Submission No. 001
Received 1 July 2016

[redacted]

Health, Communities,
Disability Services and Domestic and
Family Violence Prevention Committee

Parliament House
George Street
Brisbane Qld 4000

Dear Research Director,

**Re. Inquiry into the performance of the Queensland Health Ombudsman's functions pursuant to section 179 of the Health Ombudsman Act 2013**

This is a submission to the aforementioned public inquiry by myself, Dr Jenny Namkoong, junior medical officer a large tertiary teaching hospital.

It addresses section 179 of the *Health Ombudsman Act 2013,* and the committee's function to:

**Identify and report on particular ways in which the health service complaints management system might be improved.**

Thank you for your consideration of the submission.

Jenny Youn Namkoong

[redacted]

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## Submission Summary:

This submission focuses on the committee's function to "**identify and report on particular ways in which the health service complaints management system might be improved"** and makes eight evidence-based recommendations for consideration.

**Maximise the use of data**

1. Ensure the accuracy of data already gathered by the National Scheme, by reviewing information sharing arrangements between the Queensland Health Ombudsman Office and the Australian Health Practitioner Regulation Agency (AHPRA).

2. Form partnerships with research organisations (such as universities) to sophisticatedly analyse the data already available through the National Scheme, to determine trends in complaints, health registrants and outcomes.

**Broaden outcomes**

3. Develop a broader range of possible outcomes to a health service complaint investigation, implementable by the Health Ombudsman Office and AHPRA.

4. Develop a policy of effective referral of issues outside the scope of the Health Ombudsman or AHPRA's role, that is identified by the health service complaint investigation process, to partner organisations that can manage the issue within its scope of practice.

**Engage with the notifier**

5. Commit to continual communication with the complaint notifier, with an aim to increase public confidence in the health complaint management process.

6. Identify ways to determine the expectations of each complaint notifier, and to satisfactorily manage notifier expectations within the scope of the Health Ombudsman Office and AHPRA.

**Strengthen internal workings**

7. Identify the impact of co-regulation of the Queensland health complaint management system on issues of efficacy including but not limited to the duplication of work and impact on cost. Commit to earlier coordination of activities both by altering internal structures and liaising with external bodies to maximise efficacy.

8. Develop a common set of regulatory principles and frame of reference for considering risk in a health complaint, and ensure its adoption by the Health Ombudsman Office and AHPRA in Queensland, with an aim to ensure national standardisation.

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## Introduction

The purpose of the proposed commission is to review the workings of the Queensland health complaint management system, particularly since the Health Ombudsman commenced operations in 1 July 2014 to work alongside the Australian Health Practitioner Regulation Agency (AHPRA) and its related practitioner registration boards.

This submission is written in the perspective of a health practitioner in the Australian health system, a junior medical practitioner, with a 'service design thinking' approach.

Service design is a method of improving the quality of service, that "starts from the needs and requirements of users and looks for solutions together with these users and stakeholders" (Stickdorn, Schneider et al. 2011).

Three key stakeholders have been identified in the health service complaints management system: the health registrant, complaint notifier, and complaints management system worker. Thus, the submission outlines recommendations to improve the experience of these three stakeholders, for consideration by the inquiry committee.

## Improving the experience of the health registrant

International reviews into the nature of health service complaints have unanimously revealed that the majority of adverse events are failures of systems rather than that of individuals (Bayne 2012). This is because "structure, conditions and circumstances always trump desired behaviour" (Porter-O'Grady 2003), and in health, the working environment of impact can be as local as the ward level, or even shift-level as immediate leadership changes shift to shift (Cayton 2014). Investigations into cases of whistle-blowing inform the regulatory community that very few individuals can make a stand against toxic culture (Cayton 2014).

Of course, this is not to diminish the responsibility of individual practitioners for the quality of decisions they make, but to recognise the 'precursors of harm' (Bayne 2012). It is here that there is a significant role for data to inform regulatory organisations.

Since 2014, Australia has boasted a national registry of health professionals, with the unification of 38 regulatory organisations and 75 separate pieces of legislation to one, whilst maintaining local management of notifications (AHPRA 2014). This large-scale single database, which is deemed more comprehensive than any of its kind internationally, provides a unique opportunity to thoroughly

investigate the nature of health complaints in its multiple aspects (Bismark, Fletcher et al. 2015). Extending from its breadth and depth, the unified data under the National Scheme allows measures of interest to be compared against a parallel baseline population (Bismark, Fletcher et al. 2015).

To date, this data has largely been used to create demographic profiles of high-risk health professional groups, revealing that male, medical practitioners between the ages of 45-55, in rural areas and in certain specialties such as Plastic Surgery and Dermatology are at highest chance of receiving a health complaint (AHPRA 2014). Subsequently, some literature has suggested earlier targeting of the behaviour of these high-risk populations (Bismark, Spittal et al. 2013).

These efforts are commended, however, this submission highlights the potential of even more meaningful use of the available data and recommends two ways to maximise its use.

**Maximise the use of data**

**Recommendation 1:** Ensure the accuracy of data already gathered by the National Scheme, by reviewing information sharing arrangements between the Queensland Health Ombudsman Office and the Australian Health Practitioner Regulation Agency (AHPRA).

Data is only as good as it is accurate, and currently the co-regulatory arrangement of the health complaint management process in Queensland creates room for missing data (Health and Ambulance Services Committee 2015). As all health complaints are first received by the Queensland Health Ombudsman then referred to AHPRA and the relevant National Board, complaints that are received but determined by the Ombudsman that no further action needs to be taken is exempt from the National Scheme database (Health and Ambulance Services Committee 2015). AHPRA Queensland argues in its public briefing that even though a complaint does not meet the threshold for action, its capture is necessary for a complete view of concerns expressed about health practitioners and in identifying trends in health professional complaints (Health and Ambulance Services Committee 2015).

With the understanding that a faulty system can result in error or cause injury from even the most competent health practitioners, holistic and accurate data can be used to identify environmental stressors that influence clinical judgement, performance and communication. Stressors may include difficult team situations, and analysis may reveal different stressors for different types of complaints

received. As the complexity of such data analysis may be beyond the current capacity of regulatory bodies, this submission recommends forming strong partnerships with research institutions.

**Maximise the use of data**
**Recommendation 2:** Form partnerships with research organisations (such as universities) to sophisticatedly analyse the data already available through the National Scheme, to determine trends in complaints, health registrants and outcomes.

In this way, AHPRA's core regulatory functions, such as the impact of its disciplinary decisions or the effect of participation in continued education and development (CED) programs, may be better understood.

Such research may also expose the psychological and by extension performance impact of being the health practitioner subject to a current complaint investigation. The 2013 BMJ report on the *Identification of doctors at risk of recurrent complaints: A national study of health complaints in Australia* revealed that "regardless of the number of previous complaints, doctors' risk of further complaints increased sharply in the first six months following a complaint, and then declined steadily thereafter", hinting at the reality of excessive stress in receiving a complaint that likely influences practitioner psyche and behaviour at work (Bismark, Spittal et al. 2013).

Thus, acknowledging human fallibility and the impact of the larger system, it is important to consider the experience of the health registrant in the health complaint management process. As a first step to address this, Bayne distinguishes between individual human error, at-risk behaviour and reckless behaviour (Bayne 2012).

At present in Australia, reckless behaviour requires mandatory notification by law. A recent national study of disciplinary outcomes for medical practitioners who were reported for reckless behaviour revealed that 43% were de-registered and 37% had conditions placed upon their practice (Beaupert, Carney et al. 2014). It is recognised that these penalty rates are significantly higher than those observed in studies internationally (Beaupert, Carney et al. 2014).

Further, although studies exploring health complaint handling strategies for human error and at-risk behaviour is minimal, given that the Health Ombudsman Office and AHPRA as regulatory bodies do not possess many management options other than placing restrictions on practice, this submission recommends the following.

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**Broaden outcomes**
**Recommendation 3:** Develop a broader range of possible outcomes to a health service complaint investigation, implementable by the Health Ombudsman Office and AHPRA.

At times, the result of a complaint investigation may find a system faulty. In such a case, where possible ways to address the problem is outside to scope of the work of the Health Ombudsman or AHPRA, this submission recommends a transfer of investigation results to the appropriate organisation that may act in accordance to it.

**Broaden outcomes**
**Recommendation 4:** Develop a policy of effective referral of issues outside the scope of the Health Ombudsman or AHPRA's role, that is identified by the health service complaint investigation process, to partner organisations that can manage the issue within its scope of practice.

Such organisations that address system and training issues include, as an example, the Health Education and Training Institute (HETI), the Australian Medical Council (AMC). This submission further urges that a referral by AHPRA be accompanied with a commitment by the health regulator to follow through with the external organisations to ensure appropriate system changes be made in health institutions.

## Improving the experience of the complaint notifier

Data specific to Queensland is not so clear, but a New South Wales study on complaint notifier satisfaction revealed that almost two-thirds of complaint notifiers were not satisfied with the process and outcome of their complaint (Beaupert, Carney et al. 2014). Similar rates of dissatisfaction to health service complaint systems are reflected around the world, with less than one-third of complaint notifiers from Holland reporting that they felt justice from the process (Beaupert, Carney et al. 2014).

The public's confidence in the regulatory bodies of health practitioners is essential to its functioning, and as an extension, essential to the continued safety of the public through effective regulation (Leape and Fromson 2006). Details of why a complaint notifier may report dissatisfaction has not been explicitly studied, but may be extrapolated by understanding the reasons given by both patient and professional parties of not reporting complaints. These include "uncertainty and unfamiliarity of the legal requirements, fear of retaliation, lack of confidence that appropriate action would be taken, and loyalty to colleagues that supports a culture of 'gaze aversion'" (Beaupert, Carney et al. 2014).

Admittedly, the current process treats the complaint notifier largely as an informant, with communication with them limited to transfer of information sheets and written notifications of process (AHPRA 2014).

An AHPRA commissioned investigation titled *Setting things right: Improving the consumer experience of AHPRA* highlighted that despite concerted efforts, complaint notifiers did not understand the written communication they received (HIC 2014).

This submission thus suggests trying other methods of communication, verbal, case-managerial or otherwise, within the provisions of the National Law confidentiality standards, and with a pursuit that communication be personal and continual.

**Engage with the notifier**
**Recommendation 5:** Commit to continual communication with the complaint notifier, with an aim to increase public confidence in the health complaint management process.

In considering the experience of the complaint notifier, it is important to also recognise the range of notifiers, with 64% of all notifications being from the patient community in Australia, whilst close to all mandatory notifications are from fellow health professionals (AHPRA 2014). The different

backgrounds and motivations of the complaint notifier may shape their expectations about how their concerns should be addressed by the board. Understandably, the degree to which the outcome aligns with an initial expectation will determine the level of notifier satisfaction with the process. It is important to note that notifier expectations may not correlate with the board's scope of action though, and that the notifier is not the decision-maker of the outcome of the complaint. However, public engagement and confidence will certainly be increased in approaching the notifier as an important partner in the health service complaint management process (AHPRA 2014).

**Engage with the notifier**

**Recommendation 6:** Identify ways to determine the expectations of each complaint notifier, and to satisfactorily manage notifier expectations within the scope of the Health Ombudsman Office and AHPRA.

Further, this submission notes that notifier involvement may be best approached as a responsive system, with a goal to improve the health system and structures that give easy rise to complaint-inducing health practitioner behaviour, rather than as a reactive system that reprimands individuals considered to be at fault.

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## Improving the experience of the regulatory system worker

The experience of the regulatory system worker has not garnered much attention or research, but for the purposes of this submission it will be addressed in line with improving system efficacy. The submission recognises that Queensland has only recently undergone structural changes to its health service complaint management system, with all notifications now being directed to the Health Ombudsman, who considers whether they should be referred to the National Boards (AHPRA 2014).

In the Health Ombudsman public meeting for the inquiry, the complex nature of many notifications that require initial reviews by third parties such as the employer, coroner or police before being presented to the Ombudsman was identified as a delaying factor in complaint investigations (Health and Ambulance Services Committee 2015). AHPRA appeared to deem the extra layer of notification to the Ombudsman before the National Board could investigate an issue a further barrier to efficiency (Health and Ambulance Services Committee 2015).

Thus, this submission suggests an earlier coordination of activities, with the following recommendation.

**Strengthen internal workings**
**Recommendation 7:** Identify the impact of co-regulation of the Queensland health complaint management system on issues of efficacy including but not limited to the duplication of work and impact on cost. Commit to earlier coordination of activities both by altering internal structures and liaising with external bodies to maximise efficacy.

Such early coordination of activities would be easier with a clear set of standards that define thresholds for risk for any received health service complaint. A common frame of reference is not yet adopted by the Queensland Health Ombudsman office, to the understanding of this submission's authors. This presents a problem other than hindering timeliness, in that varying thresholds for decision making across jurisdictions and perhaps even within jurisdictions in Queensland, would render a national registry meaningless as it would alter the accuracy of the data.

**Strengthen internal workings**
**Recommendation 8:** Develop a common set of regulatory principles and frame of reference for considering risk in a health complaint, and ensure its adoption by the Health Ombudsman Office and AHPRA in Queensland, with an aim to ensure national standardisation.

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