
9. Was any financial amount payed to the complainant or waived by the service or any other person?	2.15%
10. Was the complaint or any part of it referred to another agency?	5.00%
11. Was the complaint or any part of it referred back to the Health Care Complaints Commission?	7.15%
12.Did any disciplinary action follow the investigation of the complaint?	5.00%

The survey clearly showed that Area and District Health Services took complaints referred by the Commission very seriously. In almost all cases, Area/Districts interviewed the health professionals involved in a complaint.

In most cases, an explanation was provided to the complainant following the investigation, and in more than half, an apology was provided.

In at least half of the cases, Areas/Districts accepted as valid the complaints referred to them.

Changes in policies or procedures resulted from the investigation of a significant number of complaints. In some cases, Areas/Districts disciplined staff about whom complaints had been made.

HEALTH CARE COMPLAINTS COMMISSION

INDEPENDENT COMPLAINT REVIEW COMMITTEE

Terms of Reference

1. Introduction

1.1 Section 28(6) of the *Health Care Complaints Act 1993* (the Act) provides that the Commission must review a decision made after assessing a complaint if asked to do so by the complainant.

1.2 Section 41(3) of the Act provides that the Commission must review a decision on the action to be taken after an investigation if asked to do so by the complainant.

1.3 The Commission has resolved that where:

- a complainant has sought review by the Commission of its decisions under these provisions of the Act; and
- where following the review by the Commission, the complainant is dissatisfied with the results of the review; then
- the complainant may seek a further review by the Independent Complaint Review Committee (the Committee).

1.4 The Committee is constituted and operates in accordance with these terms of reference.

2. Membership

2.1 The Committee consists of three members, appointed by the Health Care Complaints Commissioner, as follows:

- a member of the Commission's Consumer Advisory Committee;
- the Head of the Commission's Legal Team or nominee;
- a person nominated by the relevant health registration authority or other appropriate body for the purposes of a particular review.

2.2 The Chairperson of the Committee is the member who is a member of the Commission's Consumer Advisory Committee.

3. Functions

3.1 The Committee has the following functions:

- to review decisions referred to it by the Commission;
- to consider any other matter relating to a complaint referred to it by the Commission;
- to make recommendations to the Commission in respect of the decisions reviewed and matters considered.

3.2 Following its review of a complaint, the Committee may recommend that:

- the Commission re-open a complaint file;
- a complaint file should remain closed.

The Committee cannot direct that the complaint being reviewed be re-opened or remain closed.

4. Procedure

4.1 The procedure for the calling of a meeting of the Committee and for other conduct of business at those meetings is to be determined by the Committee.

4.2 All members of the Committee are required to be present at a meeting of the Committee for a quorum to be constituted.

4.3 The Chairperson is to preside at a meeting.

4.4 A decision supported by the votes of at least 2 members at a meeting of a Committee at which a quorum is present is the decision of the Committee.

4.5 Minutes of meetings are to be kept recording the main points of discussion and the decisions of the Committee.

5. Access to Information

5.1 The Committee is entitled to have access to all the material obtained by the Commission concerning the matter being reviewed.

5.2 Subject to clause 6.2, and following consultation with the Commission, the Committee may obtain the advice and assistance of any person who, in the opinion of the Committee, is sufficiently qualified or experienced to give expert advice on the matter being reviewed.

6. Confidentiality

6.1 The members of the Committee must sign an appropriate confidentiality undertaking required by the Commission.

6.2 Before obtaining the advice or assistance of an expert, the Committee must ensure that the expert has signed an appropriate confidentiality undertaking required by the Commission.

7. Disclosure of Interest

7.1 If a member of the Committee has a personal, financial or professional connection with any person involved in a matter to be reviewed by the Committee, the member must disclose the nature of that interest to the Commissioner and to the Chairperson of the Committee.

7.2 A member of the Committee who discloses a connection must not take part in any deliberation of the Committee with respect to the matter, unless the remaining members of the Committee and the Commissioner all agree otherwise.

7.3 Where a member may not take part in a matter to be reviewed by virtue of the operation of clause 7.2, the Commissioner must appoint another member to the Committee, of the same category of membership, to review the matter.

Our Ref: GFLETT\SC\L234

ATTACHMENT 5

Ms A.C. Richards
[redacted]

11 JAN 1996

Dear Ms Richards

I refer to your letter dated 7 December which was received by the Commission on 15 December 1995.

I enclose a copy of the then Complaints Unit letter to you dated 19 October 1993. No where in that report has your complaint been referred to as vindictive or a communication breakdown. The Commission is required by legislation to provide the subject of the complaint with a copy of the complaint. In 1993 it was the Complaint Unit policy to do so.

I note that you do not wish to speak to the doctor concerned and I suggest that you may wish to pursue the matter with Orange base Hospital.

I am concerned that your letter significantly misquoted the Commission's correspondence with you and note that this matter was referred to in a public submission made by the M.C.A. to the Commission's Parliamentary Committee. I advise that a copy of the relevant correspondence will be forwarded to the Committee to ensure it has an accurate record.

Yours faithfully

SIGNED
G. FURNESS

Gail Furness
Deputy Commissioner

Our Ref: GFlett\sc\l33.96
File No: 896

HEALTH CARE COMPLAINTS COMMISSION

27 FEB 1996

Mr J Mills MP
Chairman
Committee on the
Health Care Complaints Commission
Room 813
Parliament House
SYDNEY NSW 2000

RECEIVED 28/2/96

Dear Mr Mills

Thank you for providing me with a copy of the corrected transcript of the Committee's Public Hearing on 20 December 1995.

There are a number of matters raised in the evidence given before the Committee which require clarification by the Commission.

I note that on 16 January 1996 I provided you with statistics by financial year, the evaluation of the complaints referred to Area and District Health Services and information concerning the Commission's Independent Complaints Review Committee.

The President of the Nurses Registration Board gave evidence that I was an observer on their Screening Committee. In fact Ms Furness the Deputy Commissioner sits on that Committee and her role is more than merely an observer. She provides information and advice and participates in the decision-making of that Committee.

In relation to the questions by Dr McDonald concerning policy recommendations, I advise that the Commission frequently makes recommendations for policy change to nursing practices. Those recommendations are made directly to the health facilities, the Department of Health or Area Health Service responsible for the facility. Those complaints would not necessarily be dealt with by the Screening Committee of the Nurses Registration Board because it is more likely that the complaint was against an institution and concerned institutional practice rather than the conduct of a particular nurse. Accordingly, the Nurses Registration Board would infrequently be aware of the Commission's recommendations concerning changes to nursing practices and procedures.

Accordingly much policy change has been initiated by the Health Care Complaints

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Commission, however, it would not necessarily be a matter that would be within the knowledge of the President of the Nurses Registration Board.

The Commission frequently liaises with eleven Health Registration Boards in relation to seeking advice on members who may provide peer reviews for the Commission. It is the Commission's understanding that it has approached the Nurses Board in this regard as it has certainly approached other Boards. Such an approach may have been informal rather than formal.

In relation to the Health Conciliation Registry, I advise that the Registrar and her staff and relevant Commission staff meet monthly to discuss matters of relevance between the two bodies. While the Registry has no input into the assessment process of the Commission, as required by the legislation, the two bodies certainly meet regularly to discuss aspects of the conciliation process.

In addition the Commission established guidelines for the referral of matters for conciliation after consulting with the Registrar as to the content of those guidelines. Accordingly, the Registrar is not only aware but was consulted in the drafting of those guidelines.

I am happy to answer any questions in relation to these matters if you wish me to do so.

Yours faithfully

[redacted]

Merrilyn Walton
Commissioner