

## **Partial Brief Notes: submitted by Kathy Kendell to the Health Quality Complaints Commission Select Committee on 13 August 2007**

Firstly, I wish to affirm my overall praise of the progress to date made by the Commission's hard working and committed staff, many who I have personally met.

I have not yet had an opportunity to have a close look at how complaints are actually being managed by the Commission. In the past, few complaints were assessed or investigated, by comparison to the numbers of complaints overall.

The public need to have clarity about the sorts of complaint issues that will not be assessed or investigated. Also, how does information from very serious complaints dealt with locally, by a single hospital for example, flow back to system regulators and overseers in order for everyone to better understand quality and safety issues and to inform and improve the whole of the system.

I have some doubts about the effectiveness of section 20 of the Act, and worry that improvements will remain haphazard and slow, and that actual accountability will not be substantially progressed on a large scale.

### **Three specific issues of concern, however.**

#### **1. Code of Health Rights must have legislative standing.**

Page 4 of the 2006 annual report of the Commission identifies and summarizes the key learnings over 14 years of the HRC's life. The report states that complaints were predominately about treatment, communication and consumer rights issues. It was reported that the most common communication issues were the attitudes of health practitioners and staff, and the provision of wrong, inadequate and misleading information. It also reported that complaints of patient rights focused largely on what many of us would agree are most the most minimum requirements we all expect; patient privacy, confidentiality and access to patient records.

The report acknowledges the key issues remained consistent over 14 years, and it is clear there has not been much progress improving consumer health rights. This is despite the fact there has been published codes of health rights as a requirement under the Australian Health Care agreements for 15 years.

It is also highly relevant that we put in context the potential contribution these identified key issues make towards avoidable errors and deaths in health care, which by estimates in papers presented by John Menadue and Jeff Richardson at the National Health Summit of the Australian Health Reform Alliance in July

2007 are conservatively adding to the national cost of health care by 4 to 5 billion dollars a year.

During drafting of the 1991 Health Rights Commission Act a group of us fought hard to have the potential for enforcement of the code of health rights built in to the wording of the Act. However section 33 (1) of the new Act deleted the word "enforcement" from the Act in reference to the code of health rights and its application. In whose interest was this deletion meant to serve It was certainly not the public's interest.

I know the Commission is making good progress on the development of the code, and there is some suggestion that my recommendation to the Commission that the code be at least recognized in a standard of the Commission, might be taken up. But I still want to emphasize as strongly as possible, that it will not be sufficient for the code of health rights to simply remain an ideology or a nice set of principles.

The Code must have legislative standing in some form, so that patients have something to rely upon. For example what role will the code of health rights play when a medical superintendent simply decides a particular patient will not be accepted in his hospital for treatment.

This happened to my child at the [redacted] I have written admissions from the [redacted], and although a federal health minister requested the then Queensland health minister to investigate on the basis there was sufficient evidence to raise serious questions of a breach of the Medicare principle of a right to choose a public hospital, neither would the then Queensland health minister or the HRC investigate this most serious complaint of a child being deliberately denied his right to required medical treatment. At additional expenses in excess of \$30,000 I was forced to take my child out of state for the same treatment it was admitted by [redacted] doctors, he was entitled to receive at the [redacted]. Had I not done so, my son would not be walking today without great disability. This matter was raised in the Queensland Parliament 5 times to no avail.

Ultimately health consumers have no enforceable right to receive health care or to be treated respectfully and equitably. This example of a denied right to receive required medical treatment based on prejudice, discrimination or because someone in a position of power has an axe to grind, is not uncommon. It usually happens most often to our most vulnerable citizens, the mentally ill, the drug addicted, the socially inept, the indigenous, the homeless, etc.

As the Commission's summary of fourteen years on the key issues in complaints demonstrate, people need a code of health rights that they can rely upon to ensure their protection when the system or those working within the system fail them.

## **2. There must be a mandatory requirement to report the causes of complaints.**

In the Commission's annual report of 2005/06, the more detailed categories of primary issues in complaints were eliminated, making it more difficult for the public to know the causes of complaints. The categories of primary issues in complaints need to revert back to the HRC's former method of breaking them down into further explanatory categories so the public can better understand the nature of complaints. For example in last year's annual report the category is "treatment issues" which include over 2,343 complaints. However in the 2003/04 annual report the treatment category is further broken down to flesh out the sorts of treatment issues to include further information such as wrong diagnosis, inadequate treatment, denied treatment, etc. Certainly up to 2003 /04 it was possible to compare just how many were complaining of being deliberately denied access to treatment as a separate distinct category to those complaining about the lack of bed or other resources.

The public have a right to know this information for better understanding. The nature of complaints tell us a lot about the culture of the system.

Further on this matter of the public's need and the system's need to understand the causes of complaints, I note that the Commission's complaint management standard requires mandatory data reporting only for the consequences of complaints and the likelihood of reoccurrence. There is no mandatory reporting to understand the **causes** of complaints. In my opinion this is a mistake. How can data feed into the overall improvement of the system if none of the data from each individual health facility informs anyone about the causes of complaints made by users. We are now losing a whole body of information that helps regulators, over-sighters and the public understand what people are concerned about in their health care, where there are problems, what are areas of waste, patterns, and so on.

## **3. The difference between human error and blameworthy conduct must be clearly articulated and understood by all.**

Finally there is insufficient content found anywhere within the Commission's standards; awareness raising material; or publications; that addresses the need to explain the difference between human error conduct that rightfully falls within the privileges of a blame free culture and the sort of conduct which falls outside of that, known as blameworthy conduct.

In fostering a blame free culture, it is important to make certain everyone clearly understands the difference between what is considered to fall within the blame free culture of reporting errors, and that which is blameworthy conduct for which there should be zero tolerance for and consequences for, such as fraudulent behavior, deliberate violation of policy and procedure, reckless behavior, serious breaches of patient rights.

**We all want a system that fosters a safe culture of reporting human error and adverse events to promote learning and understanding.**

However, it is critical that the Commission, Queensland Health and all service providers reasonably balance the benefits of a learning culture with the need to retain personal accountability and discipline among the health professions.

As I said, from the material I have seen from the Commission and Queensland Health, and that in particular contained in the Commission's new Standards, there is a worrying lack of content from both the Commission and Queensland Health in promoting any awareness and understanding of the differences between blameworthy behavior, human error, and systems error, among health professionals. These behaviors cannot be lumped together and treated as if they are one and the same.

Providers of health care need to have a clear awareness of the scope of blame worthy behavior; how to avoid committing blameworthy behavior; to know there will be "zero tolerance" for blame worthy behavior; and that the consequences for blameworthy behavior are different than those events caused by human or system error. The public also must be assured that accountability and discipline does exist when there is evidence of blameworthy behavior happening.

Perhaps there should be a standard, regulation or policy that sets out and explains the criteria that can amount to blameworthy behavior, ie the components of blameworthy behavior including reckless behavior, fraud, unreasonable risk taking, deliberate rule violation, serious breaches of the rights of patients, etc.

I have no problem supporting a blame free culture for human error, mistakes and systems error. But the failure to know the difference and clearly articulate between what constitutes "error" and what constitutes blameworthy behavior undermines true progress in quality and safety, and this is really in no ones best interest.

One only has to consider the evidence recorded in the last annual report of the HRC as key issues spanning 14 years, and the potential of these key issues to contribute in a big way to adverse outcomes, to know that the public remain seriously vulnerable to unacceptable conduct within our health care system.

Therefore I fail to understand why the sole emphasis of the Commission and Queensland Health is on promoting a blame free culture of reporting human error, without any discussion about what constitutes behavior that won't attract blame free privileges and for which there were be zero tolerance for.