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'Does shaming, naming and blaming improve the quality of our health services? Adversarial versus conciliatory approaches to investigating health complaints'

Chair: Prof. Don Chalmers

It is an enormous honour to be asked to deliver the Michael Kirby Oration on behalf of the Australian Institute of Health Law and Ethics in conjunction with Australian Bioethics Association. His Honour is, as anyone who has ever heard him speaking, knows a brilliant orator. His speeches (and writing) are always interesting, well researched, intelligent and thought provoking. If anyone has ever heard me speaking before you will know I adopt a somewhat different approach being better known as "the light relief" preferring humour and anecdotes to illuminate the more serious side of the messages I try to convey. However, this is an oration so I shall try to behave myself.

The first time I heard Michael Kirby speaking was in 1981 at an international gathering of law librarians in Sydney. Prior to the lunchtime break the final speaker for the morning delivered a most protracted address. It went on and on and on and on. This was embarrassing for the organisers and the delegates, as we had all been invited to lunch at the offices of various local law firms. When the address finally ended, we raced out, grabbed a sandwich and ran back to the venue to hear Michael Kirby.

His Honour, blissfully unaware of the morning's events, began by telling a story about a judge who was rather long winded. It went something like this: "You are very brave to ask a judge to speak at your conference as

judges are so notoriously long-winded." (The delegates were already laughing and his Honour looked rather surprised.) He continued: "There was once a judge who delivered an address that went on and on and on. When he finally finished he said, "Oh I'm sorry, have I gone over-time? There is no clock in this room." "No" said the MC, "there is no clock but there is a calendar."

I was also a member of a large and attentive audience who heard Michael Kirby speaking at the R G Myer Memorial Lecture on behalf of the Victorian Branch of the Australian and New Zealand Association of Psychiatry, Psychology and the Law. I remember waiting in the doorway of the gracious Crossar Hall at the Victorian College of Pharmacy, Monash University, admiring the Leonard Annois[1] mural when the sound and lighting technician approached me and asked, "Do you want the full flood lights on?" At that very moment Michael Kirby arrived and I said, "Why don't we ask the Judge?" I greeted him and said, "Judge, this gentleman wants to know do you want the full flood lights on?" His Honour placed his hand gently on my shoulder, looked right into my eyes and said, "Well Beth, why ever not?" How can you not love him?

The last time I saw Michael Kirby was just after the first anniversary of September the eleventh. We were both at Los Angeles Airport being searched by security people. We both had our arms outstretched as we were scrutinised with those electronic zapper things. I had been picked out because of the wire in my bra. I don't know what the judge was wearing at the time.

My topic today is:

'Does shaming, naming and blaming improve the quality of our health services? Adversarial versus conciliatory approaches to investigating health complaints'

I shall be examining different approaches to the handling of health complaints. This Oration doesn't pretend to be an erudite piece of

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[1] The mural is The Sissons Mural depicting the life work of Sissions who was at the Pharmacy College from 1920 until 1962. The Mural depicts the evolution of science, medicine and pharmacy.

research but is more of a reflective piece put together from experiences and observations as Victoria's Health Services Commissioner and also from 25 or more years working in multi disciplinary areas of administrative law with medical and lay people. I hope it will be thought provoking.

I shall begin by explaining briefly the work of my officers and that of the other health complaint commissions, which exist in all States and Territories of Australia and New Zealand. We were established to receive and resolve complaints from health service users about health services providers. Until very recently South Australia was the only State, which did not have a health complaints agency that could take complaints about both the private and public sectors. That has just changed with the passing of the *Health and Community Services Complaints Act 2004* (SA).[2] Previously the South Australian Ombudsman, who only has jurisdiction over the public sector, handled health complaints. The Victorian model has been adopted (and adapted) in all States and Territories (except New South Wales) with a strong emphasis on conciliation, but there are important differences in the way the complaints agencies carry out their work. Some conduct far more formal investigations than others.

New South Wales is the only State where formal conciliation proceedings take place outside the complaints commission. This may have led to a stronger emphasis in New South Wales on investigation rather than on conciliation and on having a reputation (whether deserved not) for taking a more adversarial approach. In other health complaints commissions including my own office, informal mediation and formal conciliation are the principal means used to resolve health complaints and the object is to assist the parties to an agreement with a view to improving the quality of health services. Most complaints are resolved in the early stages by assessment officers using mediation. The more complex complaints, which cannot be resolved at assessment, are referred to conciliation and may involve claims for compensation.

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[2] The Health and Community Services Complaints Act 2004 (SA) establishes the office of the Health and Community Services Complaints Commissioner and is expected to become operational early to mid 2005.

Conciliation provides an alternative to the adversarial system of law and, in my opinion, is more effective, speedier, less risky, less expensive, and more therapeutic than litigation. Why do I say more therapeutic? In my experience, the current adversarial approach of our courts to medical negligence claims does not give claimants a great deal of incentive to get well. I do acknowledge important initiatives in some of our courts in introducing mediation and alternative dispute resolution processes and even referring potential litigants to the Health Services Commissioner for conciliation. Judge Wodak's list at the County Court of Victoria is an excellent example of this.

In a joint submission to the Victorian Law Reform Committee the National Association of Specialist Obstetricians and Gynaecologists and the Royal College of Obstetricians and Gynaecologists said of conciliation:

"Liability is arrived at by consensus, and theoretically, both parties should be satisfied with the result. This is the opposite outcome to the adversarial system where there are 'winners and losers'. We strongly support this mechanism of settling disputes as it has so far been applied by the Health Services Commissioner in the State of Victoria. We see this mechanism as being able to make reasonable settlements and as a very useful tool in the settlements of disputes between doctors and their patients."[3]

Obviously I agree with those comments and would also emphasise the important role of conciliation settlements in bringing about quality improvements.

It is sometimes argued that conciliation is unable to lead to significant quality changes in our health services because it is tailored to meet the aspirations of individual complainants and is strictly confidential. Nearly all patients who come to our Commission with complaints are seeking quality changes. They usually want to know what happened, why, and they want to make sure that what happened to them does not happen to someone else. We hear this every day. It is very common for conciliation agreements to include assurances from the health service that the complaint has led to changes of practice so the same mistakes won't

[3] Report of the Law Reform Committee of Victoria 1997

reoccur. De-identified examples of this are published in our quarterly and annual reports and are used by my staff and I in education and training programmes for health services.

Conciliation can also result in apologies being made and accepted (apologies are very powerful in complaints resolution and are really important to people) payments of compensation and explanations. Compensation payments are made, not because the Commissioner orders them, but because the parties come to an agreement. When they do so, a legal release is signed and that is the end of the matter. Currently the success rate of conciliation is around about 95%. Very few people withdraw to go to law.

Conciliation processes are infinitely flexible and may include formal meetings, informal meetings, shuttle diplomacy, written information, expert opinions and so on. Compensation payments may be millions of dollars or a wheel chair, a car, or in one case a washing machine. It depends upon the nature of the complaint and the aspirations of the complainant. My office enjoys the support and advice of a large number of medical and other specialists who provide oral and written opinions and who have greater confidence in conciliation than in adversarial approaches.

Conciliation or Investigation?

In deciding how to proceed with health complaints the health complaints commissioners have a broad discretion. We can decide to mediate, conciliate, investigate or refer matters elsewhere. The aspirations of the complainant are taken into account, as is the likelihood of a successful outcome in conciliation. The Commissioners can also inquire into matters referred to them by the Minister or Parliament and can initiate formal investigations themselves.

Complaints dealing with allegations of professional misconduct or clinical standards are usually referred to the relevant registration board. Difficulties can arise in dealing with complaints about unregistered practitioners for example, counsellors, as there are no registration boards for them. A doctor could be struck off the register for sexual misconduct

but then continue practising as a counsellor or psychotherapist. Complaints against such people can be received by the Commissioners but can be difficult to resolve without the spectre of disciplinary action by a registration board. The criminal law may be useful in some cases but is a blunt instrument and difficulties of proof arise. In some cases prosecuting authorities have been reluctant to proceed where the victim is mentally impaired.

I have already mentioned there are important differences between the approaches to health complaints between the commissioners. In Victoria I rarely use my formal powers of investigation preferring conciliation. The most recent data I can obtain reveals that in the last financial year Victoria's HSC closed five investigations, in percentage terms that was .19% of our case load and was an unusually high number for Victoria. By comparison in the financial year 2002-2003 New South Wales conducted 387 investigations representing 13.1% of their caseload. Tasmania conducted 12 investigations or 0.24% and New Zealand investigated 178 or 15.3% of their caseload.[4]

An important difference between New South Wales and the other commissioners is that in New South Wales the Health Complaints Commission also prosecutes registered practitioners at registration boards. This may also be why New South Wales is often seen as being more adversarial in approach.[5] From a Victorian perspective New South Wales appears to be very adversarial. It has the highest rate of litigation outside of Southern California (according to Dr Paul Nisselle) and, at the end of last year, we witnessed an extraordinary chain of events that resulted in the dismissal of the Health Care Complaints Commissioner, Amanda Adrian.

Ms Adrian's dismissal by the Minister for Health could not have occurred elsewhere and highlights the lack of protection for the Commissioner in that State. In other jurisdictions Commissioners are statutory appointees

[4] There are some problems with the data as different agencies use different terminology. They are intended as a rough guide only.

[5] See for example Paul Nisselle, Book review, "The Trouble With medicine" Merrilyn Walton, *Medical Observer* 18 September 1998.

and can only be removed for proven misconduct by Parliament. It is worth recapping briefly the events that led up to the dismissal.

The release of what are, in my opinion, excellent and thorough investigation reports into the Camden and Cambellfield Hospitals by the HCCC was followed by an extraordinary media flurry. The investigations revealed there had been unnecessary deaths - a finding that would, unfortunately, not be surprising in any of our large health services. "Shock jock" Allen Jones ran with the story day after day, as did the Sydney Morning Herald, and, in media-talk, the issue quickly became labelled as "the hospital crisis". The ABC's Radio National approached me to speak about the hospital crisis in Victoria. When I asked, "what hospital crisis?" the story was dropped.

The NSW Minister for Health Morris Ienna responded by sacking the Health Complaints Commissioner. This classic case of shooting the messenger action surprised and dismayed the other health complaints commissioners and we took the unprecedented step of issuing a joint press release expressing our concerns. Ironically Amanda Adrian had been taking a far more conciliatory approach to complaints handling than her predecessor yet she was sacked for not shaming, naming and blaming enough doctors.

The work of Fiona Tito and many others has demonstrated that "shaming and blaming" approaches in health care do not assist in bringing about quality changes. At the end of the day quality is what it is all about and I believe the actions of the New South Wales Government and the media following the release of the HCC's Investigations have the potential to set quality improvements in NSW back by at least ten years.

Is There a Better way?

We hear frequent calls in the media for more investigations and Royal Commissions of Inquiry to be conducted into areas of controversy. In Victoria, this is currently being played out in response to the media captioned "Gangland murders" and allegations of police corruption. In the year 2000 sensational headlines concerning allegations that nurses at the Royal Melbourne Hospital (RMH) had been taking drugs while on duty and

had allegedly boasted of killing patients led to the biggest media frenzy I have ever personally been involved in. The Minister for Health responded by, among other things, requesting the Health Services Commissioner to conduct an Inquiry into the systems in place at the Hospital. Investigations were also carried out by the Homicide Squad and the Coroner and the allegations were not proven. The Nurses Board of Victoria is still pursuing its own inquiries. Internal inquiries were also conducted by the Management and Board of Directors of the Hospital.

I have ample powers in my legislation to conduct formal investigations, take evidence on oath, and apply for search warrants and so on. In the Royal Melbourne Hospital Inquiry I chose not to take this course of action but, instead, sought and achieved cooperation from the Hospital Board, management and staff. That cooperation was freely given.

The feedback we have received following our Inquiry is that it has been successful, speedy and cost efficient. It took three months and cost $55,000 – a real bargain. I hope that others investigating hospital based incidents will consider whether the approach we took may be a better or alternative way to inquire into and improve systems and quality issues in health services. To this end my office has produced a "road map" describing the methodology used and this is available on our web site at www.health.vic.gov.au/hsc.

In my introduction to that road map I wrote:

"The HSC Inquiry Terms of Reference were systems and procedures oriented, although the final Term of Reference allowed for a broader investigation of unforseen issues in the event that areas in need of improvement were identified. The reputation of the HSC as an independent expert in conducting conciliatory complaints resolution assisted in developing an atmosphere from the outset that reduced fears of recrimination and blame. A pledge of full support from the RMH management and Board of Directors was important in promoting openness and honesty, negating the Commissioner's need to invoke her formal powers of investigation under the *Health Services (Conciliation and Review) Act* 1987.

The Inquiry proceeded on the basis of research into quality improvements in health settings indicating that "shaming and blaming" approaches do not promote quality changes. The promotion of quality is enhanced by open disclosure and a commitment to addressing systemic issues. The methodology of the Inquiry was informed by this reasoning and was designed to identify systems issues and to recommend ways of addressing them.

Good communication between the HSC and the other two independent examining bodies, the Coroner and the Nurses Board of Victoria, was established at the outset, and a system of joint consultation and communication assured clear demarcations were established, and maintained, to ensure minimal duplication between the respective inquiries.

The Commissioner communicated openly with the media, to keep RMH patients, their families, and the public informed throughout the Inquiry and following the release of The Report. The Commissioner made herself available for comment on radio and television, as well as being accessible to print media."

Subsequently Melbourne Health has reported to the Department of Human Services and the HSC on progress made by the Melbourne Health Improvement Plan (MHIP). On 5 April 2004 Melbourne Health hosted a MHIP Day at which a panel of stakeholders, including the Health Services Commissioner and other independent experts, attended and a Stocktake Report was presented by MHIP Safety and Service Improvement Unit reviewing progress in implementing the recommendations of the Inquiry.

While the Hospital still has more work to do significant progress has been made. I was particularly impressed by the enthusiasm and commitment to quality change demonstrated by Melbourne Health Staff and a visit to the Hospital confirmed progress has been made, especially in the area of drug storage and control. Many other hospitals in the private and public sectors, throughout Australia and overseas have used the HSC Inquiry as an audit tool to see how they would measure up if scrutinised in the same way and to improve the quality of their services.

Conclusion

I can't help wondering whether our Inquiry, which cost so little comparatively speaking, has led to as many, or even more, quality changes than, say the Royal Commission into the King Edward Memorial Hospital. Royal Commissions cost millions of dollars, lead to a great deal of angst and huge volumes of paper – much of which is never released to the public. At the end of the day we all want to achieve the same thing – safer and better health care. I am strongly of the view that the best way to achieve this is to work <u>with</u> our health services not <u>against</u> them. This does not mean there should be no accountability. We have the Coroner, we have the registration boards, the criminal law and strong powers to conduct formal investigations. In Victoria we have rarely needed to invoke those powers.

My experience as Commissioner has persuaded me that our health workers are overwhelmingly decent people who want to help others and who work in risky, difficult and often dangerous endeavours. It is essential to have good risk management strategies in place, however we need also to recognise that when human beings work with human beings in high risk endeavours from time to time things will go wrong. It is then necessary to have effective complaints handling procedures in place, to be open and honest so we can remedy wrongs and minimise their recurrence.

The most exciting project I have been involved with in my career is the Open Disclosure Project, which is currently being piloted in several hospitals on behalf of the Australian Quality and Safety Council. It has developed an Australian Standard for responding to adverse events in hospitals to allow for timely information and assistance to patients and their families. Legislation has been passed by States and Territories to prevent apologies being used as a basis for findings of medical negligence. In my opinion this was unnecessary as an apology never was likely to lead to health services being sued – on the contrary genuine apologies are

more likely to keep people out of court. I just hope that a legislated apology does not loose any of its therapeutic value.

A senior plaintiff lawyer once said rather plaintifuly, "Hey Beth, we don't get to do all that nice stuff you do like getting people to say sorry and forgive each other". Yes – we have difficult work to do but it can also be "nice stuff" and my staff and I feel very privileged to be able to do it. From our perspective mediation and conciliation are more therapeutic for all parties. I'm not saying that there is no place for individual accountability, nor that medical negligence cases should disappear – all I'm saying is that there are other constructive ways of resolving disputes in the public interest and I know which arena I would prefer to continue working in.