



**Resolution Resource
Network**
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BRINGING IN THE CONSUMER PERSPECTIVE

FINAL REPORT

**Consumer Experiences of
Complaints Processes in Victorian Health
Practitioner Registration Boards**

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STUDY TEAM

This study was undertaken by an independent consortium consisting of Resolution Resource Network (RRN), a consultancy firm specialising in complaints issues, and the Health Issues Centre (HIC), an independent non-government research and policy organisation that focuses on consumer perspectives.

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EXECUTIVE SUMMARY

This report describes a study of the experiences of health care consumers who have lodged complaints with a statutory health practitioner registration board in Victoria.

DHS Review of Health Practitioner Registration Acts

The Department of Human Services (DHS) commissioned this study to inform a Review of the 'Regulation of the Health Professions in Victoria' (the Review) it is undertaking. 'Consumers' in this context included not only people who are aggrieved about the standards of health care they have themselves received as patients or clients, but also carers and others who lodged complaints on behalf of those close to them — usually family members.

Context

Victorian health practitioner boards are established under state government legislation. They have a range of powers, including registering suitably qualified or competent persons to legally practise as health practitioners in Victoria. They also have important roles to investigate complaints about, and inquire into, the conduct, ability to practise and professional performance of persons registered under their legislation.¹

Consumer complaints are absolutely essential to the regulation of professional misconduct by health professionals. They provide a unique form of information about substandard practice by registered health practitioners. Such information would be difficult to source from anywhere else.

Overview of Disciplinary Process

Any person may make a complaint against a registered practitioner, and boards are empowered to:

- initiate a preliminary investigation into a registered practitioner's professional conduct and/or fitness to practise;
- conduct an informal or formal hearing into the matter if necessary;
- make a range of findings and determinations (from 'no further action' to imposing restrictions on practice, to terminating the practitioner's registration).

A board may close a complaint:

- after the preliminary investigation, deciding there is no further action (NFA) required or appropriate;
- after an informal hearing;
- or
- after a formal hearing.

Study Aims

The purpose of this study was to:

- specifically target complainants as consumers of board processes, and ensure that what they have to say about board processes is heard and given due weight as part of the Review;
- provide a balanced range of consumer views;
- develop evidence concerning the experience of complainants and their levels of satisfaction;
- assess and identify some of the commonalties and differences in types of complaint, and how each board handles these.

¹ Victorian Department of Human Services, Policy & Strategic Projects 2003, *Regulation of the Health Professions in Victoria: A Discussion Paper*, Victorian Government, Melbourne. p 25

Thus the research focussed on consumer experiences because consumers are major stakeholders in the complaints handling process, have a limited organised voice to present to the Review, and might not be heard without this research.

Study Methodology

DHS engaged Professor Shane Thomas at La Trobe University to develop the initial study design. This was subsequently amended slightly by the Study Team in light of participant availability and to optimise the breadth of complainant experiences of different boards and processes.

The research design developed was primarily based around qualitative interviews with complainants to one of five boards.² The research also sought to recruit a reasonable number of consumer complainants who had reached each of the three points of determination in the process at which a complaint could be closed ('no further action', 'informal hearing' and 'formal hearing').

Although some quantitative questions were used to capture straightforward factual data, the qualitative approach was selected as the method best able to capture the central issues of the research; that is, the 'flavour', depth and breadth of complainant experiences, and its meaning for those complainants.

The Study recruited and interviewed consumer complainants whose complaints had been closed by one of the five boards in the 18 months between 1 January 2002 and 30 June 2003. The Study Team selected over 300 complainants at random from de-identified lists supplied by the boards. Boards wrote to these complainants asking them to participate in the Study and 120 directly contacted the Study Team to participate. Of these, 60 were selected to be interviewed through allocation to one of fifteen 'cells'³ (to a maximum of seven in each cell). These 60 included complainants to all of the five boards, whose complaints had been closed at one of the three determination points.⁴

Ethics approval was obtained from the DHS Ethics Committee. Interviewees were paid for their participation in the interview, and, given the sensitivity of the content for some interviewees, independent counselling support was offered.

A Stakeholder and Consumer Reference Group was established for the project; comprising consumers, two board Chairpersons (representing all the participating boards), and DHS representation.

Constraints

Data is not available as to whether the sample of interviewees was representative of the population that lodges complaints with registration boards. The profile of the 60 interviewees was certainly not typical of the general population of health care users. Interviewees were mainly English speaking, of Anglo-ethnic origin, educated to tertiary or higher school levels, and were from professional and managerial occupational groups. However it was not dissimilar to the profile of other categories of service complainants described in the literature.⁵

Findings

Profile of complainants and complaints

Complainants interviewed were mainly over 35 years of age, the largest group being in the 45–54 years age group. They were predominantly women (73%).

² Medical Practitioners Board; Dental Practice Board; Nurses Board; Chiropractors Registration Board; Psychologists Registration Board.

³ Made up of five Boards X 3 points of determination – 'NFA'; informal hearing; formal hearing. (see p. 25 & Appendix C).

⁴ In addition to these 60, two additional interviewees who fell outside the sample pool in terms of their closure dates were added at the request of DHS. They were complainants who, from their perspectives, were particularly aggrieved by their experiences of board processes. This brought the total to 62, although these last two were analysed separately from the main group of 60 recruited. See Appendix E for a summary of these 2 interviews.

⁵ For example, Daniel et al (1999) and McCutcheon V. and Neri S (1993)

Complaints by interviewees typically fell into one of three broad categories: complaints about clinical practice, communication problems, and ethical issues. Interviewees described complaints with varying levels of seriousness, from minor incidents (e.g., rudeness); to issues considered to be very serious, such as clinical malpractice leading to death; or sustained sexual abuse of a patient over several years.

Half of the 60 interviewees had their complaints closed after the preliminary investigation (i.e., NFA). An approximately equal number of the remainder had their complaints referred to either a formal or an informal hearing. However, a number of interviewees were confused about which stage their complaint had reached.

Key themes

The major finding is that the system, at the time of the participants' experiences, was only meeting the reasonable needs and expectations of some complainants. For the significant number who expressed dissatisfaction with processes, (and even for those who expressed overall satisfaction but dissatisfaction with some aspects) this was not occurring. This was evident in a range of ways, outlined below. Further, these findings were fairly consistent across all boards.

The other key themes that emerged were:

- tensions between many complainants' expectations of boards' processes (and their disappointment with them) and the boards' legislatively mandated public interest role;
- concerns of many complainants about the unexpected length of the delays in processing complaints;
- concerns of many about the lack of regular board communication and insufficient support for them during the processes;
- concerns of some complainants about whether the boards were perceived to be sufficiently independent, impartial, and fair in their processes.

a) Satisfaction with board processes

A significant finding was the relatively high level of dissatisfaction by complainants with the boards' processes. A little over half of the interviewees reported they were not at all satisfied or were only partly satisfied with the board processes in dealing with their complaints. One-third of interviewees stated that they would not complain again or recommend to a friend that they do so. Among those who did state that they would complain again, many did so with qualifications, such as: "only if the processes are improved".

Many of the dissatisfied interviewees reported experiencing the complaints handling processes as "difficult", "unsympathetic", "inaccessible" and/or "ineffective". Interviewees also reported they found board processes as "impenetrable", "confusing", "stressful", "frustrating" and "not user-friendly", despite the higher-than-average levels of education and occupational skills of the complainants interviewed:

The victim is squashed.

I wasn't taken seriously.

On the other hand, just under half of the interviewees were reasonably or very satisfied with their experience.

Satisfied Acceptable.

I am glad I did it. It helped me with healing. It was not pleasant, but I was satisfied with the outcome. It was worthwhile.

Sometimes, though, members of this group also noted some dissatisfaction with outcomes and processes.

Some confirmation of these perspectives on satisfaction was provided by interviewees' assessment of the impact of the experience on them. Opinions were divided equally three ways between complainants thinking that the complaints handling process:

- had improved the situation for them;
- had made it worse; or
- had a mixed impact on them.

Results in relation to this question indicate again, over half had a poor or partially poor outcome.

Complainants' levels of satisfaction varied according to the determination point reached in the process. Complainants whose complaints did not proceed beyond preliminary investigation were least satisfied, while those going to formal hearing were most satisfied. However, nearly half of this group was still dissatisfied to some extent.

These variations by determination point could reflect a couple of factors. Complaints that reached either formal or informal hearing had, by definition, received more attention and board resources. This was likely to have been seen by interviewees as recognition of the seriousness of their complaint. For many complainants whose complaints proceeded no further than being dismissed with 'NFA', the opposite could well have been true – boards were seen as not treating their complaints seriously enough, and, as later results show, as not 'listening' or accepting the complainant's version of events.

Variation in complainant satisfaction by board was not significant enough to report.

b) Gaps in expectations about processes between complainants and Boards

A second major finding was the considerable gap between many consumers' expectations of the processes and those of the boards. For many interviewees the process turned out to be quite different from what they had expected at the outset or even after the initial information or contact. A majority of interviewees perceived board processes to be confusing, frustrating and onerous. Many suggested that processes could be less bureaucratic, less formal and not so legalistic:

Unhappy. I never wanted to end up in an adversarial situation.

Yes but the process was not what I wanted when I made the complaint.

c) Timeliness

One element of dissatisfaction was the issue of timeliness. Interviewees reported times for the processing of their complaints ranging from a few months, to two years. For about three-quarters of interviewees, the process took a year or less. A quarter of the complaints took over a year to be finalised, and several took two years or more. Delays and the time taken to finalise the complaint, combined with lack of information flow, was probably the most commonly expressed grievance about board processes:

Time lines. I had no idea it would take so long. I wasn't told.

This raises issues of the functioning and membership of health practitioner registration boards. Several possible improvements are suggested. These could include: the introduction of benchmarked timelines, regular reporting to complainants on the board's compliance with these; plus improvements to the availability of Board members to sit on hearings. This latter improvement would involve issues of resourcing and better payment of members performing quasi-judicial functions.

d) Complainant status

There is an inherent tension between expectations of complainants, and the legal role of boards. Complainants perceive their role as central to boards' proceedings. In fact, in each board's exercise of its statutory purpose and powers, the complainant is often not so important. They will often be no more than one source of information in a larger case, and hence no more than a potential witness in disciplinary proceedings against the practitioner. Sometimes the complainant's purpose and that of the board coincided. More often they did not.

The complainant's lack of status in board investigation and disciplinary processes was an issue for many interviewees. This had various components.

First, many interviewees reported no opportunity to review the response of the health professional to their complaint allegations, to reply to this, and to be able to correct what they perceived to be factual errors, misconceptions and untruths, before the board made a decision.

I expected to receive a copy of his reply and be told what he said and then sit in a hearing and talk about it I was never given the chance to give any feedback.

From a complainant perspective, consideration could be given to affording them the legal opportunity to present whatever evidence they wished at a hearing. At the very least, reforms to the legislation could entitle them to access to the health practitioner's evidence/statements if they wished it, and guarantee them an opportunity to present their own versions/refutations in hearings.

Complainants could also be able to exercise this right before the end of the preliminary investigation, and before the board decided whether to proceed or not. Legislation could require a board to offer the complainant the chance to review the health practitioner's statement and reply to it before making a decision. From interviews in this research, it would appear that some boards already do this for some complaints, but it is not the norm.

There are a number of complainants' issues identified by interviewees that potentially would be addressed if their legal status as participants in the proceedings were clarified and, where useful, enhanced. For example, several interviewees raised the issue that they did not understand the reasons for the board's decision. The right to request a statement of reasons (SOR) for legal determinations made by the board about their complaint, including a decision not to conduct a hearing/or proceed further with the complaint following a preliminary investigation, would be one way of addressing this problem. The right to have decisions reviewed is another example — an important one given that many interviewees disagreed with the findings and/or determinations of the board in relation to their complaints.

A number of interviewees whose complaints resulted in a formal hearing also described negative feelings and experiences in the hearing. These were identified (in part), as linked to not having enough support when giving evidence, not being believed, and not being able to effectively present their point of view. Provision for complainants to have their own legal advice and support, would be one solution to this. Such options need further exploration.

e) Gap in expectations about outcomes

Initially, even though some interviewees were unclear about possible outcomes, the majority expected their board to exercise its investigative powers to thoroughly investigate the complaint, look at all the evidence, and bring down a finding. They wanted changes to the health professional's behaviour or procedures or, occasionally, de-registration to protect other consumers. They at least wanted to gain an

acknowledgement or apology from the practitioner. They saw themselves as essential to this process:

The Board's role is a critical part of accountability of the medical profession and the complainants' healing journey.

Over one-quarter of the interviewees said they did not understand the reasons for the board's decision. The remaining three-quarters stated that they did, but this did not necessarily mean that they agreed with the reasons given, or that they felt a reasonable decision had been reached:

Yes I was given the reasons for the decisions. I understood the reasons why he couldn't be given a heavier penalty.

I understood what they said. I didn't agree with the reasons.

Yes but they missed the point of my complaint.

It was never explained. I was told the Board met and the outcome of the meeting. That is all.

A significant number had not anticipated the outcome of their complaint at all — that it would be closed or dismissed without a finding against the practitioner.

f) Communication issues

A further consistent set of themes for complainants emerged in relation to the complainant's level of communication and interaction with the boards. The first of these was the need of interviewees for more information and support through the complaints handling process. Although there was reasonable satisfaction with the initial information given by the boards, not all interviewees reported receiving useful information about the board's processes and powers. Even where there was satisfaction with initial levels of information and communication, there were very mixed levels of satisfaction with subsequent information flows – and hence levels of understanding about what was happening or was likely to occur.

Yes fairly helpful. Gave me a general idea of what would happen.

Appalling, the information process was appalling.

Two-thirds of interviewees said they were able to present all the relevant information they wished during the complaints handling process, but one-third stated they did not.

A common theme was that board staff were very helpful and pleasant when contacted, but that complainants had to initiate these contacts to find out what was going on.

Interviewees suggested a number of improvements to communication problems, including:

- clearer and more consistent information and communication;
- opportunity for face-to-face meetings;
- assistance with putting a complaint in writing; and
- more support for complainants throughout the process.

The suggestion in the Review Paper⁶ that boards be required to provide a contact/liason officer, who would liaise with each complainant, would be one way to address the concerns and the suggestions made by complainants above.

⁶ DHS 2003

During the preliminary investigation, someone from the Board needs to "eyeball" the complainant. It should be the first step into the process.

Another potential approach to increased support would be to develop stronger advocacy and support services for complainants, separate from the boards. Currently some boards do refer complainants to such a support service, and feedback about this service was generally positive. However, two important qualifications were raised. First, some interviewees reported that these support services lacked the capacity to assist them to the level they felt was necessary, perhaps pointing to a lack of resources. The second was a perceived conflict of interest due to insufficient independence from the board; for example, the support person was subpoenaed in one case to give evidence on matters that the complainant had confided in her.

An advocacy service independent of the boards could provide complainants with assistance through all processes (whether with health care providers, boards, or the Health Services Commissioner) and could advocate/ inquire on their behalf to these agencies.

g) Closure and understanding the outcome

All interviewees said they received a letter from the board informing them that their complaint had been finalised and giving the outcome of the process. However, interviewees reported substantial variation in the interval between conclusion of the proceedings and receipt of this letter – from a few days to several months. However, some interviewees who waited some time for their letter did receive more timely communication about outcome, in that a board staff person rang them shortly after the determination.

Further, as stated earlier, a quarter of interviewees did not understand the their board's decision. The remainder did understand, but did not always agree with it.

h) Concerns about the Boards' independence, impartiality and fairness

Interviewees were equally divided on their perceptions of how fairly their complaint had been handled. Some were positive:

Very professional process. Sent follow-up letters, indirect apology from the doctor.

Other complainants doubted that the board had properly investigated their complaint.

A number of interviewees expressed doubts about the impartiality of boards. They perceived the board members who were responsible for investigating complaints about practitioners and discipline, as being fellow professionals; and questioned whether this led to independence, impartiality and fairness; for example, "*they look after their mates*".

The researchers are not in a position to assess the merits of claims that the boards are not independent, fair, and unbiased in their deliberations (this was beyond the scope of the study). The perception of bias noted above was a recurring theme, however, and links directly to the issue of public confidence. It is possible that complainants who are aggrieved by board processes or outcomes may be more predisposed to perceive that the boards are biased. However, maintenance of public confidence in the regulatory system for health practitioner requires not only that the system be fair, unbiased, and independent, but also that it is seen to be so. A board investigation and deciding about complaints made up of membership dominated by members of the same profession as that of the practitioner under scrutiny does not necessarily inspire community confidence.

Consideration could be given to reforms designed to address this perception of bias. Such reforms could include:

- changes in the membership mix of practitioner and non-practitioner board members;

- separation of investigation, and discipline determination functions between two bodies, rather than the current one board conducting both; and
- increased transparency, and involvement of board members who are not health practitioners in the same profession, in processes of investigation and hearings
- better information for complainants about the norms of acceptable practitioner care and behaviour.

i) Referral or parallel processes

Only four of the 60 interviewees reported receiving information from boards about other processes or avenues of appeal available to them and only one person was referred back to the Health Services Commissioner. This is despite the fact that the Office of the Health Services Commissioner is set up to meet many of the consumers' expressed needs (e.g., mediation). If the law enabled these processes to run in parallel (as far as practicable) Health Services Commissioner processes could advance the complainant's objectives and needs in resolving the complaint, while the board could investigate individual health practitioners and apply disciplinary sanctions if necessary 'in the public interest'. This option is worth further investigation.

j) Consistency

The findings suggested considerable variation in processes not only between boards but also within the same board across individual complaints. This suggests a strong need for more uniformity in both the process and in the accessibility and levels of support for consumers in making complaints.

One possible approach to these last issues is for there to be a 'one stop shop' to receive health complaints. Within Victoria an independent investigation body such as the Health Services Commissioner could conduct a preliminary investigation of the complaint for the complainant to clarify the issues, support the complainant in the process, and attempt to find a resolution that meets the needs of all involved. Issues of substandard practice by registered health practitioners could then be more thoroughly investigated by the independent investigation service, which would pass on the complaint to the relevant board for performance assessment of that practitioner, and disciplinary hearing where necessary. Alternatively, once the body receiving the complaint investigates and determines there are issues of substandard practice by registered health practitioners, those issues (and only those issues) could be referred directly to the relevant board for further inquiry.

This 'one stop shop' would also address concerns that, from a consumer perspective, there are a (potentially confusing) number of agencies and boards where complaints about health care practitioners can be lodged. A single portal would enable broader promotion of complaints processes, and education of the public about where and how to make a complaint.

Conclusions

Caution is needed in implying too much from precise numbers of complainants who, in general, expressed 'satisfaction', or 'dissatisfaction' with board processes. A significant proportion of complainants (although a minority overall) were satisfied. However, within that context, the general quantum of dissatisfaction with the current processes of health practitioner registration boards and outcomes of complaints is an important finding. Virtually all complainants interviewed were dissatisfied with some elements of the current system.

This does raise some critical issues. First, from a health care consumer perspective, it is of concern that a significant number of people are dissatisfied with a 'public good' process that is reliant on their involvement. This is especially of concern because it means that those people had two unsatisfactory processes – the initial health care episode and then the complaint process itself. Such experiences, if they become too endemic, can lead to an ebbing of public confidence in the system. Second, the

regulation system is highly reliant on consumers coming forward to complain. Significant levels of dissatisfaction would seem to undermine its sustainability and effectiveness.

The findings in this study should set off some warning bells. It suggests a need for review and reform of structures and practices to make the system both more consumer-friendly and more consumer-trusted. Even without the current Review of legislation, such findings would imply that the boards need to pay some urgent attention to their relationships with complainants.

Based on the analysis of complainant experiences above, the Study Team proposes a number of key principles upon which the future regulatory and complaints handling system should be based. The Team also recommends that the actions that flow from these principles be implemented.

Recommended Principles for Future System

Based on the findings of this research, the Study Team suggests that the following principles be adopted to underpin any reform of the health practitioner regulatory system. Some of these have already been articulated as the basis for the Review.⁷ Additional principles are proposed below, to reflect the importance of consumers to the regulatory system.

The future regulatory and complaints handling system should be:

- fair and unbiased, and seen to be so
- independent and seen to be so
- transparent
- effective (from a consumer complainant perspective as well as that of the broader public, health services and professions)
- timely
- accountable.

In addition, the health practitioner regulatory system should comply with principles of therapeutic jurisprudence in that it:

- recognises the central role of health care consumers in the regulatory system and its reliance on consumers making complaints in good faith when they perceive poor care or behaviour;
- is designed to meet reasonable expectations of consumers when they make a complaint;
- acts to minimise the harmful impact of its legal processes on complainants;
- acts reasonably in its demands on complainants.

The principle of 'do no harm' is central to the concept of therapeutic jurisprudence. It recognises that legal processes can have a harmful effect on community members who are caught up in its procedures, particularly people who are 'victims' of unacceptable behaviour, who bring it to the attention of the legal system through reporting or complaining about it. Principles of therapeutic jurisprudence recognise that a victim/complainant has the potential to be twice harmed — first by the behaviour (in this case poor health care) and second, by the legal process. This was evident for a number of our interviewees. Therapeutic jurisprudence requires the legal system to consciously act to minimise (to the extent reasonably compatible with its public interest purpose) the impact of the harmful effect of its processes on people, and particularly to endeavour not to compound the harm done to those who have been victimised once already.

⁷ See DHS 2003 Table 1.1 at p. 10.

Other Conclusions

The results of this research have implications for both the DHS Review, and for Boards. There are many options for action that could be explored that could make the system more user-friendly.

For example, the Review could investigate including legal reforms which facilitated a more 'consumer friendly' complaints system. Legislative reform could be considered which would provide for a single point of entry to the complaints system (the 'one stop shop'). It could improve the legal standing of complainants in relation to their rights to notification, to access to reasons for board decisions, and for a review. Legislative reform could upgrade requirements for support of and communication with complainants, including the possibility of a separate complainant advocacy service such as that which exists in NSW and in New Zealand. Lastly it could tackle perceptions of bias through review of board membership, and address questions of timeliness.

Similarly, boards themselves could use this research effectively to improve consumer responsiveness in their own processes. Suggestions that are worthy of further discussion include:

- establishment of consumer reference / advisory groups (already being developed by the Medical Practice Board of Victoria);
- development of benchmarks for timely complaint processing and regular reporting to the community as to compliance; and
- periodic data gathering about complainant experiences of the complaints handling processes as a quality control measure – using this research as a 'base line'.

Finally, the researchers would like to commend DHS for commissioning this research, and the participating boards for their foresight in supporting it. The impact of legal processes on ordinary people who get 'caught up' in their labyrinth-like processes is an area of research and reform that has only recently begun to be examined. This work provides an important contribution to that development, and a significant insight into the strengths and weaknesses of the current system in terms of its impact on consumers of its processes.

SECTION ONE: INTRODUCTION

This report describes the findings from a study of the experiences of health care consumers who have lodged complaints with a statutory health practitioner registration board in Victoria. It was commissioned by the Department of Human Services to inform a review of the 'Regulation of the Health Professions in Victoria' (the Review) it is undertaking.

The stated aims of this Review are:

- to strengthen consumer and community confidence in the regulatory system;
- to ensure the maintenance of an up-to-date and responsive regulatory framework for the registered health professions where the public is satisfied that it operates fairly, effectively, independently, consistently, transparently, and is accountable; and
- to ensure good links between mechanisms that ensure practitioner quality and those which ensure health system quality.⁸

The research focussed on consumer experiences because consumers represent the major stakeholder group that has a limited organised voice to present to the Review; and which, without this research, might not be heard.

Context

The services provided by Victoria's health professionals are central to the delivery of high quality health care to all in Victoria. Most mainstream health care professionals, such as medical practitioners, nurses, dentists, pharmacists and physiotherapists, are subject to legal regulation through statutory registration boards (simply described as 'boards' in the remainder of this report). These are established under separate Acts of the Victorian Parliament. All health practitioners registered with each board have a legal obligation to act professionally and provide services to the public that are of reasonable standard.

Statutory health practitioner registration boards play an important role. They set standards that health professionals must attain in order to be registered and practice their profession, and they receive and investigate complaints of poor performance or unprofessional conduct by registered practitioners. Their powers to investigate professional conduct and apply sanctions if necessary protects the public and afford confidence for Victorians that health professionals are well qualified, and maintain high standards in providing health care to the community.

Consumer complaints play a vital part in the regulation of poor performance or professional misconduct by health professionals. Without consumer complaints, it would be more difficult for boards to become aware of and address substandard practice by registered health practitioners.

The term 'consumer' in this context is used to include not only people who are aggrieved about the standards of health care they themselves have received as patients or clients, but also carers and others who lodge complaints on behalf of those close to them — usually family members⁹. For all boards (except the Nurses Board of Victoria) the large majority of complaints are from health care consumers.

⁸DHS 2003, p. 9

⁹ This had one un-anticipated effect on the research – in relation to the Nurses Board, it reduced the 'pool' of potential complainants to only a few: as nurses are the largest group whose practice is in employment rather than as individual practitioners, most complaints against nurses are lodged by their employers, – generally large institutions such as hospitals.

Background

In 1987–90, the Victorian Government carried out a major review of health practitioner legislation. During 1993-94, reforms were introduced, focussing first on the regulation of nurses and of medical practitioners, and in later years on other professions.

In all, 10 Acts of Parliament were passed between 1993 and 2000, and common core provisions to regulate the registered health professions were introduced. In 2002, the Victorian Government legislated for further reforms to the Medical Practice Act. These reforms introduced substantial new powers for the Medical Practitioners Board of Victoria to regulate practitioners who may be performing poorly. However, not all health practitioner registration Acts have been updated to include these reforms. The current Review was established (amongst other things) to reassess the operation of professional regulation in the light of these reforms, and to examine whether more recent changes to the Medical Practice Act should be extended to all health practitioner registration Acts.

Current powers and functions of registration Boards

Victorian health practitioner registration legislation specifies a number of functions for which registration boards are responsible. These include:¹⁰

- to register suitably qualified persons and/or persons meeting approved competency standards, which legally allows them to practise their profession in Victoria;
- to investigate complaints about, and enquire into, the conduct and capacity to practise of persons registered under the Act;
- to regulate the standards of practice of the profession in the public interest;
- to issue guidelines about appropriate standards of practice;
- to carry out such other functions as are vested in the board or by the Act.¹¹

Overview of Disciplinary Process

Under the current arrangements for managing complaints and discipline, registration boards are empowered to:

- receive complaints regarding registered practitioners;
- initiate a preliminary investigation into a registered practitioner's professional conduct and/or fitness to practise (either on their own motion or in response to a complaint);
- conduct an informal or formal hearing into the matter if necessary (either on their own motion or following a preliminary investigation); and
- make one or a number of findings and determinations, which vary according to the seriousness of the conduct.

Furthermore, the Acts set out which functions registration boards may delegate and to whom, who may be appointed to hearings panels and what powers the boards and delegates have in conducting disciplinary and hearings functions.¹²

Any person may complain about a registered health practitioner to the registration board with which the health practitioner is registered. When a complaint is received, the board initiates¹³ an investigation by an investigator and/or a panel unless it considers the complaint to be 'frivolous or vexatious'. This is the 'preliminary investigation'. The board investigator will usually (but not always) go back to the complainant and obtain more detailed information concerning the complaint. The practitioner against whom the complaint is lodged will then be asked to give his/her version of events. The investigator

¹⁰ Additionally, Board powers over medical practitioners under their Act include power to investigate complaints of unsatisfactory professional performance.

¹¹ DHS 2003, p. 25

¹² *ibid* p 67

¹³ Procedures as between the Boards may vary in the detail, according to the different Acts, and individual Board directions. However, essentially all of the Boards complaints handling processes follow these broad parameters.

will follow up any other relevant information, and then prepare a report and recommendations to the board, or to a disciplinary committee of the board.

At the conclusion of the investigation, the board decides whether there is sufficient justification (in terms of the seriousness of the complaint and the evidence gathered by the investigator) to proceed to a hearing about the complaint. If it considers that there is not, it will decide that the complaint warrants no further action. Once that decision is made, the board closes the case, and the complainant is informed that no further action will be taken.¹⁴

At this point, in some cases, limited powers also exist to negotiate with a practitioner. As a substitute to conducting a hearing the board may accept an agreement by the practitioner to change the way they practise; or to agree to the imposition of conditions, limitations or restrictions imposed on their registration; or to undergo a suspension of registration for a specified period.¹⁵

If, after the preliminary investigation, the board considers that there are sufficient indications of substandard practice or professional misconduct to justify a disciplinary hearing, a two-tiered disciplinary system exists. The practitioner against whom the complaint is lodged will be referred either to an informal hearing, or to a formal hearing, where the board appoints a panel of board members or other qualified persons to hear the matter.

Formal hearings are conducted by quasi-judicial tribunals in accordance with the rules of natural justice. The board formally enquires into the allegations of substandard practice/professional misconduct. Evidence is presented from the investigation, and the practitioner has an opportunity to present a defence to the complaint. The board may consider several complaints against a practitioner at the same time; the complainant may or may not be required to give evidence.

Informal hearings involve more of a 'conversation' between a practitioner and a board panel or disciplinary committee, about the complaint and the results of investigation. At informal hearings, panels can make determinations, but their capacity to impose penalties on a practitioner is limited. Their focus is more on rehabilitative penalties — re-training / re-education; counselling; cautions; and reprimands.

The complainant has no right to have either a board's decision not to proceed (NFA), or a decision of an informal panel, legally reviewed. There are some limited rights to have board decisions made at a formal hearing reviewed by the Victorian Civil and Administrative Tribunal (VCAT). However, there is some doubt as to whether a complainant has sufficient legal 'standing' to apply for review of a decision.

The Health Services

The registration boards and the Health Services Commissioner perform complementary roles in receiving, investigating, and managing complaints against health practitioners. When a complaint is lodged with the Health Services Commissioner and the complaint involves a registered health practitioner, the Health Services Commissioner generally refers the complaint to the relevant registration board when appropriate and after discussion with the complainant.¹⁶ Equally, registration boards are required to advise the Health Services Commissioner of any complaint received concerning a registered practitioner's behaviour and, if the matter is considered suitable for conciliation as

¹⁴ These complaints are referred to in this report as the 'no further action' cases, and identified by the acronym 'NFA'.

¹⁵ All health practitioner registration Acts in Victoria provide Boards with powers to enter into an agreement with practitioners suffering from ill health, incapacity, or drug or alcohol addiction, to alter the way they practise. Recent amendments to the Medical Practice Act extend these powers to cover matters of unprofessional conduct or unsatisfactory professional performance by medical practitioners.

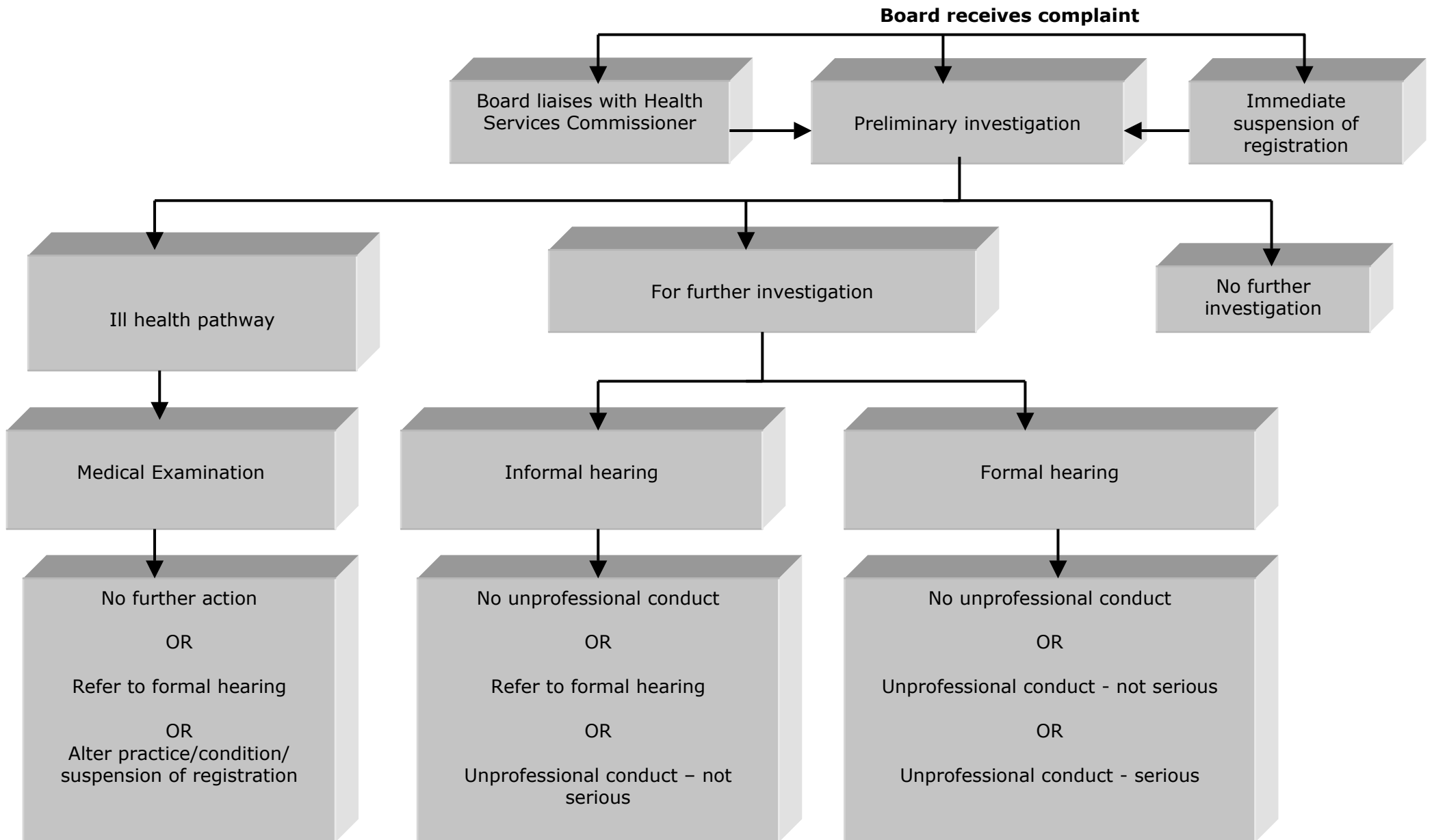
¹⁶ Under the Health Services (Conciliation and Review) Act 1987 Sec. 19 (6), if a complaint relates to a registered provider the Commissioner **must** refer the complaint to the appropriate registration board if, after consultation with the provider's registration board, the Commissioner considers that the board has power to resolve or deal with the matter and the matter is not suitable for conciliation under this Act.

between the practitioner and the complainant, boards must refer the matter to (or back to) the Health Services Commissioner. In practice, at least from the results of this research, this rarely seems to occur.

Figure 1 sets out a simplified version of the flow chart of typical board disciplinary processes. A fuller version, as provided in the Review Paper, is on page 79.

Figure 1

SIMPLIFIED OVERVIEW OF CONSUMER COMPLAINTS HANDLING PROCESS



The Review

In December 2002 the Minister for Health initiated a fresh review all health practitioner registration Acts. In undertaking this, Victoria is part of a recent trend of review and reform of health practitioner registration legislation that has occurred in a number of states (notably Western Australia, Queensland, and Northern Territory) and overseas (in particular Ontario [Canada], United Kingdom and New Zealand).¹⁷ The stated aims are noted above.

As part of the Review, DHS funded several research studies to generate information to guide policy development and recommendations for legislative change. This report is the product of one of these — a qualitative research study into the experiences of health care consumers who have lodged complaints with a statutory health practitioner registration board in Victoria. Boards receive complaints from a range of complainants including employers, other health professionals, institutions, government agencies, and WorkCover. However, this research focussed on consumer experiences because, as noted above, consumers are the major stakeholders who have a limited organised voice to present to the Review.

The Study

Purpose of the research

The purpose of this study was to:

- specifically target complainants as consumers of board processes, and ensure that what they have to say about those processes is heard and given due weight as part of the Review;
- provide a balanced range of consumer views;
- develop evidence concerning the experience of complainants and their levels of satisfaction;
- assess and identify some of the commonalities and differences in types of complaint, and how these are handled by each board.

There are several reasons why the Review considered this study necessary.

- Boards and other stakeholder groups have ample opportunity to make submissions and discuss their views with the reviewers but complainants are not an organised group who can collectively ensure that their perspective is understood by the legislators.
- Although there is a common statutory framework within which boards operate, each board has developed its own processes and approaches to complaints handling. The boards also vary considerably in terms of their size and the number of practitioners whose activities they regulate and monitor. The research provided an opportunity to identify a complainant perspective of some of the commonalities and differences between the respective boards in the types of complaint they receive, and how these are handled.
- A small number of complainants are very vocal and have expressed negative views about board processes to the Minister and DHS. Some stakeholders expressed concerns that their experiences are not typical of most complainants, and therefore the Review might receive a distorted picture of the impact of the processes if they were the sole source of information about complainants' experiences. This research would obtain accounts from a broader range of complainants.
- Complainants are absolutely essential to the capacity for health practitioner registration boards to monitor maintenance of standards of care by health professionals. If board processes are inaccessible, complainants will be discouraged from 'whistle-blowing' when they receive poor care or experience breaches of professional ethics, and the system will not become aware of crucial problems.

¹⁷ For an overview of review and reforms in these jurisdictions – see 'DHS' 2003.

- It is critical that the public should have confidence in health professionals and the standards of health care they provide. The community will only have this confidence if they are assured that the systems of monitoring are rigorous, including those administered by health practitioner registration boards. Few members of the community have direct experience or contact with health practitioner registration boards. One group that does are those health care consumers who lodge complaints against health professionals. Therefore, perceptions held by complainants who have experienced board processes directly are a useful barometer of the confidence with which the general public views the current system.
- Finally, complainants are consumers of board processes. The system must work for them as well as for the general public and health professionals.

For all these reasons, asking complainants about their experiences and perceptions of the health practitioner registration board system was seen as important for the Review. It provides important information in evaluating the current system, and assisting government to identify where change is needed if community confidence is to be maintained.

The Task – Terms of Reference

DHS designed the research project to support the Review process. Specifically, independent researchers were commissioned to:

- conduct qualitative and quantitative research into complainant experiences and levels of satisfaction with statutory registration board complaints handling processes, through a series of interviews with a stratified sample of consumer complainants (noting that for all boards, except for the Nurses Board, the large majority of complaints are from health care consumers);
- report the findings to DHS.

Five of the 12 health practitioner registration boards in Victoria were asked to participate in the study:

- Medical Practitioners Board of Victoria
- Nurses Board of Victoria
- Chiropractors Registration Board of Victoria
- Dental Practice Board of Victoria
- Psychologists Registration Board of Victoria.

This mix of boards was selected to provide a range of types of health professional practice and consumers and to represent both large and small boards.

Research Team

Through a selective tendering process, DHS commissioned an independent consortium to carry out the research. It consisted of Resolution Resource Network (a consultancy firm specialising in complaints issues) and the Health Issues Centre, an independent non-government research and policy organisation that operates from a consumer perspective. The researchers were Liza Newby, Tony McBride, Tere Dawson, and Panayiota Romios. All of whom are experienced in the concerns of consumers of health care and familiar with the issues for health care consumers who lodge complaints. Neither group is employed by or associated with the Victorian Government, or any of the boards in any areas.

SECTION TWO: METHODOLOGY

The research study was undertaken from August 2003 to March 2004.

Literature Review

A comprehensive literature review was not part of the research brief.

However, a brief literature review was conducted as an initial scoping exercise to identify previous studies on surveying/interviewing complainants about their experiences of lodging complaints, particularly those that could provide models of survey and interview tools. A number of relevant studies were referred to, including research into police complainant experiences in Canada (Landau 1994), research into Australian complainant experiences in the financial industry¹⁸ and various studies into complainants' experiences carried out in Britain under the auspices of the National Health Service or the Citizens' Charter (see e.g., Mulcahy, Allsop Shirley 1996; MORI 1994).¹⁹ As well, the researchers drew on various general methodological texts on qualitative research and interview tool design (see e.g. Patton 1990; Power & Single 1996).

Reference Group

A Stakeholder and Consumer Reference Group was established for the project. The Reference Group comprised consumers, two Board Chairpersons (representing all the participating Victorian health practitioner registration boards), and DHS representation. Its role was to oversee and monitor the scope and progress of the study. It met twice, once in September 2003 to consider the project plan and methodology (in particular the draft interview tool), and in July 2004 to review the draft report. (For a list of members and terms of reference see Appendix B).

Research Design

The Department of Human Services engaged Professor Shane Thomas at La Trobe University to develop the initial study design. This was subsequently amended slightly in the light of participant availability and to optimise the breadth of complainant experiences of different boards and processes.

¹⁸ 'Australian 'Review of the Financial Industry's Complaints' Service – What are the Issues' in 2002' – FICS Issues Paper' – Elix and Sourdin; Community Solutions, La Trobe University/University of Western Sydney 2002.

¹⁹ 'Attitudes towards and Experiences of Complaints Systems'; MORI for the Citizen's Charter Complaints Task Force London 1994; and 'The Voices of Complainants and General Practitioners in Complaints about Healthcare'; Mulcahy, Allsop, and Shirley; Social Science Monographs No 3, south Bank University, London 1996

Qualitative research approach

The research design developed was primarily based around qualitative interviews with complainants. Although some quantitative questions were used to capture simple facts, the qualitative approach was selected as the method best able to capture the central issues of the research – that is the ‘flavour’, the depth and breadth, as well as the meaning, of complainant experiences for those complainants.

Qualitative research design therefore recruits participants purposively by focussing on people who have information valuable to the research. Whilst it tries to ensure there is minimal bias in this approach, its primary aim is not to seek a sample of participants who are statistically representative of a broader population,²⁰ as occurs in much quantitative research; its focus is on mapping and exploring experiences in depth, not on quantifying. However, within this information-rich approach, care can be taken to select people within broad categories of experience in a random way, so that their responses and characteristics will reflect those of the whole category from which they were drawn. This then makes the simple quantitative data collected along the way more valuable too. That is the case in this research.

Categories of complainants and matrix design

The aim of the study was to explore complainants’ experiences in some depth, and to ensure a balanced range of complainant experiences. It did not seek to simply quantify all complainants’ experiences.²¹

Although it was not possible to anticipate all the key categories of experience of complainants in advance, it was clear that different boards were likely to have different processes, and that the seriousness of the complaint (and hence the phase of the process reached by participants) were both likely to significantly influence their experience.

Professor Thomas’s design was therefore based on the assumption that it was necessary to ensure the study included a satisfactory sample of complainants to both large and small boards. Five boards were asked and subsequently agreed to invite complainants from their lists to participate in the research.²²

It was also assumed that it was necessary to ensure that the study included complaints of all levels of seriousness and outcome. Thus, the research design established quotas for complaints that had concluded at the end of each of the three main points of board decisions about complaints within the process²³: no further action (NFA), informal hearing panel, or formal hearing panel.

With five boards and three determination points within each board process, 15 categories or ‘recruitment cells’ of potential participants were therefore identified. The study thus aimed to recruit equal numbers of randomly selected complainants within each cell. This would allow for sufficient interviews about complaints to each board to give a reasonable picture of all the boards’ processes.

Recruitment

The recruitment phase involved a number of steps.

- Each board wrote a letter of invitation to participate directly to all eligible complainants in the study period.

²⁰ See M. Q. Patton (1990) *Qualitative Evaluation and Research Methods* (2nd edition), Sage Publications US for a description of purposive sampling.

²¹ To have reflected the actual numbers of complaints to each board in the sample would have skewed the sample interviewed too much in favour of boards with large numbers of consumer complaints; for example, there would have been 16 times as many Medical Practitioners Board interviewees than from the Nurses Board. This would have meant that, for the smaller boards, there would have been insufficient interviewees to allow any meaningful conclusions to be reached.

²² For a more detailed account of the recruitment process and steps taken to protect the confidentiality and privacy of complainants, see Appendix C.

²³ Generally referred to as a ‘determination point’ within this report.

- Interested complainants then volunteered by contacting Health Issues Centre directly, when, unless there were more volunteers than the sample size for each sub-category of determination point for each board they were added to the participant list. Where there were more volunteers than required for the sample size for that sub-category, a random sample was taken so that, as far as possible, there were comparable numbers in each sub-category across the five boards and three determination points.
- Health Issues Centre then contacted the participants to confirm their agreement to participate and to arrange an interview time.

Selection Criteria

(a) Cases closed in last 18 months

The study recruited and interviewed consumer complainants who were drawn from complainants those who recently lodged a complaint to one of the five boards selected. This was necessary to ensure that their experience of board processes was as contemporary and relevant to the current situation as possible. However, it was also essential that the complaint's progress through board processes had been completed prior to the study, and their case closed by the board. Complaints that were still under active consideration were excluded from the study because of conflict of interest considerations.

For this reason, and to contain numbers in the sample pool from the larger boards, the target group was all²⁴ complainants whose complaints had been closed by each board in the 18 months between 1 January 2002 and 30 June 2003. The exception to this was the group of complainants to the Medical Practitioners Board. This board has much greater numbers of complaints than the other boards, and it was decided to limit the target group to complainants whose complaints closed in the six months between 1 January and 30 June 2003. This would still enable sufficient numbers of participants to be recruited.

(b) Recruitment for each cell

The detailed method for recruiting participants within each cell is described in Appendix C.

The initial target recruitment number was seven interviewees from each of the 15 cells, totalling 105 interviews. However, particularly for the smaller boards, and for the more infrequent formal hearings in all boards, the target of seven in every cell was not reached. This reduced the numbers of interviewees to 60. This was sampled from a response of 120 complainants to the study invitation — a response rate of approximately 34%.

This reduced sample size was not considered to be a problem within the context of selection of interviewees for qualitative interviews. Patton (1990) suggests that, as the aim of qualitative sample selection is reasonable coverage of the issues, the selection of interviewees is determined by informational considerations; the group is big enough and recruitment can cease when no fresh information is forthcoming from new interviewees and they are just repeating themes from earlier interviews.²⁵ This was the case in this study where the Study Team considered that no new themes were emerging in the latter set of interviews; interviewees were simply providing confirmation of the key themes that had already been identified and explored by earlier interviewees.

²⁴ One further qualification was agreed upon. The Reference Group agreed that, for a very few complainants, the actual act of requesting participation in the study would be unnecessarily intrusive and disturbing. Boards were therefore requested to use this judgement.

²⁵ Ibid

In addition to the 60 volunteers, two additional interviewees who fell outside the sample pool in terms of their closure dates were added at the request of DHS. They were complainants who, from their perspectives, were particularly aggrieved by their experiences of board processes when they complained. This brought the total to 62, although these last two were analysed separately from the main group of 60 recruited.

Interview tool development

As noted above, the research methodology comprised a mixed quantitative, but predominantly qualitative, interview approach. Complainants were interviewed by a researcher using a semi structured interview tool; that is, using a predetermined 'map' of questions and areas which interviews were to cover, but without being prescriptive in the order or way the questions were put, or the information obtained.²⁶

The interview tool was developed by the research team, based on experience of complaints handling processes, a brief scan of the literature and consultation with the Reference Group. The tool was designed to allow the interviews to focus on three major areas:

- complainants' knowledge and understanding of the boards' processes.
- complainants' experiences of boards' processes relative to their expectations and objectives in lodging the complaint.
- complainants' suggestions and recommendations for change to boards' processes arising from their experiences.

Interview Scope

The interview collected data concerning the demographics of the interviewees, the nature of complaints made, the interviewees' perceptions of the processes followed by the board in handling their complaint, and the outcomes of the complaint from the interviewees' point of view. It also sought information concerning interviewees' experiences of these processes and their satisfaction with how they were conducted. Interviews lasted between 45 and 90 minutes.

Interview Mode

Generally the preference was for face-to-face interviews between the interviewee and the researcher at a place of the interviewee's choosing; however, telephone interviews were necessary for some. These included those living outside of Melbourne or more than one hour from the research base, or those who did not wish to be interviewed in person. The interviews were recorded through structured note taking, but were not audio recorded.

The interview tool was trialed on the first nine interviewees, and some modifications were made.²⁷

Ethics approval

Ethics approval was obtained from the DHS Ethics Committee in October 2003. All participating complainants signed consent forms before being interviewed face-to-face or by phone by a Study Team member.

Interviewer training

The project used four interviewers experienced in conducting qualitative interviews with consumers. Targeted training was conducted for interviewers that focussed on the particular issues and processes likely to arise for board complainants in interview.²⁸

²⁶ See Appendix D.

²⁷ The nine pilot interviews were included in the data analysis as the information gained from them was able to be adapted to the format for analysis developed from the final interview tool.

²⁸ Training was conducted by the project manager, and by two experienced Registration Board personnel – an ex- investigator from the Medical Practitioners Board and the Director of the complainant advocacy and support service whose services are utilised by a number of Boards.

Support for interviewees

In line with Health Issues Centre policy, interviewees were paid \$50 for their participation in the interview. Given the possible sensitivity of the content for interviewees, counselling support (from counsellors independent of the researchers) was routinely offered in all interviews. Two interviewees took advantage of this offer, and they requested that the project cover the costs of a counselling session with their own counsellors to assist them in 'debriefing' after the interview.

Data analysis

Qualitative

The content of the interview records was analysed and the data was coded for common themes and concepts (including phrases, descriptions or exchanges between interviewee and researcher) as these related to the interview questions.²⁹

Open coding was used; a method based on grounded theory.³⁰ This involves coding categories that reflect the content of the data collected rather than the interview tool questions; that is, data that does not pre-fit categories and findings are 'grounded' in the experiential world.

The themes, patterns, categories, descriptive examples and quotations identified through the analysis formed the basis of the interpretation of the findings. These are presented in Section Four.

Quantitative

Analysis of the limited amount of quantitative data used SPSS version 10.1. Both uni-variate and bi-variate techniques were used. Uni-variate analysis provided descriptive statistics about the interviewees. The function of cross-tabulations was to provide demographic information about the interviewees, to map complainants' views on some very specific questions (e.g., around satisfaction) and highlight potential associations between variables. However, given the focus of the study was on the qualitative data, and the sample designed accordingly, no tests of significance were considered necessary³¹.

²⁹Powel, R. and Single H., (1996) 'Methodological matters- V: Focus groups', *International Journal of Quality in Health Care*, Vol: 8 No. 5, pp. 499-504

³⁰ Patton 1990

³¹ Note also that, as is usual in primarily qualitative research, results are only expressed in percentages when this is considered useful / of material significance. Otherwise general descriptors such as 'a majority', 'a large group', etc are used.

SECTION THREE: RESULTS

The Sample – Profile of complainant interviewees

The Study interviewed 62 complainants. Sixty were selected through the process described above. Their complaints had been closed between 1 January 2002, and 30 June 2003. Two were interviewed at the request of DHS. They were complainants with particular grievances about the way boards handled their complaints. The results presented refer to the 60 interviewed because they were recruited following an independent and non-skewed selection and sampling process. The additional two interviews contribute to the results where they differ from the general themes expressed by the sample of 60. In addition, their results are presented as a separate analysis in Appendix E.

Age

The majority of the interviewees were over 35. Most were between 45-54 years old. The second largest group was in the 35-44 years age range.

Gender

The majority (73%) of interviewees were female. This reasonably reflects the gender balance of persons in this age range accessing health care professionals.³²

Ethnicity

English was the first language for all but four interviewees; however, no interpreters were required.

Levels of education and occupation

The interviewees were, on average, a well-educated group. Forty-five per cent were educated to university level, and 8% had TAFE qualifications. An additional twenty per cent had finished Year 12 at school.

Forty-two per cent were in the professional occupations group and 30% were retired, on 'home duties', or receiving a pension.

Where interviewees lived

Most interviewees lived in the Melbourne metropolitan area — 38% in inner metropolitan Melbourne and 30% in outer Melbourne. Twenty-seven per cent (27%) of interviewees were from regional and rural Victoria and 8% were living outside Victoria at the time of interview.

Nature of complaints

Interviewees were asked what they lodged complaints about. Their responses fell into one of three broad categories:

- Clinical practice issues – refusal to treat; undertaking clinical procedures that the patient considered unjustified or inappropriate; failure to obtain patient consent; incompetence.
- Communication issues – rudeness; billing practices; misinformation.
- Ethical issues – boundary violation/sexual misconduct; misleading advertising; breach of confidentiality.

Interviewees described their complaints as falling within a range of levels of seriousness. Some reported what to them were relatively minor incidents in order to "simply let them (the Board) know something was wrong with this practitioner". A few interviewees assessed their complaints as raising very serious issues, such as clinical malpractice leading to death; or sustained sexual abuse of a patient over several years. Most complaints fell somewhere in between these two extremes.

³² See e.g. Commonwealth Department of Health and Aged Care. (2000) *General Practice in Australia*

Specific examples cited by complainants included:

- the mother of a receptionist employed by the health practitioner, complaining about sexual harassment of her daughter;
- expensive dental treatment which did not relieve pain symptoms — in fact made them worse;
- unjustified billing and overcharging;
- inadequate treatment and diagnosis;
- entering into sexual relationships with complainants while they were patients;
- rough handling of a young child during immunization combined with rudeness and inappropriate communication with the child's mother;
- excessive drug prescriptions to a patient addicted to a prescribed drug without addiction treatment or support;
- inappropriate or inaccurate comments on patients' files and reports to WorkCover or the Family Court; and
- poor nursing treatment of elderly patients.

Most complaints were about poor clinical practice, and/or poor communication. However, there were differences in the profile of typical complaints between boards. These appeared to be related to the type of health practice involved, and the source of payment for the service offered.

More interviewees who complained to the Psychologists Registration Board did so about boundary violation and sexual abuse than for other boards (although there were some of these complaints to the Medical Practitioners Board). This is perhaps to be expected given that the nature of the therapeutic relationship in psychology (and to a lesser extent in medicine) leaves patients of these health practitioners more vulnerable to this kind of professional misconduct.

In dental practice, where consumers' out-of-pocket expenses in paying dentist bills can be high, a higher proportion of complaints to the Dental Practice Board had a greater emphasis on 'value for money' and disagreements over fees charged than for other boards.

On whose behalf interviewees lodged complaints

Interviewees were asked whether they lodged a complaint on their own behalf, or on behalf of someone else. Two-thirds lodged complaints on their own behalf, following treatment they had received. Of the rest, almost all were lodged on behalf of a family member — a child (half), parent, or spouse. One complaint was lodged by a health practitioner on behalf of a patient. Thirteen of the patients who had complaints lodged on their behalf were male and seven female. All spoke English, and for all but two it was their first language.

Reasons cited by interviewees for lodging complaints on behalf of another included the patient being too ill at the time, the patient being under age, or the patient had died. In two cases, interviewees reported it was they, as the spouse of the patient, who lodged the complaint because they were outraged by the behaviour of their partner's health practitioner, even though the patient did not see a problem or wish to complain.

How complaints were lodged

Interviewees were asked how they lodged their complaints. Forty-two per cent initially contacted the board via telephone, and followed this up with a letter detailing their complaint. A similar number wrote to the board in the first instance, and a significant number of these continued a largely document-based interaction with the board for the duration of the process. One complainant attended the board in person and four complainants telephoned only. These four complaints lodged by telephone were accepted and recorded as having been officially lodged and the process thereby initiated. This surprised at least one complainant, as:

It wasn't serious I just wanted to let the Board know anyway as an early warning (about a young doctor's rudeness) in case they got later complaints about this medical practitioner.

When complaints were lodged

Interviewees were asked about when they lodged their complaint. 76% of complaints were lodged in 2002, or 2001.³³ Twenty-three per cent of interviewees lodged their complaint before 2001.³⁴

(a) Time between event/issue and complaint being lodged

Interviewees were asked when the event(s) that were the subject of complaint occurred. This allowed calculation of an approximate average time between the event and complaint lodgement. Over two-thirds of interviewees reported making the complaint within six months. Some complained within a few days — one on the same day, and another the day after. For 17%, however, the delay was over 12 months; and for 3% it was longer. One person waited about 25 years — it was only in later therapy that the real impact of the health professional's behaviour was understood and the interviewee motivated to make the complaint. For another, the behaviour complained about occurred over a four-year period, with a delay of several years from that behaviour coming to an end to the interviewee making a decision to lodge a complaint. In a third case, the behaviour occurred over a nine-year period. These three were all serious boundary violation complaints.

(b) Duration of board processes

Interviewees were asked how long it took the relevant board to process their complaint; that is, the time period from acceptance of the complaint, through investigation and hearing (if a hearing was held), to when it was finalised. Finalisation occurred either through the complaint being closed following an investigation (NFA) or through the board conducting a hearing that reached a decision.

Interviewees reported times for the processing of their complaints ranging from a few months, to two years. For about three-quarters of interviewees, the process took about a year or less, but for about a quarter it was longer. That is, their complaints were lodged in or before 2000, and were closed in 2002 or 2003. All MPBV complainants' cases were closed in 2003, but just over half Medical Practitioners Board complainants lodged their complaints before 2002, implying their cases took a minimum of 12 months to resolve.

Twelve per cent of complainants had complaints 'in process' within a board for two years or more. For some of these, it was more than three years from the time they first lodged the complaint to closure by the board. For complainants who were referred to boards from the Health Services Commissioner, a further period for the initial Health Services Commissioner processes added between several months and a year to the total processing time for the complaint.

Complainants' perceptions of how far their complaint progressed through board processes

Interviewees were asked what their understanding was of how far their complaint had proceeded through board processes. Table 1 sets out outcomes in terms of what point interviewees said their complaints reached in the process.

³³ 48% in 2002; 28% in 2001.

³⁴ Out of the total complainants interviewed, 11% lodged their complaints in 2000, and 12% in 1999 or before. The older complaints (1999 and before) were all lodged with MPBV or the Psychologists Registration Board.

Table 1: Board by complainant perception of determination point reached

	Psychologists	Dental	Medical	Chiropractors	Nurses	TOTAL
No Further Action	7	8	7	5	4	31
Informal Hearing	4	1	7	0	0	12
Formal Hearing	4	5	8	0	0	17
TOTAL	15	14	22	5	4	60

(a) *Complaint closed after preliminary investigation:* For just over half of the interviewees, their complaints were investigated but following completion of the investigation, the board made a determination to take no action (NFA).

(b) *Formal hearings* The complaints of 17 interviewees went to formal hearings. The complaints that were referred to a formal hearing were those where the board considered there was some evidence of serious unprofessional conduct. Where the board conducted a formal hearing, interviewees reported that, if the health practitioner was found to have engaged in unprofessional conduct, a disciplinary sanction such as retraining and supervision, suspension for a period, a fine, or deregistration was imposed by the board.

(c) *Informal hearings:* Many of the 12 interviewees whose cases went to an informal hearing reported the proceedings as being just a meeting between a small group of board members and the complainant. Informal hearing outcomes imposed remedial sanctions such as reprimands and orders for retraining.

It is worth noting that some interviewees whose complaint did not go to hearing, were unclear as to whether their complaint had actually gone to a hearing or not. They would report, "I went to a meeting with some Board members – I assume they spoke to the practitioner as well". However, they were not certain whether this meant an interview as part of the preliminary investigation, or a process that was part of an informal hearing.)

The following quotes are representative of the kinds of comments interviewees made about the outcomes of their complaints:

He was warned and had to apologise to me.

He was de-registered.

Nothing happened because the complaint wasn't recorded according to their criteria.

Nothing, the Board couldn't see ([sic] – did not understand) the point.

Involvement of other agencies

(a) Before/during the Board processes

Interviewees were asked whether they had lodged the complaint anywhere other than with the board. Nearly two-thirds of interviewees reported lodging their complaint directly to the boards, not elsewhere. With the remaining complaints, where other agencies were involved, it was usually the Health Services Commissioner. Complainants who went to the Health Services Commissioner initially had their complaint referred to

the relevant board. Interviewees reported that this appeared to have occurred both through a formal referral by the Commissioner under the legislation,³⁵ or informally (i.e., when the complainant rang the Health Services Commissioner they were advised to contact the board directly). Other bodies receiving complaints included the relevant health care service; DHS; Victorian Civil Administrative Tribunal (VCAT); and Members of Parliament.

Interviewees who lodged their complaints with the Health Services Commissioner were more likely to report that their purpose in lodging the complaint included resolution or conciliated outcomes. These included a desire for an apology or compensation or simply, "meeting the health practitioner around a table to validate my experiences". This had implications for their levels of satisfaction [see below]. Boards did not generally deliver these outcomes (principally because this is not part of their role). However, complainants did not understand this. When the board did not refer the complaint back to the Health Services Commissioner, (as legally they could), these interviewees were more likely to be dissatisfied with their complaint process because their expectations were not met.

(b) After Board decision

Three-quarters of the interviewees did not use other processes or take further action following the closure of their complaints (to other agencies – some continued their interaction with Boards). Of the quarter of interviewees who were dissatisfied with the board's decision (see later section) and did pursue other avenues, the most common agencies contacted were the Health Services Commissioner, lawyers, and the Human Rights Commission. A few complainants sought help from DHS, the Minister, or the media. Surprisingly, given the capacity in the Health Services (Conciliation & Review) Act noted above, only one interviewee reported that their complaint was referred by the board back to the HSC for conciliation.

Typical 'follow-up' paths taken by this quarter of interviewees were to:

- use rights under Freedom of Information legislation to seek access to and review the board files on their complaint; and/or
- investigate avenues for a review or appeal before VCAT on decisions from formal board hearings (there being no legal capacity for VCAT to review other board decisions such as from an informal hearing or NFA).

Knowledge, experience and expectations of Boards

Contacting Boards

Interviewees were asked how they knew to lodge a complaint about a health practitioner with a registration board. The main sources of information they cited were – the telephone directory, health practitioners and friends. Several said they had prior knowledge of boards as the appropriate body with whom to lodge their complaint. This level of understanding may reflect the higher-than-average educational and occupational level of those interviewed. Some had gone first to the Health Services Commissioner and been referred to the relevant board.

Expectations of Boards at time of complaint

Interviewees were asked what expectations they had of the board, and what outcomes or solutions they were seeking.

Not all those interviewed had clear expectations. Some interviewees were unable to identify their expectations. They simply registered their complaint, with little expectation or understanding of what was involved. A few did not have much understanding of the board's role, particularly if they were one of the complainants who had first approached another agency such as the Health Services Commissioner. For example, several of these complainants reported that their original intention was to "meet around a table" with the

³⁵ Health Services (Conciliation and Review) Act 1987; Sec. 19(6)

health professionals involved, and get an apology, and/or a conciliated settlement (such as compensation or waiver of fees.) Some of these complainants commented that they felt they had been 'caught up' in a process that they had not expected, and which perhaps could not lead to the outcome they sought.

However, a majority of complainants interviewed were clear about why they complained. Interviewees expected their board to exercise its investigative powers to thoroughly investigate the complaint, look at all the evidence, and address the issues through reprimanding or disciplining the individual practitioner involved.

The Board's role is a critical part of accountability of the medical profession and the complainant's healing journey.

In terms of outcomes or solutions sought, a majority of interviewees wanted either changes to the health practitioner's behaviour or procedures to protect other consumers and/or an acknowledgement or apology from the practitioner. They reported primary motivations as "to stand up for themselves" and their rights as patients. That is, they were looking to obtain acknowledgement from the practitioner that his/her treatment or behaviour had been inappropriate, and for him/her to recognise the consequences for complainant.

I was looking for the psychologist to be made accountable.

I wanted an apology and a validation of my being upset.

Not expecting de-registration or anything as drastic. We just wanted to impress on the Board the inappropriateness of the medical practitioner's behaviour.

I wanted him to tell the truth about what he did; be reprimanded; and give me an apology.

Investigate and check out what I said about him - validation. I was not necessarily looking for him to be punished. Just what I said - acknowledged.

I thought they would take it seriously, contact me more. I never wanted money.

That the Board would thoroughly investigate. I thought the situation was serious.

That the Board investigates the complaint and reaches a just decision.

Most complainants said they were not primarily interested in monetary recompense. Rather they wanted some improvement in the quality of the health care provided.

Levels of information, assistance and support from Boards to complainants

Interviewees were asked a series of questions about the information and assistance they received from the board both initially and subsequently. They were also asked whether the process their complaint followed was as initially expected.

Initial written information

Nearly two-thirds of interviewees said they initially received some written information from the board explaining the process.

More than half of those interviewed considered the information received at this early stage had been clear and easily understood.

Yes fairly helpful. Gave me a general idea of what would happen.

Very helpful. Excellent. Within two weeks of lodging the complaint I got a letter of acknowledgment saying they would investigate.

Yes, they sent me information, it was very clear and straightforward.

However, the significant remainder reported that either they did not receive any helpful information about the process, or the information they did receive was not helpful.

Not helpful or clear. I received no documentation from the Board until the complaint went to the Board subcommittee nine months after. Then I received a letter inviting me to attend.

Most of the specific information I received (apart from the pamphlet, which came early) about the informal hearing and what it would involve came nine months after I sent them the letter.

It took months for the Board to respond. I rang them when I was upset after the contact with the doctor. I never spoke to anyone about the situation.

Appalling, the information process was appalling. I received some written information on the general process and practicalities of what I would be involved in. Otherwise nothing.

Initial assistance from board staff

Half of interviewees stated that their initial contact with a board staff member was helpful. A few of the interviewees also nominated subsequent meetings with board staff on their case as assisting in increasing their understanding of the board's powers.

Fine - they went through the whole process.

I spoke with the Board's solicitor, he explained everything, then another person as well.

The other half felt that their first contact was confusing or unsatisfactory, and they remained unclear about what was required of them.

Not at all helpful. No guidance was provided about the process.

The first solicitor was helpful but young. She couldn't handle it when I got upset.

Yes at the initial contact they should have explained the whole process and included the "downside" as well.

Subsequent contact and support from Board

About half the complainants stated that they were kept informed of processes. For example, some felt that the board kept in touch effectively.

Very helpful, they were fantastic. I spoke with their solicitor.

An equal number of interviewees reported that they were not kept adequately informed or helped.

No, I needed an initial interview. With the Board.

Yes they were respectful and rang back a few times but they missed the point.

The problem was time – some eight months waiting for a response and suddenly I received a letter.

I felt no involvement from the Board. The process was too formal, not user-friendly.

Of those who were dissatisfied, reasons included:

- an expectation of ongoing contact and advice from the board;
- receiving intermittent contact from the board, the length of the complaints handling process exacerbated feelings of being uninformed;
- delays in communication regarding their complaint and hearing;
- lack of clarity about the board's investigation process.

Some of those who were pleased with their initial contact subsequently questioned the effectiveness of the follow-up.

When I was interviewed (by board investigator) she was empathic and a good interviewer who listened well. But after the first call and (acknowledgement) letter, I received no information other than that (i) I would be interviewed (ii) fill out the form and (iii) I would get a support person (which I didn't for a long time - 15 months)

No, there was no value added from (after) my initial contact.

Another theme was that board staff were very helpful and pleasant when contacted, but that the complainant often had to initiate the contact to find out what was going on. For many it appeared that contact was quite infrequent or, if they waited to hear, there were long gaps between intense periods of contact.

When we finally went in for an interview after five months, they were very helpful.

Some complainants commented on the board's provision of support liaison persons. For some this was very valuable, but for others it was not enough and they perceived some conflicts of interest.

The support person is not privileged. She was not allowed into the hearing to support me because she could be called as a witness. This was very distressing for me. I was given to understand the support person would be there for me all of the time. In fact, she was just a liaison person. The boundaries are not clear.

The support person was a poor substitute for legal advocacy and support. She was well meaning but inadequate.

I was provided with some (support), but not enough to help me through the process. For the first 15 months I had no contact except an interview with a support person. There was no support or help for me. The whole question of what and how information is transferred to educate and empower was very poor.

Understanding of Board processes

As noted above, many interviewees reported they had some initial understanding of board processes. However, as their complaints progressed, the number reporting understanding decreased. Other interviewees stated that they remained unclear throughout the process.

Some interviewees commented that they would have benefited from assistance in understanding the role of the board, so that they would not have had unrealistic expectations. As they considered that they did not receive such assistance, they reported remaining confused about board roles.

No, I was not clear about what they could do.

It was very general – an overview of process only. It didn't help me.

Nobody explained the power. I didn't know what the outcome would be. I think they were less powerful than what I thought. I lost faith.

In writing everything was explained. But I am not sure I understood their power, they didn't explain that in particular – only the process.

But [they] gave no information on (the limits) of their powers, what they could or could not do, until the end.

A minority of interviewees stated that the actual process experienced followed their initial understanding of what would happen. By contrast, many did find their experience quite different to their expectations. They also found it frustrating and onerous. A majority used comments in interview that indicated their surprise at the formality and length of the process.

Yes [I understood the process] but I didn't think it would be such a lengthy legal procedure.

Yes but the process was not what I wanted when I made the complaint.

Closure of complaint

Interviewees were asked what was the final decision and outcome of their complaint, how they were informed, whether they had the reasons explained to them, and whether they were informed of other processes or avenues of appeal available to them.

All interviewees said they received a letter from (and initiated by) the board informing them that their complaint had been finalised and the outcome of the process. Interviewees reported a wide range of intervals between conclusion of the proceedings and receipt of this letter. Some reported it arriving within a few days, whilst others noted delays of weeks and sometimes months. Some also received information about outcomes through other means of communication fairly quickly (e.g., informally, through a phone call). There appeared to be no *automatic* immediate notification from any board, although it did occur sometimes from all boards. This failure concerned some complainants, who reported increased levels of anxiety because of the delay. Several complainants (whose notification letters were delayed) stated they had to initiate contact themselves to find out what had occurred.

One-third of respondents reported that they did not have the reasons for the outcome explained to them (either in the letter, or over the phone).

(The) letter was the worst part – it came across as aggressive. Its language could make the complainant quite distraught; for example, (baldly stating) "case closed!" with no other explanation.

One interviewee had written a letter regarding a minor complaint without any clear intention that the board should do more than note it. She said she was "surprised", after months of not hearing anything (or necessarily expecting to) when she received a letter announcing that the complaint had gone to informal hearing, and the practitioner had been cautioned.

Only four of the 60 interviewees reported receiving information from boards about other processes available or avenues of appeal available to them.

Understanding of decision/outcome

Just over one-quarter of the interviewees said they did not understand the reasons for the board's decision. The remaining three-quarters stated that they did, but this did not necessarily mean that they agreed with the reasons given, or that they felt a reasonable decision had been made.

I guessed why and what it meant.

Yes I was given the reasons for the decisions. I understood the reasons why he couldn't be given a heavier penalty.

I understood what they said. I didn't agree with the reasons.

Yes but only because I asked for the reason myself.

Yes but they missed the point of my complaint.

It was never explained. I was told the Board met and the outcome of the meeting. That is all.

A significant number had not anticipated the outcome of their complaint at all – that it would be closed or dismissed without a finding against the practitioner.

Interviewee suggestions for improving assistance to complainants with process

Interviewees stated a number of things would have helped them to better understand the process. These included:

- clearer information more consistently received and presented;
- the opportunity for complainants to meet face-to-face with a board staff member and ask questions about their case and the complaints handling process;
- assistance with putting a complaint in writing;
- improved communication by the board in keeping them informed about their case;
- more support for complainants throughout the process.

During the preliminary investigation, someone from the Board needs to "eyeball" the complainant. It should be the first step in the process.

To be told how they were going to investigate would have been good.

Explain the process, please.

It would have been nice to see someone from the Board in person so I could ask questions.

Impact of Board processes on complainants

Interviewees were asked whether the complaint process cost them anything – either financially, or in terms of time, emotional stress, pressure on their work, and so on. Two-thirds stated that the process did not cost them anything. For the third that answered in the affirmative the nominated costs were mainly time and stress, although, for a handful, financial cost was an issue.

Some complainants who lived outside Melbourne made several trips to the city for statements to be taken, to give evidence in hearings, or to observe disciplinary proceedings. The reported lack of monetary compensation for travel costs and unpaid time off work was seen as an issue for these participants. They said this was particularly so when they had to make several extra trips due to appointments being cancelled or arranged for too short a duration to cover the matters needed, or when hearings were adjourned without notice.

Stress and trauma was a significant factor for some. This was particularly so for those involved in complex boundary violation hearings where telling their story publicly was difficult and painful, and being cross-examined by the practitioner's lawyers even more stressful.

(it cost me...) money and time.

I had to retrain my son into going to the doctors and get confidence again.

Travelling cost, STD calls, postage. High stress and fear of threats, problems in the community, being labelled a troublemaker.

Significantly (when asked about financial costs incurred). At no time was there any talk of putting me up in a motel or other reimbursement for my expenses - travel costs, overnight accommodation, STD telephone calls.

Over time I got stressed – not knowing or hearing from them.

A few complainants who were critical of the board expressed concern about the general costs of the board's (perceived inadequate) complaint processes to the community.

How much did all this cost [Board processes]? And just for a reprimand!

Complainants' need to participate and be heard

Interviewees were asked whether they were able to present all of the information they wished. Almost all interviewees stated they presented details of their complaint to the board in their initial letter.

Two-thirds of interviewees stated they were able to present all the relevant information they wished during the complaints handling process.

One-third of interviewees stated they were not able to comprehensively present their case to the board. Indeed, half of this group stated that they were not asked for more information after they lodged the initial letter of complaint. Other reasons included:

- confusion about the complaints handling and investigation process;
- the formality of the hearing preventing information from being presented.

A particular issue for many interviewees was the lack of opportunity to review the response of the health professional to their complaint allegations; to reply to this; and to be able to correct what they perceived to be factual errors, misconceptions, and untruths before the board made a decision. Sometimes they reported that the board investigator did not get back to them to check the veracity of the practitioner's account or response to the complaint at all.

I expected to receive a copy of his reply and be told what he said and then sit in a hearing and talk about it. I was never given the chance to give any feedback.

A small number were not contacted at all after their initial statement, until they received notification of the outcome. When, subsequently, they obtained the practitioner's statement, they were upset at what they perceived to be the misconceptions and untruths in the health practitioner's response to their assertions.

Timeliness

As noted above, a quarter of complaints took 12 months or more to be finalised, and several took two years or more. Delays and the time taken to finalise the complaint, combined with lack of information flow, were probably the most commonly expressed grievances about board processes.

The time taken by the board to decide whether to proceed was often longer (sometimes clearly much longer) than complainants expected. Interviewees frequently commented that they were informed about one timeline ("within about six weeks the Board will consider your case and decide what to do with it"). In fact it often reportedly took weeks or months more than that – in one case longer than a year. Some interviewees said they did receive an explanation about the delay.

Time lines. I had no idea it would take so long. I wasn't told.

It was longer than expected, it went over months and months. I never intended it to be so long, it was just a small issue. But it took such a long time.

Level of satisfaction with Board experiences

Interviewees were asked a cluster of questions that explored their judgments, perceptions, and levels of satisfaction with the processes they experienced.

They were asked the following five questions, the responses to which are further developed below:

- i.** To rate their levels of satisfaction.
- ii.** How they felt about the whole process.³⁶
- iii.** Whether they thought their complaint received a fair investigation.³⁷
- iv.** Whether the whole experience made the situation better or worse for them, a mixture of the two, or neither.³⁸
- v.** Whether they would use the process again or would recommend it to a friend.³⁹

i. Rating levels of satisfaction

Respondents were asked to rate their satisfaction with the overall board processes, on a four-point scale ("Very Satisfied", "Satisfied", "Partly Satisfied" and "Not at all Satisfied" [see bottom line of Table 2]). About a quarter (23%) of complainants were very satisfied with the way their complaint was handled, and another 17% were satisfied, making a total of 24 interviewees (40%) who expressed satisfaction with their experience of the board's complaints processes. More than half of the interviewees (35) reported that they were dissatisfied or only partially satisfied. Twenty-four (40%) said they were not at all satisfied.

It was not so clear-cut for three interviewees who expressed satisfaction with some aspects of their experience and dissatisfaction with others.⁴⁰

I was partly satisfied with the Board outcome but not at all satisfied with the impact of Board processes on me.

I was only partly satisfied with Board staff/processes, but very satisfied with dealings I had with Board lawyers' (once the complaint went to formal hearing).

Table 2(a) sets out interviewee levels of satisfaction according to the determination point within the complaints process that their complaint reached.

³⁶ Question 35 (Information Tool – App. 3) - they were asked here for 'feeling' words to describe how they felt.

³⁷ Question 33 (ibid)

³⁸ Question 45 (ibid)

³⁹ Question 48 (ibid)

⁴⁰ These were rated as 'partly satisfied'

Table 2(a): Satisfaction with Board’s complaints processes by phase at which complaint closed

	<i>Phase complaint reached</i>			TOTAL	Per cent
	No Further Action	Informal	Formal		
Very Satisfied	6	3	5	14	23%
Satisfied	3	3	4	10	17%
Partly Satisfied	7	2	2	11	18%
Not at all Satisfied	14	4	6	24	40%
Unknown	1	0	0	1	2%
TOTAL	31	12	17	60	100%

Thus two out of every five complainants in this study were “not at all satisfied” with their experiences of Board processes (including outcomes), and nearly three out of every five were not at all or only partly satisfied.

On the other hand, it is important also to note that two out of every five complainants in this study did state that they were satisfied or very satisfied with how their complaint was handled.

As might be anticipated, levels of satisfaction varied according to the determination point within the complaint processing at which a complaint was closed. NFA interviewees were most likely to be dissatisfied, while those going to formal hearings were most satisfied. However, nearly half of this latter group were still wholly or partly dissatisfied.

Five interviewees were quite satisfied with the outcome, even though their complaints did not proceed past preliminary investigation:

The practitioner was called into the Board. This gave him a “wake up call” and put him on notice that his behaviour was not acceptable.

As the Registrar told me, it is quite traumatic for practitioners to be called before the Board and asked to account for themselves. I feel sure he learnt his lesson.

ii. Feelings about the process

Most respondents expressed some negative feelings about the process they had gone through, including many of those who had achieved satisfactory outcomes. They used words such as “confusing”, “frustrating” and “intimidating” to describe how they found the complaints process. These interviewees felt the processes did not provide complainants with a sense of having any important role in the process, or of making a valuable contribution. Comments included:

You are not (seen as) worthy ... it is a no-win situation.

The victim is squashed.

I wasn’t taken seriously.

Unsatisfactory

I gave up on the whole thing.

When asked to describe how they felt, interviewees used descriptors like "angry"; "bewildered"; "mystified"; "disappointed"; "depressed"; "disempowered"; "humiliated"; "victimized all over again"; "anxious (but afterwards relief)"; "overwhelmed"; "disgusted"; "traumatized"; and "stunned":

Unhappy. I never wanted to end up in an adversarial situation.

From my perspective it is not appropriate to have such a formal process with the involvement of barristers. The case information was lost through legal arguments.

A significant number of interviewees felt they were unable to establish and maintain adequate communication with staff members. They cited the existing board protocols and staff turnover as key reasons. They reported feeling increasingly hampered in communicating aspects of their case. As a consequence, the interviewees in this category were often unclear about how the board's decision was reached, as well as feeling frustrated and angry at the delays and lack of information.

The smaller group who had only positive comments used descriptors like "good", "satisfied"; "acceptable"; "fair"; "positive"; and "confident":

I am glad I did it. It helped me with healing. It was not pleasant, but I was satisfied with the outcome. It was worthwhile.

For some it was a mixture:

Up to the result/finding, I was satisfied. It seemed like they were serious... then they turned powerless... the finding made me angry.

iii. Perceptions of fairness of investigation

Just under half of the interviewees stated that they felt their complaint had received a fair investigation by the board:

Very professional process. Sent follow-up letters, indirect apology from the doctor.

Yes surprisingly.

An almost equal number did not think their case had been fairly handled:

The Board needs to change (its) attitude. They appear to be on the doctor's or hospital's side.

No, they took the word of the doctor. They didn't bother to find out what actually happened.

They missed the point.

No the process was too formal and prevented me from presenting my case.

The remainder did not know:

I don't know, they didn't say what they did.

The interviewees who felt that their complaint had been handled fairly cited various reasons⁴¹. Common to these reasons was a perception of the professionalism and 'even-handedness' of the investigation and the board process. More of this group fell into the group of complainants whose complaints proceeded to formal or informal hearing.

For those who felt the process had not been fair, there were some common themes among their reasons for this view. Many felt the board's complaints handling processes prevented them from presenting their perspective adequately; that is from expressing what was important to them. They felt constrained to respond somewhat passively to what they saw as the board's criteria. Others said that the formality of processes (particularly the structured evidence-taking procedures within the hearings) prevented them from putting their case forward adequately.

There were also perceptions of bias and lack of independence. For example, many interviewees saw this as a failure to thoroughly investigate or follow-up on evidence that the complainant knew to be available. Some interviewees believed that the board had simply accepted the practitioner's word about what had happened.

This view was more prevalent among two groups. The first comprised those whose complaint was closed by the board as an NFA following preliminary investigation. The second group was made up of several cases where the complainant was not contacted after their initial statement (given either in a detailed letter of complaint, or in the first statement they gave when the board investigator first contacted them after they lodged the complaint). Hence did not have a chance to see the practitioner's response to their statement before a decision was made, but subsequently obtained the practitioner's statement. They did this after requesting it from the board in some cases, and, in others, using powers under freedom of information (FOI) legislation to obtain it. These complainants commonly expressed outrage at the practitioner's statement. One described it as "full of lies and mistakes in what he said". In another case the complainant took some trouble to collect evidence himself, by approaching various health practitioners to whom his partner had gone with referrals from the health practitioner about whom he was complaining. The complainant said he was quite angry when he felt the board did not accept the information he provided, or did not go to the same providers to get it for themselves. He stated that instead they relied on what he saw as an incorrect and misleading statement from the practitioner and flawed data from the relevant Commonwealth funding body.

Finally, some interviewees expressed doubt about the board's impartiality in investigating their case.

Doctors judging doctors does not seem a fair process.

iv. Impact of the experience on complainants' situations

About a third of complainants stated that their involvement in the complaints handling process did improve the situation for them, whilst a similar number reported the contrary; that is, that they felt it made their situation worse. One-third thought the process had a mixed impact on the situation, or had no impact.

Better for patient – it vindicated him. Helped him (and me) get closure.

Up to the hearing it made me feel like jumping off a cliff. After the result it did help, I felt as though I had done something for my husband.

It made it much worse. No one could help me medically and I was in such pain.

⁴¹ Note that fewer interviewees answering 'yes' to the question about fairness added comment to their answer than was the case for those answering in the negative.

(A panel) of strangers asking me intimate questions. Very intimidating. But they listened, heard, and believed me. They said so. It was wonderful. A very healing moment.

v. Complainants' future use or recommendation of the process again

Two-thirds of interviewees stated that they would use the process again or recommend it to a friend. Many of these respondents answered the question in ways that appeared to reflect a concern for service quality; that is, they thought it an important public responsibility to report inadequate treatment and care, so as to assist in the overall maintenance of standards of health care.

One-quarter of respondent replied that they would not use the process again or recommend it to a friend.

However, a significant number of the group who would use it again or recommend it to others, placed qualifications on their answer; that is, they would recommend the process to a friend, "but only if they improve the way they treat you — I wouldn't otherwise".

For those who said they would not use the process again, the board's poor management of their complaints was central to their view. The negative (and sometimes traumatic) impact of the processes on them reported by these complainants was seen as not being worth it. This was particularly so when the outcome (as they interpreted it) was an exoneration of the practitioner, and/or what they saw as a failure by the board to validate their concerns about the way they were treated by the practitioner about whom they complained:

Yes – it is worth it in the long run

Yes – just so it goes on the record anyway.

At one point I thought I was going to die – I had a poor prognosis. I would not have wanted to die without having done something about the damage done to me. I owed it to me & to the community. I needed to do this – if I didn't; who could have? On the other hand - had I known what was involved maybe I would not have done it. I was very sick.

No, they wouldn't want to go through the trauma. Friends tell me about what happened to them in terms of being badly treated by (a health practitioner) and ask me what they should do because they know I went through the process. They hear from me what I went through and then they choose not to (lodge a complaint).

Comments/suggestions from complainants

At the end of the interview comments were sought on what interviewees thought should be done to improve the board's complaints handling process. Interviewees often commented that being asked this question by interviewers was significant to them, particularly if their reported experience with a board had not been good for them. They saw the opportunity to reply to this question as a chance to "give something back"; "make sense of what happened"; or "help prevent it happening to someone else".

Set out below are some suggestions that were raised:

Provision of information and support to complainants

(Provision of) user-friendly information about the Board's complaints handling (processes).

Support and assistance to the complainants at the initial stage to formulate and document their case and [then] throughout the process.

Effective timely communication [from the Board to the complainant] throughout the complaints handling process.

Having one investigator (assigned) for the duration of the case.

Improvement in Board processes

They (the complainant and the practitioner) need to be able to meet together and reconcile as soon as possible.

Independent and impartial process.

A less formal process, especially at formal hearing stage.

(There should be a) more efficient/speedy investigation process.

The legal status of the complainant [needs] to be strengthened.

(Board should) conduct a final interview with complainant to close case and address outstanding issues.

(The Board's) final letters should include an invitation to ring and discuss.

Monitoring of practitioners

Boards should review practitioners' performance and link it to registration.

The Board ...should be monitoring the professional conduct, competence and customer services of their practitioners [meaning staff].

Community awareness of Board roles

More community awareness (is needed). Without my sister being a dental therapist no way I would have known to go to the Board.

Comparison of complainant experiences between the five Boards

It was originally intended to use the qualitative data to draw comparisons, and identify differences and similarities between the five board processes, from a complainant perspective. Given that the basic legislative structure under which each board operated to investigate and make determinations on allegations of poor practice and misconduct were almost identical at the time that these complaints were dealt with by the boards,⁴² it was of interest to see if experiences differed markedly – for example, according to the type of health practice (and therefore membership of the Board), or the size and resources of the board.

However, it proved impossible to draw any meaningful comparative conclusions or trends between the boards from the information obtained, other than the fairly predictable observation referred to earlier that the *types* of complaints varied between the boards. There were a number of reasons for this:

- From the complainant perspective, there appeared to be little consistency of process experienced by interviewees even within boards, let alone consistency across boards. As a result, it was not possible to attribute differences in experience to differences between the boards.

⁴² Note that the addition of 'unsatisfactory performance' as a basis for a finding of unprofessional conduct in the Medical Practice Act had not come into force at the time interviewee complaints were processed.

- Two of the (larger) boards⁴³ were undergoing major internal re-organisation and process revisions/reform during at least some of the period when the complaints lodged by interviewees in this research were being processed.⁴⁴
- Two of the boards had low numbers of consumer complaints lodged during the selected period, with correspondingly few complainants available to participate in the research. The number that agreed to be interviewed was even smaller. One of these (Nurses Board) was a large board with many complaints, but few from health care consumers —only four volunteered to be interviewed. Another, the Chiropractors Registration Board, generated only five respondents from the 23 available. Meaningful comparisons from qualitative information cannot be drawn from these low numbers.

⁴³ Psychologists Registration Board; Medical Practitioners Board.

⁴⁴ The Psychologists Registration Board, for example, had several CEOs in 18 months. The MPBV, under a new CEO, Ian Stoney, completely overhauled and changed its complaint processing procedures.

SECTION FOUR: ANALYSIS, CONCLUSIONS AND IMPLICATIONS FOR THE REVIEW

Introduction

As stated in the introduction to this report, the 2003 Department of Human Services Discussion Paper on 'Regulation of the health professionals in Victoria' describes one major purpose of this Review as that of 'strengthening public confidence in the system of health practitioner regulation'. It suggests that public confidence relies on the assurance that the health practitioner registration boards are: fair and unbiased; act independently and transparently; are effective and timely; and are accountable to the public for what they do.

Community confidence is sustained if, when a member of the public lodges a complaint with a registration board, they are:

- informed, assisted and supported;
- treated with respect and dignity as participators in the process;
- have legally afforded rights within the process which ensure:
 - timely, effective, unbiased and fair processes;
 - they are heard and can present information and evidence, including the opportunity to refute information presented by the health professional they complained about;
 - their reasonable expectations are met as far as possible, and, where they cannot be, they are referred and assisted to where they may be helped; and board decisions with which they do not agree are reviewable.

Complainants have a unique perspective, and their experiences and perceptions are barometers of how well the health system is working. This can generate important insights in identifying areas of concern needing reform.

Complainants are also consumers of the health practitioner regulation system. Processes that are as consumer-friendly as possible within the objectives of the system are important to them, and their confidence in the system.

This last section of the Report:

- highlights key aspects and themes from the interviews;
- draws together some implications of these;
- suggests options and proposals for reform in the context of these key aspects, themes, and implications.

The next two sub-sections identify several key themes and their implications for the boards and the Review. These are analysed in the context of the major principles set out in the Discussion Paper (1993) as underpinning the Review, which the Study Team sees as essential to continued community confidence in the health practitioner regulatory system⁴⁵. Incorporated into this discussion are some options and suggestions for reform, generated by the themes and implications.

The final section presents conclusions, underlying principles of reform, and recommendations — including medium term recommendations for consideration by the review, and suggestions for short-term actions.

Some characteristics and limitations of the research should be considered when interpreting these findings:

⁴⁵ See para 1.3 Table 1.1: Victorian Department of Human Services, Policy & Strategic Projects 2003, *Regulation of the Health Professions in Victoria: A Discussion Paper*, Victorian Government, Melbourne

- The research was predominately a qualitative study, seeking to identify and document complainant interviewee experiences of complaints processes, and to identify key themes in those experiences. The major themes that emerged form the core of the findings. Quantitative results and percentages are only provided where appropriate and useful to supplement this.
- As qualitative research it was not necessary for the sampling and recruiting of interviewees to produce accounts of complainant experiences that were statistically representative of all complainant experiences. However, interviewees were recruited from across the full range of complainants who lodge complaints with registration boards. Thus the accounts they gave of their experiences are unlikely to be atypical of the whole population of complainants' experiences.
- The demographic profile of the 60 interviewees was not typical of the general population utilising health care, in that interviewees were English speaking, of Anglo ethnic origin, educated to tertiary or higher secondary school levels, and were from professional and managerial occupational groups. Data is not available as to whether they were representative of the population that lodges complaints with registration boards. However, research has shown that typically formal complaint processes are more likely to be used by complainants from higher socio-economic and educational groups, who are proficient in English⁴⁶
- Some caution should be exercised in extrapolating from results for complainants whose complaints were processed a minimum of eighteen months to two years before the publication of this report. The Research Team is aware that some board have been reviewing and fine-tuning their processes more recently. As suggested later in this section, what this research does is to identify issues and provide a 'baseline' against which regular and periodic audits of consumer experience by boards could measure the progress of their quality improvement processes.
- Finally, we re-emphasise that these results and the conclusions drawn from them are based in the subjective perceptions of complainants. That was the purpose of the research.

Themes

Complainants raised a wide range of issues from which emerged a number of themes. These are discussed below. Collectively they signal a need for some significant reforms of practice if complaints processes are to be more 'consumer-friendly'. The implications and inferences of these themes are explored later in this section.

Key themes concerned:

- levels of complainant satisfaction with board processes;
- tensions between complainant expectations of boards, and boards' public protection role;
- the importance to complainants of timeliness in processing complaints and of regular board communication with and support for complainants;
- the significance to many complainants that boards should both be independent, impartial, and fair in their processes, and that they should also be seen to be so;
- the consistency of board processes.

Complainant satisfaction with Board processes

Satisfaction with board processes is a key issue for the Review. Levels of satisfaction reflect how complainants evaluate the complaints process. Low levels of satisfaction may indicate lack of confidence in the board process. High levels of satisfaction may mean that complainants, at least, found boards dealt appropriately with their complaints, and with the issues they raised of health care practice standards.

Just over half of the interviewees said they were not at all satisfied, or only partly satisfied with the Board processes in dealing with their complaints. One quarter reported

⁴⁶ For example, Daniel et al 1999 and McCutcheon V. and Neri S (1999)

that they would not complain again or recommend to a friend that they do so. Many of those who reported that they would complain again did so with qualifications such as “only if the processes are improved”.

Just under half of the interviewees were reasonably or very satisfied with their experience. Sometimes, however, even these respondents used language like “confusing” and “frustrating” to describe their feelings about the impact of complaint processes on them — their satisfaction levels related to their view of the outcome to their complaints rather than to the board process in dealing with it.

Of those who stated that they were dissatisfied, many reported experiencing the complaint processes as difficult — unsympathetic, inaccessible, and/or ineffective.

Caution is needed drawing conclusions from the exact numbers of those satisfied, or dissatisfied. On the one hand, the system appears clearly to be working satisfactorily to a considerable number of those interviewed even though they raised issues in the interview that they thought needed attention. What is equally clear, though, is that a significant number of the interviewees who expressed dissatisfaction, found their experiences unsatisfactory. A considerable group of these (40%) were not at all satisfied.

Links between determination points in the process reached by interviewees’ complaints, and levels of satisfaction

Links between an interviewee’s level of satisfaction and the determination point in complaint processing that his or her complaint reached are, at one level, clearly related to how far the complaint progresses through board processes before it reaches an outcome and is finalised. If a complaint goes through an informal or formal hearing, it demonstrates to the complainant that the board has taken it seriously. If a complaint went to hearing, even where its outcome was negative from the complainant’s perspective, the complainant was more likely to be satisfied.

However, such satisfaction could also be seen to relate to the level of resources the board applied to the complaint and to the level of support provided for the complainant. Once the board has decided to conduct a hearing, the complainant changes status from that of ‘whistle-blower’ and source of information about possible instances of sub-standard practice or unprofessional conduct, to that of key witness. Particularly in complaints of boundary violation, once a complaint was referred to formal hearing, a number of interviewees reported a change in their perceptions of the process. That decision, and the shift of responsibility to the board lawyers, meant the frequency and nature of contact and the information flow to the complainant improved. They reported that the investigation became more thorough, and the support the Board provided increased.

Finally, low levels of interviewee satisfaction with the board processes and outcomes appeared to be due largely to the inaccessibility of processes to complainants, and their inability to understand what was happening, regardless of what phase of investigation or hearing the complaint reached.

These results raise a number of issues:

First, from a health care consumer perspective, it is of concern that a significant number of people are dissatisfied with a ‘public good’ process that is reliant on their involvement. Complainants may have a variety of goals in making a complaint, but many are also motivated to do so by a desire to improve the health care system. None of the interviewees in this research stated that they were seeking monetary gain through this process. Indeed, many reported that there were considerable costs to them being involved: sometimes financial, more commonly effort and stress.

Second, as enhancing public confidence in the health practitioner regulatory system is a major objective of the Review, it is significant that a majority of complainants interviewed in this research expressed dissatisfaction with regulatory processes.

Third, to some extent the concerns raised might be addressed through legislative reforms to the regulatory model under which the boards operate. These are discussed later in this section. But, in addition, interviewee comments and dissatisfaction indicate that boards may need to pay more attention to their relationship with complainants, irrespective of legal reforms that may eventuate from the review.

Complainants expectations versus Boards' public protection role

There is a gap between consumer expectations of the processes and what the boards are able to do in the context of their statutory role in regulating practice standards of registered health practitioners.

To complainants, as interviewees reported it, getting the outcome they expected or hoped for on their complaint was generally of most importance to them. The primary purpose of health professional registration boards is to protect the public by providing for the registration of practitioners and to investigate their professional conduct, professional performance and ability to practise. Sometimes complainants' purposes and those of their boards coincided. More often they did not.

Once a complainant lodges a complaint alleging poor practice or misconduct by a registered practitioner, legally, they are less central to the process. Their legal status in proceedings becomes that of a source of information and potential witness. The board, having taken the details of their complaint, may have no need to involve the complainant further in proceedings. Whilst that may reflect the board's primary purpose, complainants generally did not expect that the board might not need to involve them much, if at all, in the ongoing complaints handling process.

There is an inherent tension between these two sets of expectations. That is between the complainant's perceptions of their position as central to board proceedings, and the board's statutory purpose and powers within which the complainant may not be (and often is not) required to play such a key role.

One issue raised by interviewees that demonstrates this tension in operation, was their concern that they did not have any specific participatory rights in relation to the processing of their complaint.⁴⁷ Lodging a complaint generally takes significant emotional effort and commitment of personal resources, and is an important statement about a complainant's grievances.

Interviewees reported combination of emotionally charged events leading to the complaint, and the perceived impenetrability of processes within which complainants expressed feelings of marginalisation, led in many cases to distress, anger, and frustration⁴⁸. This was so even from those interviewees whose professional backgrounds and working environments (university manager, lawyers, health professionals, and teachers) might be expected to give them a better chance of understanding the process than some of the other interviewees.

This mismatch is to some extent inevitable in the current framework. The board's purpose is to protect the public, not to facilitate grievance investigation and resolution on behalf of and for the benefit of individual consumers. However, more could be done to address the impact of this on complainants through the legal framework, as well as by the boards.

⁴⁷ Interviewees did not talk in terms of 'participatory rights'; they uses language like '*I felt left out*'; '*I wasn't important*'.

⁴⁸ In a few interviewees complainants reported this leading to trauma requiring treatment/professional intervention

Timeliness and regular Board/complainant contact

Most interviewees stated that the time taken to deal with complaints, and the lack of regular contact by the Boards to keep complainants informed of progress, were difficult for them. Most interviewees reported having little idea of what the Board was doing to address their complaint much of the time, especially when there were delays of months, and occasionally years, between either contact from the Board, or the complaint 'progressing' to the next stage. For those that did have reasonably regular contact with a board, many interviewees said that this was only because they contacted the relevant board regularly themselves. Interviewees (with some exceptions) usually reported hearing very little from a board unless they initiated that contact. Where complainants were informed, sometimes the information was inaccurate, typically in that things took much longer than they had been told. This did not foster confidence in the process.

From the perspective of a registration board, such delays are often unavoidable. They have limited resources, and a current system of part-time semi-volunteer board members undertaking board business. However, many complainants did not understand this context and, as a result, reported they lost confidence in board processes overall. This is a crucial issue, and its implications are discussed later in this report.

Independence and impartiality

A number of interviewees expressed doubts about the impartiality of boards. They perceived board members who were responsible for investigating complaints about practitioners as fellow professionals, and questioned whether this led to independence, impartiality and fairness. A number of these interviewees also reported that this perception was compounded by the fact that the professional board that had investigated their complaint was also responsible for making decisions about disciplining the practitioner.

These doubts were expressed in terms of perceived failure to properly investigate. Typical interviewee comments on this issue included, "*they protect their own*"; "*they look after their mates*"; and "*they are unwilling to listen*".

These questions of independence, impartiality and capacity for fairness, openness and transparency, and accountability of boards are all raised by the review in relation to the current regulatory system. The findings in this research would appear to support the need for these issues to be addressed. The implications of this are developed further later in this section.

Review of Board decisions

Many interviewees disagreed with the findings and/or determinations of the board in relation to their complaints.⁴⁹ Nearly half reported that the complaint process made the situation worse for them. Just under a quarter of these complainants wished to take the matter further. There were a number of difficulties for complainants in terms of the limited opportunities for legal review of Board decisions under current legislation:

- Although formal hearings are open to the public, other decision-making processes within the boards are not. Several interviewees whose complaints were closed after preliminary investigation commented that they had no idea why the board decided not to proceed, and that they would like to have known. One or two of the most determined accessed board files through Freedom of Information provisions but said that this did not help them.
- Complainants had no clear legal avenue to pursue their complaint further, as the rights to external review of board decisions are restricted to review by VCAT of formal hearing decisions only. Even in relation to review of formal hearings by

⁴⁹ There were two types of such cases. In the first type the Board decided not to proceed after preliminary investigation (NFA). In the second type a hearing was held and the practitioner was exonerated; or the practitioner was found to have committed some level of unprofessional conduct, but the complainant considered the finding and / or penalty did not sufficiently reflect the seriousness of their behaviour towards the complainant.

VCAT — it is not clear under the legislation whether a complainant has legal standing to request a review.

Inconsistency of processes

A final theme was that the majority of complainants reported experiencing board processes as confusing. Many suggested that processes could be less bureaucratic, less formal and legalistic. The Study Team also noted considerable inconsistency in reported processes across and within boards.

For example, some interviewees reported being interviewed in relation to their complaint by someone from the board, while some reported that they were not interviewed. Some said a board panel and an investigator interviewed them, but for others only an investigator interviewed them. Some reported that they received regular phone contact from the board keeping them up-to-date, but most reported not (except where they initiated it themselves). Some complainants received lengthy correspondence explaining what was going on, while some reported receiving letters of two or three lines. Some said they were able to say what they wanted to say; some reported feeling constrained by the process and unable to put their case. Some felt they were not given the opportunity. Some processes took only a few weeks or months, while some (apparently similar) took years. This apparent inconsistency was evident at all of the points in the process where the complainant and a board might interact.

The impression created is that there is little standardisation within and across boards as to how complaints are handled. Processes as reported by interviewees seem to depend on which board, what kind of complaint, which officer was assigned to the case, how busy the board appeared to be, and so on. Under legislation, boards have a wide discretion as to how they approach investigation of allegations of unprofessional conduct. However, the apparent lack of standardised processes make it difficult for boards to communicate accurately to complainants what will happen in processing of their complaint. Consequently complainants may find it hard to understand what is going on, or to predict what will happen next.

Implications of key themes⁵⁰

This section discusses the implications of the findings of this research, and the themes and issues raised by the interviewees. It does this in the context of the principles of impartiality, independence, effectiveness and accountability underpinning the review.

Informing and supporting complainants in the process

Lodging the complaint – accessibility

Two-thirds of complainants accessed boards directly to lodge their complaint. It was the first place they accessed to complain (other than to the health care provider him/herself). Once there, in the sense that board focus and purpose remains 'policing' standards of registered health professional practice, it provided a 'one size fits all' complaints handling service, regardless of consumers' needs and expectations.

Further, even where consumers did go elsewhere first (e.g., to the Health Services Commissioner), they appeared to have been referred on to the relevant board because the complaint concerned a registered health practitioner. Although HSC practice is to only do this with the agreement of the complainant, it was not obvious from comments made by many of these interviewees that complainants understood the implications of this agreement.

⁵⁰ For the purposes of the Review we focus in this report on areas where complainants' experiences point to opportunities for reform/improvement. However this is discussed in a context where, for a large minority of interviewees, their overall experiences of Board processes were satisfactory.

In this study, virtually all of the interviewees lodged written complaints. Generally, legislation required written complaints to boards. However, for complaints processes to be as accessible as possible it is valuable if complaints can be lodged verbally as well as in written form; and if a written complaint is required, assistance is given to formulate it. It is common practice for most consumer complaints legislation to allow for this.

Occasionally, boards in this study appeared to accept verbal complaints over the telephone — one interviewee telephoned to register a concern. Her concern was recorded and investigated as a complaint, even though she did not intend that it be treated as a formal complaint. Some interviewees were offered help by the board to formulate a complaint in writing; but interviewees did not report this as standard practice — even where it appeared from their comments that they might have found it useful.

Boards should legally be able to accept verbal as well as written complaints, and to have systems in place to process them. The capacity for all boards to assist complainants to formulate and lodge complaints would improve accessibility. It would provide an initial opportunity to provide clear information regarding board powers and limitations, and the system of regulation generally; as well as to interact with the complainant to discuss and clarify their expectations and understanding of board processes.

These points suggest a strong need for more uniformity in both the process and standard of access and support for consumers making complaints.

One possible approach to this issue is to have a clearer single point of entry and receipt and investigation of health complaints — a 'one stop shop'. To some extent that occurs at present in Victoria, in that, although Boards and the Health Services Commissioner all can receive complaints from health care consumers, there is a cross referencing' and liaising between them as to processing the complaint. However, the researchers in this study were surprised at the numbers of complaints where this liaison did not appear to have occurred, particularly in relation to complaints made directly to boards, where the complainant's expectations could have indicated that Health Services Commissioner processes could have been useful to the complainant.

Within Victoria a more formalised (in the legal sense) 'one stop shop' body could conduct a preliminary investigation of the complaint for the complainant to clarify the issues, support the complainant in the process, and attempt to find a resolution that meets the needs of all involved. Issues of substandard practice by registered health practitioners could then be more thoroughly investigated by that body and passed on to the relevant board for disciplinary hearings. This approach would address one issue of impartiality and fairness raised⁵¹ by interviewees — that of having the same body both investigate and conduct disciplinary hearings in a complaints handling process. Alternatively, once the body receiving the complaint investigates and determines there are issues of substandard practice by registered health practitioners, those issues (and only those issues) could be referred directly to the relevant board for further inquiry.

An obvious candidate agency in Victoria for this is the Health Services Commissioner. There would be a strong argument for having all complaints lodged initially with the Health Services Commissioner, where a preliminary investigation could be conducted, and the complainant's reasons for complaining and desired outcomes explored. The Health Services Commissioner could then deal with those aspects that it could appropriately address (e.g., a conciliated resolution). Referral to a disciplinary board would only occur if there were issues of professional misconduct, or of poor practice, that needed to be addressed in the public interest.

This approach has the advantage of allowing the complainant to have their needs addressed through involvement in the Health Service Commissioner process, possibly

⁵¹ And also a general issue of natural justice — see DHS 2003 at pp. 75.

supported by an upgraded patient advocacy service.⁵² It might minimise complainants experiencing the mismatch identified by interviewees in this study between their objectives and those of the boards investigating professional misconduct or poor practice to protect the public. Such a model carries the potential for improving complainants' capacity to achieve their objectives when they complained. They could remain relatively uninvolved in board processes, with a better understanding of the limitations in the board's role and purpose, and confident in the knowledge that their objectives were being met elsewhere if they did not coincide with the board's commitment to protect the public interest. Complainant status as a board witness (if required) would be clearer.

Further, from a consumer perspective, there is still a large array of agencies and/or boards where complaints can be lodged, as is evident from answers given by interviewees who reported approaching more than one agency with their complaint. A single portal would also clarify for consumers where complaints could be lodged, and enable broader promotion and public education of this.

Information flow – contact person/regular contact

Timely communication to complainants about the progress of their complaint was seen as essential by nearly all complainants interviewed. They wanted this to be proactively and regularly initiated by boards throughout the various stages of the process. This is not necessarily a legislative issue. However, the suggestion in the DHS Discussion Paper⁵³, that boards be required to provide a contact/liaison officer who would liaise with each complainant, would be one way to address complainants' concerns about the lack of information and support.

Support services

Results from the research demonstrated the advantages of advocacy and support services for complainants separate from the boards. Currently, some boards do refer complainants to such a support service. Interviewees who accessed these services were generally positive about what they offered. However, two issues were raised in relation to their use:

- *Inadequate resourcing* – some interviewees reported that these support services lacked the capacity to assist them to the level they felt was necessary. Several commented that the support person was very valuable when she was available, but there were long periods when they had little or no contact with her, or found it difficult to get in touch with her. A couple of interviewees made comments such as that, "all she did was show us the hearing room and explain the process. That was helpful, but it didn't really provide us with much support". This may point to a lack of resources being directed to this role.
- *Perceived conflict of interest* – for some interviewees, the support service was not seen as sufficiently separate from the board. Indeed, one person saw the service as being greatly compromised. She reported great distress on discovering, on the day of a hearing in which she was to give evidence, that the support person was a potential witness (for the practitioner) in that she (the support person) could be subpoenaed to give evidence on matters which the complainant had confided in her; and also, for this reason, the support person could not be in the hearing room with her when she gave evidence.

An advocacy service independent of the boards could provide complainants with assistance through all processes (whether with health care providers, boards, or Health Services Commissioner) and could advocate/ inquire on their behalf to these agencies. Such a service could also be a valuable source of information and support. Its purpose

⁵² See e.g. NSW; New Zealand models

⁵³ DHS 2003

would be primarily and solely to assist the complainant, and the opportunity for perceptions of conflict of interest would be removed.⁵⁴

However, a separate service requires a major investment of planning and resources. The feasibility of this could be investigated, and funding options explored. Even if this approach is not taken, some form of properly resourced support for complainants to health practitioner registration boards would be of great advantage to complainants. It requires, as a minimum:

- professional and properly resourced advocacy and support services to which all of the boards have access and can refer their complainants;
- clarification of the legal status and role of the service to, for example, avoid conflict of interest and protect the relationship between the complainant and the support service (e.g. through legally privileging the relationship between the complainant and the support person so the latter cannot be cross examined in a hearing by the practitioner about information obtained from the complainant).

Legal representation

Several interviewees commented that they felt vulnerable without their own lawyer representing their interests, particularly when appearing before a board panel, or in a hearing. This feeling was exacerbated when the health professional was legally represented in a formal hearing and their counsel defended their client (as is their right) by challenging the evidence of the complainant. For those complainants whose complaints went to formal hearing, cross-examination by the lawyer for the health practitioner was one of the most stressful aspects of the whole process. While, technically, board processes are inquisitorial rather than adversarial⁵⁵ and therefore a board can disallow lines of questioning as not relevant to the issues they are considering, in practice interviewees almost never reported this happening when discussing their experiences of cross-examination.⁵⁶ Although the interviews did not specifically ask complainants about their own legal representation, several proffered the comment that they wished they had had their own. Provision for complainants to have their own legal advice and support, if they wished, would be supported by the Study Team on the basis of the negative feelings and experiences described by interviewees whose complaints reached this phase.

Timeliness

As noted above, this was a key theme. It has implications for some of the issues raised in the Discussion Paper, and for the principles of effectiveness and timeliness governing the Review. These related to:

- functioning and membership of health practitioner registration boards including resourcing and payment of members performing quasi-judicial functions;
- introduction of benchmarked timelines and regular reporting to consumers on compliance.

Functioning and membership of Boards

One reason for (the often considerable from a complainant perspective) delays in processing complaints could be related to resources and the nature of board membership. Board administrations are funded entirely from registration fees paid by registered practitioners. For the boards with smaller numbers of registered professionals, this may not be enough to employ sufficient staff to meet the workload. One small board, for example, has one executive officer and a part-time administrative assistant. It hires sessional investigators if it required them — one complainant to that board observed

⁵⁴ Models in the form of Patient Advocacy Services exist in NSW, and in New Zealand.

⁵⁵ That is, under their legislation boards can inform themselves in any way they see fit and are not bound by the rules of evidence (as compared to adversarial procedures in courts)

⁵⁶ This does not necessarily mean that disallowance of questioning of the complainant did not occur within a board hearing; it could be just that the interviewee did not remember it. However, the general discomfort reported by interviewees who gave evidence in formal hearings indicates that, at least, this issue is worth further exploration.

that, while the sessional investigator knew his job and was helpful, he was external to the board and therefore could not really assist the complainant with understanding board processes, or have any knowledge or influence over the progress of his complaint.

Additionally, under the current system, board members are part-time and semi-voluntary (in that their sessional pay scales are generally not commensurate with income foregone from being absent from their practices seeing clients/patients).

Several complainants commented, for example, that hearing or panel interview dates were frequently changed (sometimes without notice to the complainant participating as a witness or observer) or delayed by as much as a month at a time; often, it appeared, to accommodate part-time members who were involved in professional work other than their work with the board, and therefore had other priority work commitments. At least one board holds its hearings in the evenings for the same reasons — this limits what can be covered in one sitting. A number of interviewees who had to travel from outside Melbourne commented that they were disadvantaged in that they had to repeat the journey several times, or they had to stay overnight. This meant costs in time, emotional wear and tear, and sometimes financial — income lost, travel costs (several journeys), accommodation. They were not reimbursed the full monetary costs.

Interviewees who gave evidence at formal hearings reported frequent adjournments, sometimes in mid-evidence, with the hearing not reconvening for days or weeks afterwards. This affected both the consistency with which they were able to present their evidence and added to their stress.

Case Study examples

- One interviewee, giving evidence in a difficult boundary violation complaint, reported that she felt traumatised by intensive cross-examination and challenge, over several days, by counsel representing the health professional. She considered that this was exacerbated by the fact that these days were spread over several weeks, and because adjournments and delays occurred at short notice. The complainant commented that she came close to withdrawing from the process as a result. She reported needing extensive counselling support for some time afterwards.
- Another interviewee reported that she planned to take a day off work and travel some distance to attend the scheduled hearing of her complaint, the date of which she had received written notice some weeks before. The day before, she decided to ring and confirm the hearing was on for the next day. She was then told it had been postponed for several weeks. She had received no notice, or phone call advising her of this postponement. As she said:

What would have happened if I had gone to all the expense and travel of coming to Melbourne, arriving at the hearing, only to be told it was not on. I would have been furious. But if I had not rung, that is exactly what would have happened.

Further analysis is required to determine more precisely causes of delays and the extent to which these are attributable to the issues identified above; however, in that context, consideration could be given to a range of initiatives suggested in the DHS discussion paper that would meet the concerns put forward by the interviewees in this research⁵⁷:

- provision of adequately resourced board administrations;
- payment of board or panel members appropriately and professionally for quasi-judicial work to undertake and complete the work in a timely fashion;
- a daytime professional tribunal to conduct formal hearings
- benchmarked timelines for complaints processing.

⁵⁷ See Chap. 12 & 13: Victorian Department of Human Services, Policy & Strategic Projects 2003, *Regulation of the Health Professions in Victoria: A Discussion Paper*, Victorian Government, Melbourne.

A major finding of this research is that most interviewees were concerned about timeliness in complaints handling; that is, the need for boards to deal in a more timely fashion with each stage of the complaints process. Consideration could be given to the introduction of benchmarked timelines and regular reporting to consumers against those benchmarks. The boards could develop these collaboratively and voluntarily as part of discharging their responsibilities to be accountable to the community, or they could be introduced legislatively. There are obvious difficulties in setting time limits on different phases of board processes. These include the problem of providing sufficient resources to allow boards to do the job within the time, and the complexity of some cases that may require longer due to unavailability of parties and evidence. However, such limits would at the very least give the complainant some benchmarks against which to judge the progress of their complaint.

Status of complainant in process

The lack of status or involvement for complainants in board investigation and disciplinary processes was an issue for many interviewees. The report had commented previously on this. Various themes emerged in terms of interviewees' understanding of their capacity to participate fully in board processes, and the impediments inhibiting them from doing so. The DHS discussion paper addresses this issue, asking if complainants should be given more legal standing as participants in the process, as well as legal entitlements to information, notification, participation, and review of decisions about their complaints⁵⁸.

Complainant participation

Many interviewees reported that, much of the time, they did not understand and/or were not informed as to what was happening in relation to their complaint. They did not perceive that boards supported or encouraged them to understand processes or participate fully; where help was offered, it was through 'direction' or 'advice' (which limits choices) rather than information (which enables choices):

There is no empowerment. It is more like a parent-child relationship than adult to adult. For example I didn't hear the doctor's testimony because they advised me not to go on the grounds it would be too painful. Instead they should have told me when it was on, told me the pros and cons of going, and left the choice up to me! For example,.... the board should have to set out the options to complainants in terms of the different courses of action, and then support them in making decisions. Instead I was just "put on the track" and trundled along.

Ideally, participants in legal or quasi-legal processes have legal entitlements and status. They are supported and assisted to utilise them fully. For example, in many judicial hearings participants may have legal representation; if they do not, the presiding judicial officer will often ensure that they are given every opportunity to fully participate. This is an area of process that the Study Team believes needs to be reviewed by the boards.

Right of reply

A number of interviewees felt that they did not have the opportunity to present all the information they wished. Several commented (some quite forcefully) on not having a chance to present refuting evidence or information.

This goes to the heart of the disjuncture between the purpose of board processes, and complainant understandings about their own role in them. The legislation currently establishes an inquisitorial legal process whereby a Board can inform itself more or less in anyway it sees fit. The complainant is a witness only. If the board considers it doesn't need further information or evidence from the complainant, it is not sought.

⁵⁸ Ibid.

From a complainant perspective, consideration could be given to affording them the legal opportunity to present whatever evidence they wished at a hearing. At the very least, reforms to the legislation could entitle them access to the health practitioner's evidence/statements if they wished it, and guarantee them an opportunity to present their own versions/refutations. This would be the case at hearings. Such a right might be exercised before the end of the preliminary investigation and before the board decides whether or not to proceed. A board could be required to offer the complainant the opportunity to review the health practitioner's statement and reply to it before making a decision. From interviews conducted in this research, it would appear that some boards already do this for some complaints, but it is not the norm.

Giving complainants legal standing

There are a number of issues identified by interviewees that potentially could be addressed if their *legal* status as participants in the proceedings were clarified and enhanced:

- The problem of information flow from boards to complainants could, at least, be partly resolved by according them a legal status where they would become entitled to various notifications informing of the different steps taken at each phase during the board investigation and hearing.
- Legal reform could afford complainants other rights within the process, including a formal 'right of reply' to evidence presented by the health practitioner, rights to legal representation, and rights to have board decisions reviewed.

For many complainants, the right to be treated, legally, as a participant with standing in the proceedings could be an important opportunity to allow them to feel more central to the proceedings, improve information flow to them, afford them various participatory rights, and assist in reducing their perceptions that their concerns and needs are marginal to the process. This in turn could improve their confidence in the process in terms of its effectiveness, even-handedness, and transparency. At this stage, the feasibility of this option has not been investigated in depth by the Review in terms of its advantages or disadvantages, cost implications and experience elsewhere. However, this approach could be worth pursuing.

Review of Board decisions with which complainants do not agree

As noted previously, some interviewees raised issues concerning their inability to have board decisions with which they disagreed reviewed by a body external and independent of the board. Several issues are raised in the DHS Discussion Paper for possible review, which have some relevance to this question.

The right of members of the public to have legal decisions about them externally and independently reviewed is a fundamental feature of our legal system. Similarly, dissatisfied complainants would benefit from access to review processes. Issues that are raised by the Review that are relevant to complainant rights to review of board decisions include:

- the legal status of the complainant
- which decisions can be reviewed
- who should carry out review.

The outcomes of this research suggest that developing and examining the following propositions could go some way towards alleviating these concerns:⁵⁹

- Complainants should have standing to seek reviews of decisions about complaints they have lodged. The fact that they lodged the complaint and are

⁵⁹ DHS 2003 - pp 84/5.

concerned about the outcome gives them sufficient interest in the case to give them that standing.

- All quasi-legal decisions should be subject to review. In particular, decisions not to proceed with a complaint following preliminary investigation, as well as decisions after informal and formal hearings, should be included in the categories of reviewable decisions.
- An independent non-professional dominated tribunal could be established to review decisions by boards. Alternatively, if such a body is not established, VCAT could review board decisions.

Unbiased, fair, independent, and transparent processes

Impartiality and independence

As noted earlier, several interviewees commented on what they perceived as the 'inherent bias' they observed in board processes. The researchers are not in a position to assess the merits of claims that the boards are not independent, fair, and unbiased in their deliberations (this was beyond the scope of the study). The perception of bias noted above was a recurring theme, however, and links directly to the issue of public confidence. It is possible that complainants who are aggrieved by board processes or outcomes may be more predisposed to perceive that the boards are biased. However, maintenance of public confidence in the regulatory system for health practitioners requires not only that the system be fair, unbiased, and independent, but also that it is seen to be so. A membership dominated by members of the same profession as the practitioner under scrutiny, does not necessarily inspire general confidence.

Consideration could be given to reforms designed to address this perception of bias. Such reforms could include:

- changes in the membership mix of practitioner and non-practitioner board members;
- separation of investigation, and discipline determination functions between two bodies rather than the current one board conducting both;
- increased transparency in processes of investigation and hearings in terms of availability of reasons for determinations, communication with complainants, and capacity for review.

Membership of Boards

One option for reform canvassed in the Review⁶⁰ is an increase in the number of non-health professional members (from the current two). In relation to panels and boards composed for disciplinary hearings, a reasonable case could be made for there being at least as many non-professionals as professionals on hearing panels.

Separate investigation and decision-making

Another issue of fairness, and the perception of fairness, is the fact that the same body — the board — undertakes both investigation and decision-making (adjudication and determinations) in disciplinary proceedings. The Review comments that this impacts on the board's capacity to observe procedural fairness in accord with the rules of natural justice, or to 'provide the appearance of integrity'.⁶¹

A number of approaches could be adopted, and are canvassed in the Review:

- Investigation and prosecution of health professionals before disciplinary hearings are handed to an independent investigative/prosecutorial service, which presents the case for action to the adjudicating body — the board. In some other jurisdictions (e.g. NSW) the equivalent body to the Health Services Commissioner in Victoria carries out this task.

⁶⁰ DHS 2003 – p. 29.

⁶¹ DHS 2003 – p.75.

- Creation of separate professional, independent, and non-profession dominated decision-making processes; for example:
 - a *statutory professional standards panel*⁶² within the board to make decisions about whether or not to proceed to hearing on a case, and to hold informal hearings;
 - and/or
 - an *independent Health Professions Tribunal*,⁶³ as suggested by the Review, to both conduct formal hearings and review board decisions.

Consideration of reforms such as these would serve to address both the perceived independence questions raised by the interviewees, and promote the procedural fairness and integrity issues raised by the Review.

Request reasons for decisions

Several interviewees reported that they did not understand the reasons for the board's decisions.

Complainants would be helped in understanding reasons for decisions by boards/disciplinary bodies if they were able to request statement of reasons (SOR). This could assist them in deciding whether they wished to apply for a review, and, (if rights of review were given to complainants), could help to prevent frivolous or ill-founded review applications.

One approach to increasing the transparency of board decision-making in complaints processes could be to allow the complainant to request an SOR for statutory decisions or determinations made by the board about their complaint, including decisions not to proceed following a preliminary investigation. SORs for every decision could place an onerous administrative/legal burden on the boards and their staff. However, if complainants were entitled to SORs, and were made aware of this the decision-making process would become more transparent. Additionally, in relation to rights of review it would:

- assist dissatisfied complainants to understand the reasons for board determinations, and decide whether they wished to apply for a review of the decision;
- facilitate access to review, in that reasons given in writing improve a review body's capacity to understand the basis of a board's determination.

Issues of meeting complainants reasonable expectations, and referring if necessary

As noted earlier, many interviewees commented on the failure of the boards, in dealing with their complaints, to meet their expectations of outcome or resolution. Interviewees would have been greatly helped had they better understood the role of health practitioner registration boards, and what the boards could and could not do. More assistance in gaining this understanding, combined with some of the other reforms mentioned in this report, could substantially reduce the potential for complainant dissatisfaction, no matter what the outcome of the complaint.

For example, boards could:

- pay more attention to clarifying what expectations complainants have when they complain;
- assist complainants to identify and articulate their objectives, with information provided as to what the board can and cannot do in relation to these, plus referral on where appropriate;
- offer greater and more consistent levels of support to complainants;

⁶² DHS 2003 – p. 81

⁶³ DHS 2003 – p. 79

- work more closely with other agencies, especially the Office of the Health Services Commissioner, whose function is grievance investigation and resolution, and which has been established specifically for this purpose.

Information on what to expect

Many of the reform options already referred to could also play an important role in establishing processes for clarifying, meeting, and, where necessary, adjusting complainant expectations. These options include 'one stop shops' for lodging complaints, a complainant advocacy or other support service, and contact liaison officers within boards. However, even if these initiatives were not introduced, it would be beneficial to many complainants to receive more assistance. This could be supported by appropriate user-friendly written materials and by assistance to complainants in clarifying and meeting their objectives. For example, board investigation and/or support staff could routinely sit down with complainants to clarify expectations, make a record of the complaint and the outcome the complainant is seeking, give copies to the complainant and provide opportunities to review and revisit statements. These could provide occasions to directly address expectations that may be unrealistic given the limits of board powers and the principles of natural justice.⁶⁴

Responsibility to assist and refer

In order to ensure that boards meet complainants' needs to understand the system, and to have as far as possible realistic expectations about outcomes, a further option would be for boards to actually have statutory responsibilities in relation to the complainant. They could be required by legislation to evaluate complainant purpose and expectations, provide support and assistance to complainants to achieve that outcome, and offer appropriate referrals (e.g., referral of complaints to the Health Services Commissioner for conciliation⁶⁵). Such a responsibility could also be discharged by a separate complainant advocacy/support service, or by the Health Services Commissioner operating as a single point for receipt and investigation of complaints, as suggested previously. However, in the absence of such a service, boards could be encouraged to provide this.

Alternative dispute resolution

The expansion of capacity to order consensual negotiated outcomes to investigations is the subject of another research study commissioned by the Review.⁶⁶

The findings in this research would support the potential for alternative dispute resolution (ADR) as one mechanism to better meet complainant expectations and objectives in lodging complaints. However, whether boards are the appropriate bodies to undertake this is a separate issue. On one hand, this could be seen as outside their role as protectors of the public interest (similar to requiring the police to facilitate payment of damages to a victim of crime after an assault, as well as to arrest and charge the offender). On the other hand, some interviewees felt there was a need for seamless processes that can both investigate allegations of unprofessional conduct, and, where these are not found to be serious, resolve issues for the complainant and the practitioner.

Parallel complaints handling processes

By definition, all of the complainants interviewed who had complained first to the Health Services Commissioner had been referred to the relevant board. At that point the purpose of complaint processing ceased to be resolution. That is, it was no longer a process between the complainant and the health practitioner, where the complainant's

⁶⁴ It is recognized (and this was apparent from the reports of some of the interviewees) that sometimes some officers within some Boards will do this. We also acknowledge that the MPBV has made changes recently to move towards such steps in the process. The point is however that it should be routine.

⁶⁵ Note however, that these responsibilities would have to be *effectively* legislated. For example the requirement on the board to refer the complainant back to the Health Services Commissioner for conciliation exists in current legislation. However, only one instance of this occurring was reported by interviewees.

⁶⁶ See DHS 2003 at p. 9

objectives and needs were central (as occurs under the legislation establishing the Office of the Health Services Commissioner). The purpose from then on became to protect the public interest in maintaining standards of care by registered health practitioners through investigating allegations of substandard practice. Until this process finished (which could take months, or years) the needs of the complainant were in many ways secondary to this broader interest in public protection.

Admittedly, under the law at present, boards can refer complainants back to the Health Services Commissioner after the disciplinary proceedings of the board are concluded. However, it appears that this power is rarely used. Only one interviewee was referred back to the Health Services Commissioner for a conciliated agreement or compensation. Additionally, a number of interviewees commented that if they had been referred back to the Health Services Commissioner at the end of an already lengthy board process, they would not have accepted it, even if resolution were one of their original objectives. At that stage, they reported feeling too worn down by the time taken to complete board processes to be willing to undergo further processing of their complaint by the HSC. This arrangement does not appear to be functioning as intended, or providing consumers with reasonable alternatives or solutions. This needs addressing and suggests the possibility of more effective parallel processes. For example, investigation of complaints of unprofessional conduct by the board could occur concurrently with mediated resolution facilitated by the Health Services Commissioner.

The legal framework could allow for parallel processes to address both the public protection function, and the needs of complainants. If the law enabled these processes to run at the same time, (as far as practicable) Health Services Commissioner processes could advance the complainant's objectives and needs in resolving the complaint; while the board addresses the public interest by investigating the allegations of unprofessional conduct in the complaint, and conducting hearings and imposing disciplinary sanctions if necessary.

Practitioners prevented from practising in related fields

One final related issue was raised by a number of interviewees. There is no scope within current legislation for boards to prevent board-disciplined health practitioners who have been de-registered, or had their rights to practice temporarily suspended in certain kinds of practice, commencing work as an unregistered practitioner undertaking similar work. For example, disbarred psychologists or doctors who continue to practice as counsellors, or chiropractors or physiotherapists who continue to practice as massage therapists — neither of these professional roles require registration.

Comments made by some interviewees would support the Review proposal that boards be given the legal capacity to prevent suspended or disbarred practitioners from practicing in related areas of expertise that do not legally require registration.⁶⁷

⁶⁷ DHS 2003 par. 13.4 at p. 90.

CONCLUSIONS

It is clear from the results of this research that, although there are important numbers of complainants who are satisfied with board processing of their complaints, there are also significant numbers of complainants (a majority of the interviewees) who are dissatisfied with the current processes and outcomes of health practitioner registration boards. Virtually all complainants interviewed were dissatisfied with some elements of the current system. The findings of interviews with 60 complainants across five boards strongly indicate that the current system is not meeting complainants' needs or expectations well.

Given complainants' centrality to the effectiveness of the whole regulatory system, this should be cause for considerable concern. An effective system that is based on consumers coming forward, often at some emotional and other costs, should operate so that a vast majority of complainants are satisfied with both the process, and either the outcomes or the rationale for the outcomes.

The current situation, where this is clearly not the case, can only lead to an ebbing of public confidence in the system. It needs to be addressed.

Based on the analysis of complainant experiences above, the Study Team proposes a number of key principles⁶⁸ upon which the future regulatory and complaints handling system should be based. The Study Team also recommends a set of actions that flow from these principles⁶⁹.

⁶⁸ See post pp 72; also Executive Summary.

⁶⁹ See post pp 73; also Executive Summary.

RECOMMENDED PRINCIPLES FOR FUTURE SYSTEM

Based on the findings of this research, the Study Team suggests that the following principles be adopted to underpin any reform of the health practitioner regulatory system. Some of these have already been suggested by the Review.⁷⁰ Additional principles are proposed below, to reflect the importance of consumers to the regulatory system.

Principles

Review Principles

The future regulatory and complaints handling system should be:

- fair and unbiased, and seen to be so
- independent and seen to be so
- transparent
- effective (from a consumer complainant perspective as well as that of the broader public, health services and professions)
- timely
- accountable.

Principles of Therapeutic Jurisprudence

In relation to health care consumers who utilise board processes as complainants the health practitioner regulatory system should comply with principles of therapeutic jurisprudence in that it:

- recognises the central role of health care consumers in the regulatory system and its reliance on consumers making complaints in good faith when they perceive poor care or behaviour;
- is designed to meet reasonable expectations of consumers when they make a complaint;
- acts to minimise the harmful impact of its legal processes on complainants;
- acts reasonably in its demands of complainants.

The principle of 'do no harm' is central to the concept of therapeutic jurisprudence. It recognizes that legal can have a harmful effect on community members who are caught up in its procedures, particularly people who are 'victims' of unacceptable behaviour, who bring it to the attention of the legal system through reporting or complaining about it. Principles of therapeutic jurisprudence recognise that a victim/complainant has the potential to be twice harmed – first by the behaviour (in this case poor health care) and second, by the legal process. This was evident for a number of our interviewees. Therapeutic jurisprudence requires the legal system to consciously act to minimise (to the extent reasonably compatible with its public interest purpose) the impact of the harmful effect of its processes on people, and particularly to endeavour not to compound the harm done to those who have been victimised once already.

⁷⁰ See DHS 2003 Table 1.1 at p. 10.

CONCLUDING REMARKS

The results of this research have implications for both the DHS Review, and for Boards. There are many options for action that could be explored that could make the system more user-friendly.

For example, the Review could investigate including legal reforms which facilitated a more 'consumer friendly' complaints system. Legislative reform could be considered which would provide for a single point of entry to the complaints system (the 'one stop shop'). It could improve the legal standing of complainants in relation to their rights to notification, to access to reasons for board decisions, and for a review. Legislative reform could upgrade requirements for support of and communication with complainants, including the possibility of a separate complainant advocacy service such as that which exists in NSW and in New Zealand. Lastly it could tackle perceptions of bias through review of board membership, and address questions of timeliness.

Similarly, boards themselves could use this research effectively to improve consumer responsiveness in their own processes. Suggestions that are worthy of further discussion include:

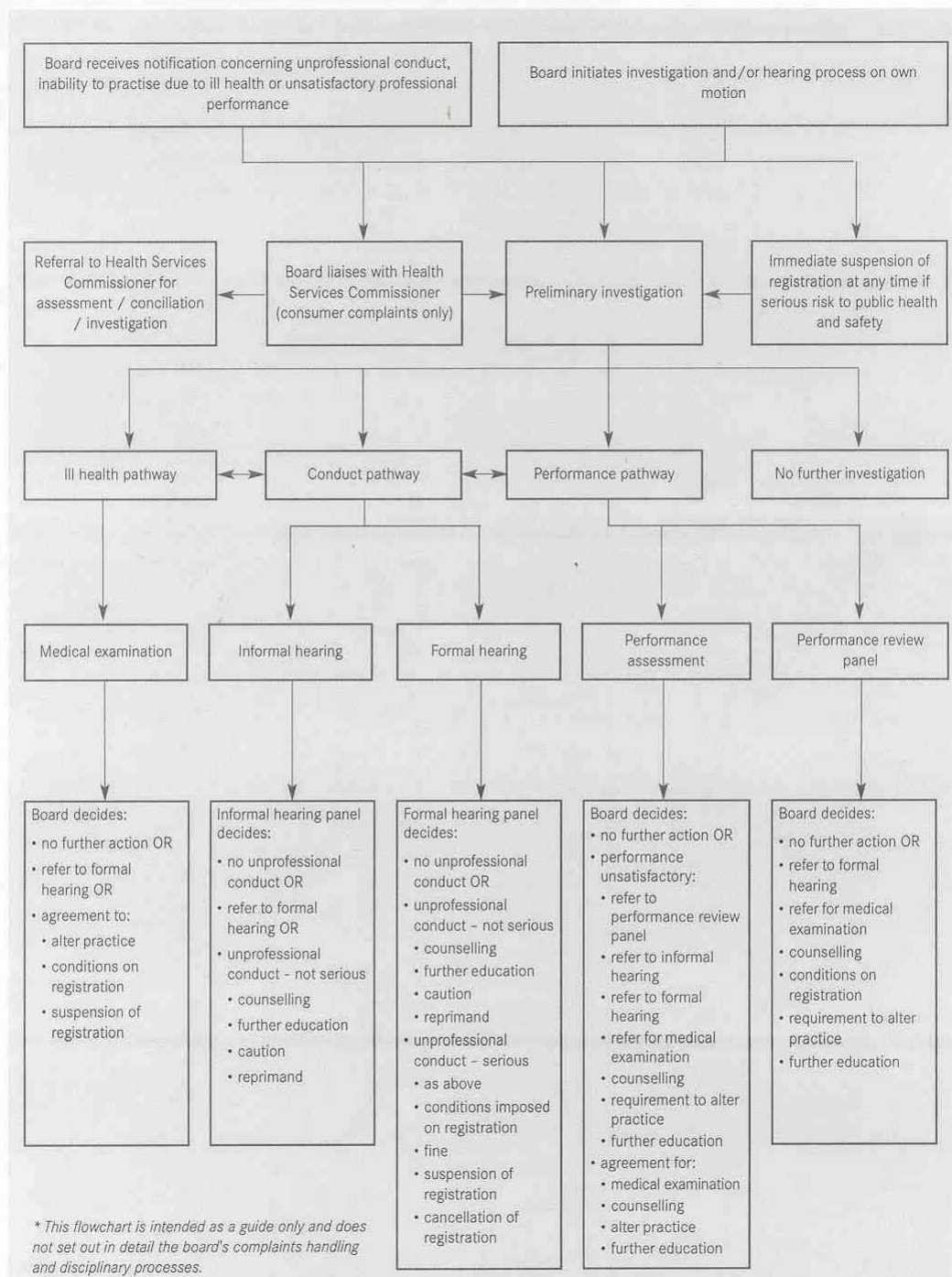
- establishment of consumer reference / advisory groups (already being developed by the Medical Practice Board of Victoria);
- development of benchmarks for timely complaint processing and regular reporting to the community as to compliance; and
- periodic data gathering about complainant experiences of the complaints handling processes as a quality control measure – using this research as a 'base line'.

Finally, the researchers would like to commend DHS for commissioning this research, and the participating boards for their foresight in supporting it. The impact of legal processes on ordinary people who get 'caught up' in their labyrinth-like processes is an area of research and reform that has only recently begun to be examined. This work provides an important contribution to that development, and a significant insight into the strengths and weaknesses of the current system in terms of its impact on consumers of its processes.

APPENDICES

APPENDIX A: OVERVIEW OF INVESTIGATION AND HEARING PROCESSES UNDER THE MODEL PROVISIONS OF THE VICTORIAN MEDICAL PRACTICE ACT 1994

(as recently amended by the Health Practitioner Acts (Further Amendments) Act 2002)*



APPENDIX B: REFERENCE GROUP MEMBERS AND TERMS OF REFERENCE

MEMBERS

- Professor Shane Thomas, Faculty of Health Sciences, LaTrobe University
- Dr David List*, representing Health Practitioner Board Presidents' Group (Chair, Psychologists Registration Board)
- Dr Gerard Condon, representing Health Practitioner Board Presidents' Group (Chair, Dental Practice Board of Victoria) (*replaced Dr List after first meeting*)
- Dr Joanna Flynn, representing Health Practitioner Board Presidents' Group (Chair, Medical Practitioners Board of Victoria)
- Ms Lynn Griffin, Manager Assessment & Investigation, Office of the Health Services Commissioner
- Dr Leanna Darvall, Senior Lecturer, Health Law, Monash University
- Ms Iva Steinke, Consumer nominee
- Ms Belinda Moyes, Director Nurse Policy, Department of Human Services
- Ms Kim Sykes, Nurse Policy, Department of Human Services, (*replaced Ms Moyes after first meeting*)
- Mr Alistair Sanderson, Community Health, Department of Human Services
- Mr Tony Triado, Community Health, Department of Human Services (*replaced Mr Sanderson after first meeting*)
- Ms Rosemary Barker, Manager Complaints & Quality Systems, Department of Human Services
- Mr Bruce Paterson, Mental Health Branch, Department of Human Services
- Ms Anne-Louse Carlton, Policy & Strategic Projects, Department of Human Services

TERMS OF REFERENCE

1. To assist the Project Team to understand the full context for the project and its links to other initiatives
2. To provide advice on the research design and interview tools
3. To provide advice on implementation issues
4. To provide feedback on the draft final report

APPENDIX C: RECRUITMENT PROCESS

Selecting the individual complainants to receive invitations to participate

Fifteen 'recruitment cells' were created to give as wide a spread of experience of Board processes as possible among the interviewees. Each of the five boards had three cells; each cell representing one of the three points of determination at which a complaint could be closed (NFA; informal hearing; formal hearing.)

To maximise the parity in numbers from each 'recruitment cell', complainants to whom invitations to participate would be sent were selected from each board as follows:

- Psychologists Registration; Dental Practice; Nurses and Chiropractors Registration Boards:
 - o All complaints by consumers
 - o Closed between 1 January 2002 and 30 June 2003
 - o After preliminary investigation / informal hearing / formal hearing.
- Medical Practitioners Board:
 - o All complaints by consumers
 - o Closed between 1 January 2003 and 30 June 2003
 - o After preliminary investigation / informal hearing / formal hearing.

To ensure both privacy and independence in selection of participants,⁷¹ the boards submitted to the researchers lists of all⁷² complaint record numbers⁷³ within the specified periods categorized by phase of closure. Anticipating a response rate of 20–25%, the researchers aimed to identify approximately five times the number of complainants who would receive invitations to participate, than the target of seven interviewees from each cell⁷⁴ Where there were more in a cell than this number, the researchers randomly selected the required numbers and sent the selected record numbers back to the boards who matched the names to their complaint record. Where there were less than 35 records in a cell, the researchers included all of the complainants from that cell.⁷⁵

Approaching the target group of complainants

For privacy reasons it was not possible for the researchers to approach the sample pool of complainants directly. Therefore the boards made the first approach by sending letters to the complainants whose complaint numbers matched those selected by the researchers, inviting them to participate in the research through contacting the researchers directly.

48 letters were sent by the Psychologists Registration Boards, 7 by the Nurses Board, 117 by the Medical Practitioners Board, 17 by the Chiropractors Registration Boards. Due to a miscommunication, the Dental Practice Board sent all eligible NFA complainants (164) the letter. However, this simply meant that a random sample was chosen at the next stage for this category. This made a total of 353 letters sent by boards (see Appendix C, Table 1).

⁷¹ Some consumer stakeholders expressed concerns that the Boards could manipulate the selection process by inviting those complainants who they knew had favourable experiences of the Boards.

⁷² See previous qualification

⁷³ The complaint records numbers received from for each Board were: MPBV – 117; Chiropractors – 23; Nurses – 7; Dental Practice – 164; and Psychologists 48. (XX check these numbers again)

⁷⁴ Anticipating a response rate of 20 – 25% based on previous comparable research – see for example Landau 1994.

⁷⁵ Note that the researchers and the Boards agreed that it would not be appropriate for complainants to be approached who might severely re-traumatized by being asked to 'relive' their experiences. Only the Psychologists Registration Board excluded a number on the list (8) from being approached for that reason – this is not surprising given that many of their complaints involved sensitive issues of boundary violation. MPBV also excluded one complainant from their list.

APPENDIX C: TABLE 1: LETTERS SENT BY BOARDS

BOARD	No Formal Hearing (NFA)	INFORMAL	FORMAL	TOTAL (353)
Psychologists Registration Board	36	7	5	48
Nurses Board	7	0	0	7
Medical Practitioners Board	38	50	29	117
Chiropractors Registration Board	6	8	3	17
Dental Practice Board	143	4	17	164

The researchers drafted a standard letter format that each board then adapted and sent out under its own letterhead. The letter advised the complainants of the research, gave detailed information as to its purpose and what it involved, and asked the complainant to contact the researcher directly if they wished to participate. Three to four weeks later, follow up letters were sent to those who had not yet responded, repeating the invitation.

Responses from complainants:

As a result of these letters, each of the participating boards generated a self-selected group of consumer complainants from each of the three points at which complaints were closed. The project received a total of 26 responses from complainants to the Psychologists Registration Board, 4 from the Nurses Board, 48 from the Medical Practitioners Board, 5 from the Chiropractors Registration Board, and 37 from the Dental Practice Board: a total of 120. This is a response rate of approximately 34%.

Sampling

The objective was to recruit up to seven (and no more than eight) complainants for interview for each of the 15 'recruitment cells'. When there were not seven available in the cell, the researchers included all that accepted. Each board (other than the Medical Practitioners Board) produced less than seven acceptances for at least some of their cells. When more than seven responded within a cell, the researchers randomly sampled from the total acceptances within that cell to allocate seven to be interviewed. The final number of 60 interviews was reached because of the need to take a maximum of seven for each of the fifteen cells, and for many cells there were not that many complainants available to recruit. In some cells there were no complainants available to recruit. The numbers involved in this sampling process are set out in Table 2.

APPENDIX C: TABLE 2: Responses received

BOARD	NFA	INFORMAL	FORMAL	TOTAL (120)
Psychologists Registration Board	18 Sampled 7	4 Took all	4 Took all	26 responses 15 interviewed
Nurses Board	4 Took all	0	0	4 responses 4 interviewed
Medical Practitioners Board	17 Sampled 7	20 Sampled 7	11 Sampled 8	48 responses 22 interviewed
Chiropractors Registration Board	5 Took all	0	0	5 responses 5 interviewed
Dental Practice Board	31 Sampled 8	1 (Took all)	5 (Took all)	37 responses 14 interviewed

TOTAL NUMBER OF RESPONSES = 120

TOTAL NUMBER INTERVIEWED = 60

APPENDIX D: SURVEY INSTRUMENT

Health Issues Centre Study of Consumer Experiences of Complaints Processes in Victorian Health Practitioner Registration Boards

SURVEY INSTRUMENT

NOTE: Ask all quantitative questions. Order of qualitative questions is a guide only.

PART A: THE COMPLAINANT

1. Did you lodge a complaint on behalf of:

Yourself
Family member
Friend
Patient
Client
Colleague
Other

Specify _____

2. What did you complain about?

3. Are you?

Male Female

4. Date of Birth

5. Is English your first language?

Yes No

If no: what is your first language?

If complaint was lodged on behalf of another person

3b. Are they?

Male Female

4b. Relationship

4c. What is their age?

Under 18
18-24
25-34
35-44
45-54
55-64
65-74
75-84
Over 85

6. What is your highest level of education?

School certificate
Higher School Certificate
TAFE qualifications
University

7. What was your occupation at the time of lodging the complaint?

Manager/administrator
Professional
Trades person
Sales person/service worker
Machine/plant operator
Home duties
Retired
Other Specify _____

8. Where is your place of residence?

Inner Melbourne metropolitan
Outer Melbourne metropolitan
Regional Victoria
Rural
Elsewhere
Specify _____

4d. Is English their first language?

Yes No

If no: what is their first language?

5b. Why didn't they lodge the complaint themselves?

6b. Were where they living at the time of the complaint?

PART B: THE CASE

9. When did you lodge the complaint with the Board? (Date)

10. When did the incident(s) occur/over what period of time?

11. * What were your expectations when you complained?

12. * What outcome or solution were you seeking when you made your complaint to the Board?

13. What did actually happen?

14. What stage has your complaint reached?

Preliminary investigation
Informal hearing
Formal hearing
Other Specify _____

15. Has the Board considered your case closed?

Yes No Don't know

If no, when was the last contact from the Board and what was it about?

16. Did you also lodge a complaint elsewhere? E.g. Health Services Commissioner.

Yes No

If yes, specify _____

PART C: CONTACTING THE HEALTH PRACTITIONER BOARD

17. How did you find out about the Board?

Were you referred by:

A health practitioner
A /family/friend/relative
A consumer organization
Newspaper/magazine
Telephone directory
Had existing knowledge
Health Care Commissioner / Ombudsman
Referred by another source
Specify _____

18. How did you first contact the Board?

Telephone call
Letter
Attended in person
Fax
Email
Other Specify _____

PROMPT: after first contact, what information did you receive and by whom, and when? (written, oral)

19. If you spoke with someone at the Board, how helpful was the person you spoke with?

20. Did you receive any written information from the Board?

Yes No

If yes, how helpful/clear was the information?

very helpful/clear fairly neutral not

21. When in the process were the Board's complaints handling process and its powers explained to you? By whom and in what form?

When

Whom

What form (oral, written)

22. Did you understand the process at that stage?

Yes No

23. Would anything have helped you to understand the process better?

24. Did you understand what the Board could and could not do?

Yes No

25. Was the process any different from what you understood from the Board's explanation?

Only use if poor command of English

26.

a. Did you need someone to act as an interpreter at any time during the complaints handling process?

Yes

b. Did the Board arrange for an interpreter?

Yes No

c. Did anyone else act as an interpreter?

Yes No

27. Was any written information provided to you in your language?

Yes No

28. How useful was this information?

**Very useful
at all**

fairly useful

not useful

PART D: THE COMPLAINTS HANDLING PROCESS

**29. At what stage were you able to present information to the Board?
(Tick as many as appropriate)**

1. In my letter of complaint

2. At interview with an investigator
3. In a sworn statement or affidavit
4. Evidence in hearing
5. I wasn't asked

30. Were you able to present all the relevant information you wanted to (written and verbal) during the complaints handling process?

Yes No

If no, what were reasons?

31. Did you feel adequately informed and advised throughout the whole process, eg were you provided with enough timely and understandable information regarding the case as it progressed?

Yes No

If no, what could the Board have done to better inform you?

32. Were you assisted adequately through the complaints handling process, e.g. staff were respectful, helpful, supportive etc?

Yes No

If no, what did you need?

33. Do you think your complaint received a fair investigation by the Board?

34. Did the process cost you any thing? (money, time, stress, etc)

35. How did you feel about the whole process? **(eg did they feel they were in charge or disempowered by it or bewildered etc)**

36. What was the final decision on your complaint?

37.a. Did you understand why was that decision made?

b. Did you understand what did it mean?

38.a. Did someone explain to you the reasons for that decision?

b. Who?

c. When

d. In what form was this explained to you (verbal, written)

39. How were you informed? (telephone, letter)

40. Who initiate this information? (you or the Board)

41. How satisfied were you with the Board's complaints handling process?

Very satisfied Satisfied Partly satisfied Not at all satisfied

APPENDIX E: SUMMARY OF EXTRA INTERVIEWS

Two additional complainants were interviewed at the request of DHS. Their complaints were finalised outside the relevant closure dates, but they were complainants who felt particularly aggrieved by their experiences of board processes. Their views are summarised here and an analysis provided of how their views and experiences compared to those of the main sample.

The complainants and complaints

Both interviewees were males over 65 years old who had made complaints on behalf of their deceased wives. One did not have English as his first language. One had university-level education, the other school-level. Both lived in Melbourne. One interviewee had been a manager at time of the complaint; the other was retired.

Both complaints had been lodged with the Medical Practitioners Board at least four years earlier — one in 1997 and the other in 1999. Both interviewees complained about the treatment their wives had received immediately prior to their deaths.

Expectations

The interviewees had slightly different expectations of the outcomes of their complaints. One wanted to find out what had happened, to have the opportunity at an open hearing to talk to the doctors about why they did what they did; for someone to be held accountable; and for some action to be taken against the doctors involved. The other sought an apology or expression of regret. They both wanted changes to the system or to practitioners' behaviours to prevent re-occurrence. Compensation was not a priority.

Both cases were closed by the Board after the preliminary investigation stage (i.e., were classed as NFAs), even though one interviewee stated that the chief investigator had recommended the case proceed to a hearing stage. Neither of the interviewees considered the cases closed:

I do not consider it closed. I will continue to fight for it.

Being kept informed

Both had received some initial information and were mixed in how helpful this had been. While both were briefed on the process, neither felt they were kept adequately informed as time went on. Both felt they had to constantly chase the Board up. One contacted the Minister because of his frustration at the lack of response by the Board:

They didn't respond to all my letters and telephone calls regarding the progress. In the end I called the Minister.

Both had met with a Board staff member; in one case, several times. Satisfaction with this contact was mixed. One said that, in later meetings:

They were evasive ... even when I met with people (e.g., doctors on the Board) they wouldn't answer my questions and ... denied me the information that I requested – transcripts of what the doctor said....

Helpful information on the Board's powers and likely outcomes was reported as being less forthcoming. Neither said they understood what the Board could or could not do:

The Board should state its limitations clearly. They were misleading in their communication.

Ability to present information

Both said they were able to present all they wanted, except to respond to the practitioner's statements.

Duration

Like many others, they felt it took too long – 20 months in one case.

Fairness and outcome

Neither thought that the decision not to proceed was fair:

Definitely NOT! It would have been fairer if it had been an open hearing so I could listen, ask questions, and get answers.

Neither said they understood the final decision or reported having it explained to them:

I received a one-sentence letter after 20 months! It was not enough. I applied to FOI to get more information.

Both interviewees were informed of other processes and took further action. One had already rung the Minister for Health who, he said, took up the case with the Board. The Board apparently promised to review its decision not to proceed to a hearing stage, but has since closed the case. He subsequently took legal action as a means of opening further communication with the Board. The other interviewee lodged complaints with a range of bodies: the hospital itself; the Health Services Commissioner; Freedom of Information (FOI); the Minister of Health; DHS; and the Victorian Administrative Appeals Tribunal (even though he was told he couldn't).

Satisfaction

Neither was satisfied at all with the process or outcomes, and both said the process had made their situation worse for them. They would not recommend that others go through the process:

I am clear and wiser. I advise people not to complain. You will experience only pain if you lodge a complaint. It's a draconian institution.

Sad, angry, disempowered. It made me very depressed and low in spirit. But a voice tells me to keep going, not give up.

Both had therefore found the process very stressful:

The four-year process has ruined my life. This negative experience has destroyed me.

Feedback to Board

Only one of these two interviewees gave some feedback to the Board, despite their considerable dissatisfaction.

Comparison to main sample

Almost all of the views expressed by the two interviewees were reflected in the range of themes discussed in the main report. This is in no way to comment on the validity of their views or complaints; it does show, however, that their experiences were not atypical just because they pursued their cases with the Minister. Other interviewees shared their perspectives on many of the elements of the processes. That is, they were similar to at least some of those in the main sample in regard to:

- The seriousness of their complaint
- Their expectations
- The level of information and support provided to them, especially as the process continued
- Their ability to present information to the Board

- The length of the process
- The fairness of the outcome
- The way they were informed of the decision
- Following up through other avenues after the case was closed
- Their satisfaction with processes and outcomes
- Their willingness to recommend the process to others
- The stress experienced during the process.

These interviewees also echoed views by several others in the main sample on how the processes could be improved. These included:

- The Board should be more open, transparent, fair and (therefore) have limited numbers of, or even no, doctors on it, in order to be perceived as fair.
- Complainants lack rights in the process (e.g., to gain information, to respond to doctors' statements or to be represented).
- There should be a right of appeal on NFA decisions.

One interviewee had further suggestions. He proposed the Board should be held accountable to the Minister and to the process spelt out in the Act; preferably be fully funded by government and independent of the medical profession.

Clearly one factor that did set these two interviewees apart from most other dissatisfied interviewees was their determination to assert their rights, and to challenge Board decisions they felt were unacceptable or unjust.

What is notable here is that only one interviewee provided feedback to the Board. If complainants who feel so aggrieved (and who are capable at asserting their rights in other ways) do not make complaints, it may well be that a range of others are also not providing such feedback; Boards are thus denied valuable input that can be used to improve the quality of their systems. This is discussed in the main report.

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