

Expectations and experience of complaints and notifications about registered health professionals in the Australian national and NSW regulatory systems:

A comparative study of complaints and notifications from the perspective of 'system users'

A thesis submitted in fulfilment of the requirements for the degree of
Doctor of Philosophy

School of Public Health, Faculty of Medicine
The University of Sydney

Suzanne Marie Pierce

2017

Statement of Authentication

This thesis is submitted to The University of Sydney in fulfilment of requirements for the degree of Doctor of Philosophy.

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

Suzanne Pierce

2 June 2017

Approval of research for submission

As supervisor for the candidature upon which this thesis is based, I can confirm that the authorship attribution statements above are correct.

Primary supervisor

Professor Marilyn Walton
Professor of Medical Education (Patient Safety)
Public Health, School of Public Health
3 June 2017

Associate supervisor

Associate Professor Jennifer Smith-Merry
Associate Professor in Qualitative Health Research
5 June 2017

Abstract

Receiving and managing complaints is a core function of Australian health practitioner regulators; complaints long recognised as an important source of information about safety and quality of care and identifying practitioners of concern.

Identified values for good complaint management include improved accountability and public confidence; consistency and integrity of decision-making; and opportunity to provide resolution, identify trends, take corrective action and make system improvements.

Australia has an enviable record in establishing and refining health complaint mechanisms to make them accessible and responsive within a broader culture of safety and learning. Notwithstanding substantial investment and experience with these processes, this study found both low levels of satisfaction and understanding of the two Australian systems under study. Consequences from these findings include the reputational standing of regulators and preparedness of individuals and organisations to raise future concerns.

Practitioner regulation, like healthcare itself, is a complex undertaking, requiring a mix of capabilities to address recurring and emerging problems, minimise perverse impacts, effectively communicate intent and manage interests and expectations. Factors influencing complainant expectations and experience are equally complex.

This mixed methods study found respondent expectations of quality complaint processes were congruent with the literature on best practice regulation and complaint management. It also found most saw themselves as a key stakeholder in the process; with a duty to raise concerns, the effort and risk involved and importance of issues raised. The most significant factors moderating respondents' perceptions and experience were power and transparency. These factors were relevant in accounting for reported views both of operational processes and underlying assumptions of the regulatory model.

In contrast with their stated interests and intentions, the majority reported issues were either not or only poorly addressed; and few were aware of any resultant changes. They wanted an explanation, an apology, improvement in standards and action by the practitioner or regulator to ensure events would not recur. Adherence to 'open disclosure' directives and frameworks appears problematic still; poor communication and lack of fulsome explanations and apologies underpinning many complaints. The majority attempted to first address their concerns through other means; reported responses and subsequent escalation bringing into question the skill of practitioners in responding to complaints and indicating a continuing need to improve management at the point of events.

Regulators were approached to 'bring to account', raise the standards of or stop practitioners regarded as unsafe, not competent or not responsive to concerns raised directly. It is notable therefore that this study found a mixed understanding about the purpose of complaint processes and the role of regulators; the nature of error; and how accountabilities or sanctions are determined. Dissatisfied respondents expressed anger or disappointment with regulators failure to exercise (or exercise sufficiently) their authority and powers. Absence of information undermined respondent's understanding or acceptance of decisions made and their confidence in regulatory agencies to address issues or effect change and improvement at individual or systems levels.

Respondents reported asymmetries of knowledge and influence; and identified an inconsistency, perceived as bias, between their standing and treatment relative to that of practitioners' subject of complaint. Tensions in regulatory principles between transparency and confidentiality; and the extent to which public or individual interests are served remain. Communication and quality of interactions, identified as core professional skills by patients do not appear to attract the same regulatory attention as traditionally identified 'technical' skills.

This study confirms findings of previous studies and inquiries of the central importance of sound operational processes, including efficiency, good communication and well-integrated structures and roles - identified here as requiring improvement. It identifies key population groups under-represented; indicating further work is required to improve access. It contributes to the literature by identifying a lack of clarity and understanding among complainants about what '*protecting the public*' – the core mandate of health professional regulators - means operationally; including the rationale for and focus of regulatory effort and underlying concepts and assumptions. It identifies a need to communicate evidence for the appropriateness and efficacy of regulatory choices, and complaint management in the context of networked governance arrangements.

Preface

I have been fortunate to be part of a research group investigating regulatory complaint mechanisms from diverse perspectives. While each of the five studies was discrete, it afforded me the opportunity to learn from experienced and knowledgeable colleagues.

Funding, including a PhD scholarship for my study, was provided by the Australian Research Council (Linkage Grant Linkage Grant LP110200075) and Linkage Grant partners - the Australian Health Practitioner Regulation Agency, the NSW Health Practitioner Councils Authority and the NSW Health Care Complaints Commission. The School of Public Health, University of Sydney assisted with printing and conference attendance support.

I was responsible for all phases and components of this research, including study instrument design and analysis under the supervision of Professor Merrilyn Walton and Associate Professor Jennifer Smith-Merry. Expert advice on quantitative and qualitative analytical methods was provided, respectively, by Associate Professors Patrick Kelly and Jennifer Smith-Merry.

Interests I declare include previous employment as a registered nurse in NSW; employment with the NSW Health Care Complaints Commission (in the 1990's) and current employment in the NSW Government (unrelated to health practitioner regulation).

Ethics approval

The study (Protocol No. 2012/2869) was granted ethics approval on 13 January 2013 by The University of Sydney Human Research Ethics Committee.

Following revisions, the Survey 1 questionnaire, protocol, Participant Information Sheet and other materials associated with Survey 1 interviews were re-submitted for HREC (variation) approval, which was granted on 2 July 2013.

Following revisions, the Survey 2 questionnaire and Participant Information Sheet were re-submitted for HREC (variation) approval, which was granted on 2 December 2013.

Letters of approval from the HREC, together with the study instruments, protocol and other resources are in Appendix 7.

Acknowledgements

Large projects are never undertaken alone, and there are many to thank. First and foremost, I would like to acknowledge and thank Professor Merrilyn Walton for her support, encouragement and great sense of humour. Her feedback has been thoughtful and detailed; assisting me to work through voluminous material and issues. I am fortunate to have had Dr Jennifer Smith-Merry as my second supervisor, whose insights and qualitative expertise have been invaluable.

An enviable position for any student is to be part of a research group. In addition to the ideas and stimulation their debates provided, particular thanks to Professor Mary Chiarella for a cleverly designed set of studies; to Associate Professor Patrick Kelly whose statistical knowledge I could not have done without; to Professors Terry Carney and Belinda Bennett for their extensive legal knowledge; and to Dr Claudette Satchell and Mary Nagy who have been superb project managers and wonderful colleagues.

I will be forever indebted to the people who took time out of busy lives to complete the surveys and participate in interviews, patiently answering my questions and relaying experiences that were often puzzling or painful to them. My apologies to those who offered interviews I could not accommodate due to the scale of the response.

I am privileged to have Bronte and Lara in my life - two gorgeous daughters, who are a constant source of inspiration and who have supported me unreservedly. To my mother Jane and broader family and friends - thank you for your encouragement and your patience. I look forward to repaying your many acts of kindness - particularly Anoka and Carol.

My thanks to Christopher Armstrong who enabled me to take time from work to undertake this project. My appreciation and thanks also to other academic and work colleagues who have shared the journey with good grace and humour.

Finally, I would like to thank our ARC partners for supporting the project. I am conscious that my study was the largest and took the greatest impost on their time. I hope that it will make some positive albeit modest contribution to the very complex field they work in.

Table of contents

Statement of Authentication	i
Abstract	ii
Preface	iv
Ethics approval	iv
Acknowledgements	v
Table of contents	vi
List of Tables	xii
List of Figures	xiv
List of Boxes	xv
Definitions and key terms	17
Presentation of data	18
Introduction	19
Thesis objectives	21
Thesis structure	22
Chapter 1. Background	27
1.1 Regulatory theory and practice.....	27
1.1.1 Best practice regulation, complaint management and care quality	27
1.1.2 Developments in regulatory thinking.....	31
1.2 Establishment of Commissions and the NSW scheme	42
1.2.1 NSW developments.....	43
1.2.2 Other Australasian jurisdictions	47
1.3 Establishment of the national scheme	49
1.4 The national and NSW schemes today.....	53
1.4.1 Reviews of the national scheme	57
1.4.2 Risk-based regulation and challenges.....	62
Summary of Chapter 1.....	65
Chapter 2. Literature review	67
2.1 Responses, explanation and apology	69

2.2	Process and outcome expectations	71
2.3	Who doesn't complain and why	75
	Summary of Chapter 2	76
Chapter 3. Methodology		78
3.1	Grounded theory	78
3.1.1	Coding.....	81
3.1.2	Sampling and saturation in theory development	81
3.1.3	Existing theory and literature	82
3.2	Use of multiple methods.....	83
3.3	Ethical issues	86
3.3.1	Bias.....	86
3.3.2	Informed consent	88
3.3.3	Privacy, confidentiality and anonymity	88
3.3.4	Harms	89
3.4	Perspective 1: individuals and organisations who made a complaint or notification .	91
3.4.1	Survey 1 development.....	92
3.4.2	The Survey 1 instrument	93
3.4.3	Survey 1 interviews	94
3.5	Perspective 2: peak organisations.....	96
3.5.1	Survey 2 development and instrument	97
3.6	Response rates and limitations.....	98
3.6.1	Survey 1 response rate limitations.....	99
3.6.2	Presenting data from different sources in Survey 1	99
3.6.3	Organisational respondents Survey 1.....	100
3.6.4	Survey 2 response rate limitations.....	100
3.6.5	Study limitations	101
3.7	Data analysis.....	101
Chapter 4. Results: about the survey respondents		104
4.1	Survey 1: who made the complaint or notification	104
4.1.1	Demographic profile of individuals completing the survey.....	105

4.1.2	Type of organisation completing the survey	106
4.1.3	Complaints and notifications that were made for someone else	107
4.2	Survey 1: which profession the complaint or notification was about.....	107
4.2.1	Gender of practitioner the complaint or notification was about.....	108
4.3	Survey 1: when and where events occurred that led to the complaint or notification and the issues involved.....	108
4.3.1	Issues giving rise to the complaint or notification	109
4.4	Survey 1: reasons for making the complaint or notification	119
4.4.1	What respondents wanted to happen to or for the practitioner	121
4.4.2	What respondents wanted for themselves or their organisation.....	125
4.4.3	Steps taken before making a complaint or notification to the agencies	131
4.4.4	Would the practitioner be used again	133
4.5	Survey 1: errors, harms and accountability	133
4.6	Survey 2: respondent profile.....	139
4.6.1	Knowledge about or engagement with agencies	139
4.6.2	Experience with individual complaints and notifications.....	140
	Summary of Chapter 4.....	141
	Chapter 5. Results: how issues were dealt with	143
5.1	Survey 1: actions taken by agencies	143
5.1.1	Referral of the complaint or notification	143
5.1.2	Referral of the complaint or notification to conciliation or resolution.....	144
5.1.3	Whether the complaint or notification was referred for investigation	148
5.1.4	Whether the complaint or notification was referred for disciplinary action	149
5.1.5	Whether the complaint or notification was withdrawn at any point	150
5.1.6	When events occurred, management times and reported delays	151
5.2	Survey 1: outcomes of complaints and notifications	152
5.3	Whether issues were addressed, awareness of change and further action.....	154
5.3.1	Survey 1: awareness of improvements following complaints or notifications...	155
5.3.2	Survey 2: awareness of improvements following complaints or notifications...	156
5.3.3	Survey 1: actions planned or taken by respondents after closure	158

Summary of Chapter 5.....	158
Chapter 6. Results: key experience measures	160
6.1 Understanding the complaint and notification systems	161
6.1.1 Survey 1: understanding of agency role and powers	161
6.1.2 Survey 2: understanding of agency role and powers	166
6.1.3 Survey 1: understanding of assessment criteria used.....	168
Summary of Sub-section 6.1: understanding of the system	172
6.2 Engagement and communication	173
6.2.1 How well was the respondent kept informed?.....	173
6.2.2 How well were reasons for decisions explained?.....	178
Summary of Sub-section 6.2: engagement and communication	186
6.3 Balance	187
6.3.1 How fair was the process?	187
6.3.2 Was the respondent treated respectfully?	195
Summary of Sub-section 6.3: balance	200
6.4 Impact on health and barriers to making complaints.....	201
6.4.1 Survey 1: comments about the agencies.....	202
6.4.2 Survey 2: barriers to making complaints and notifications	206
Summary of Sub-section 6.4: impact and barriers	208
6.5 Global measures - satisfaction with the process, the outcome and preparedness to recommend the process to others.....	209
6.5.1 Satisfaction with the process.....	209
6.5.2 Satisfaction with the outcome	213
6.5.3 Preparedness to recommend the process to others	218
Summary of Sub-section 6.5: global experience measures	222
6.6 Most negative and positive responses.....	223
6.6.1 Most negative respondents	223
6.6.2 Most positive respondents.....	234
Summary of Sub-section 6.6: most negative and most positive responses.....	237
6.7 Survey 2: observations on the management of complaints and notifications	239

Summary of Chapter 6	241
Chapter 7. Discussion	243
7.1 Developments in regulation and complaint management and the NSW and national schemes	243
7.2 Respondent profile: who is and isn't using the complaint and notification systems	245
7.3 Motivations: issues and outcomes sought	246
7.4 Expectations of the process	247
7.5 Comparing the NSW and national schemes	250
7.6 What this study adds	252
7.6.1 What 'protecting the public' means and measuring success	253
7.6.2 Accountability for and efficacy of regulatory decisions and interventions	254
7.6.3 Managing complaints and notifications in a networked governance framework	255
7.6.4 Practitioner responsibilities and skills in responding to complaints and notifications	256
Chapter 8. Conclusions and recommendations	257
8.1 Conclusions.....	258
8.1.1 Conclusions about the respondent profile.....	258
8.1.2 Conclusions about issues and professions giving rise to complaints and notifications	258
8.1.3 Conclusions about motivations and expectations	258
8.1.4 Conclusions about the NSW and national schemes relative to advances in 'best practice' regulation and complaint management.....	259
8.1.5 Conclusions about reported experience and implications for future practice ...	259
8.2 Recommendations	260
8.2.1 Regulatory objectives and operations.....	260
8.2.2 Capacity and expertise	261
8.2.3 Access	262
8.2.4 Practitioner responsibilities and skills in responding to complaints and notifications	262
References.....	263

Appendix 1: Chapter 1 (background) additional tables	287
Appendix 2: Chapter 2 (literature) additional tables	294
Appendix 3: Chapter 3 (methods) additional tables.....	300
Appendix 4: Chapter 4 (respondents) additional tables	302
Appendix 5: Chapter 5 (management) additional tables.....	311
Appendix 6: Chapter 6 (experience) additional tables	317
Appendix 7: Study materials	363

List of Tables

Table 1: Summary of select legislative provisions of the national and NSW schemes	54
Table 2: Major Australian reviews relevant to the national scheme from 2010 – present	58
Table 3: Survey 1: instrument summary	93
Table 4: Interviews: selection matrix	95
Table 5: Survey 2: instrument summary	97
Table 6: Interviews: completed and analysed	98
Table 7: Survey 1: returns	99
Table 8: Survey 2: returns	101
Table 9: Survey 1: returns by source (respondent) type and profession of subject practitioner.....	104
Table 10: Survey 1: organisational respondents: type of organisation and agency managing ..	106
Table 11: Survey 1: organisational respondents: subject practitioner and agency managing ...	106
Table 12: Survey 1: relationship to respondent where respondent acted for another person	107
Table 13: Survey 1: returns by source (respondent) type and subject profession.....	107
Table 14: Survey 1: returns compared with 2013-14 complaint/notification figures.....	108
Table 15: Survey 1: main location of events that gave rise to the complaint/notification by subject profession, source (respondent) type and agency managing	108
Table 16: Survey 1: when events leading to the complaint/notification occurred (time prior to completing survey) by subject profession	109
Table 17: Survey 1: main issue that the complaint/notification was about.....	109
Table 18: Survey 1: main issues in order of frequency by subject profession	110
Table 19: Survey 1: main issues involving medical practitioners	113
Table 20: Survey 1: issue sub-categories (where specified) involving medical practitioners	114
Table 21: Survey 1: main issues involving nursing/midwifery practitioners	115
Table 22: Survey 1: issue sub-categories (where specified) involving nursing/midwifery practitioners	115
Table 23: Survey 1: issue sub-categories (where specified) involving pharmacy practitioners ..	116
Table 24: Survey 1: main issues involving dental practitioners	117
Table 25: Survey 1: issue sub-categories (where specified) involving dental practitioners	117
Table 26: Survey 1: main issues involving psychology practitioners	118
Table 27: Survey 1: issue sub-categories (where specified) involving psychology practitioners	119
Table 28: Survey 1: reasons for making the complaint/notification by agency managing and source (respondent) type	120
Table 29: Survey 1: what the respondent wanted for the practitioner subject of the complaint/notification.....	121
Table 30: Survey 1: what the respondent wanted for themselves or their organisation	126
Table 31: Survey 1: what the respondent wanted: content analysis and exemplars of ‘other’ comments made.....	127
Table 32: Survey 1: respondents seeking compensation or reimbursement.....	129
Table 33: Survey 1: respondents that had first taken other steps before approaching agencies	132
Table 34: Survey 1: respondents that had first taken other steps by subject profession	132
Table 35: Survey 1: respondents that had first taken other steps by type of action taken	133
Table 36: Survey 1: sample of references to ‘mistakes’ and errors’ in survey responses	135
Table 37: Survey 1: whether conciliation was recommended and if recommended, the outcome	144
Table 38: Survey 1: sample of survey responses where conciliation or resolution was declined	145
Table 39: Survey 1: complaints/notifications referred for investigation by agency, source (respondent) type and subject profession.....	149
Table 40: Survey 1: complaints/notifications referred for disciplinary action by agency, source (respondent) type and subject profession.....	149
Table 41: Reasons given for withdrawing complaint/notification.....	150
Table 42: Survey 1: time taken for the complaint/notification to be dealt with and reported delays	152
Table 43: Survey 1: outcome of complaint/notification by summary categories and agency.....	152
Table 44: Survey 1: respondents that sought and received an explanation or an apology by agency	154

Table 45: Survey 1: respondents that sought and received an explanation or an apology by subject profession	154
Table 46: Survey 1: extent to which issues were addressed	155
Table 47: Survey 1: respondent awareness of service or practice improvements	155
Table 48: Survey 1: type and frequency of improvements planned or made as a result of the complaint/notification.....	155
Table 49: Survey 1: whether further action was planned or taken by the respondent, and if so, type of action	158
Table 50: Survey 1: experience domains and questions	160
Table 51: Survey 1: whether the agency's role and powers were clear: Likert scale responses	161
Table 52: Survey 1: thematic categories of survey comments: whether agency role and powers were clear	162
Table 53: Survey 1: whether the assessment criteria used were clear	169
Table 54: Survey 1: thematic categories of survey comments: whether assessment criteria were clear	169
Table 55: Survey 1: how well the respondent was kept informed: Likert scale responses	173
Table 56: Survey 1: thematic categories of survey comments: whether the respondent was kept informed	174
Table 57: Summary comment sub theme 1A1: no contact	174
Table 58: Survey 1: how well reasons for decisions were explained	178
Table 59: Survey 1: thematic categories of survey comments: how well reasons for decisions were explained	179
Table 60: Survey 1: whether the process was perceived as fair: Likert scale responses	187
Table 61: Survey 1: thematic categories of survey comments: whether the process was fair ...	188
Table 62: Survey 1: whether the respondent was treated respectfully: Likert scale responses.	195
Table 63: thematic categories of survey comments: whether the respondent was treated respectfully	196
Table 64: Survey 1: impact of the complaint/notification process on health: Likert scale responses.....	201
Table 65: Survey 1: main issues raised by all respondents and by respondents reporting health impacts.....	202
Table 66: thematic categories of survey comments: whether the process affected the respondent's health	202
Table 67: Survey 1: satisfaction with the process.....	209
Table 68: Survey 1: satisfaction with the outcome.....	213
Table 69: Survey 1: preparedness to recommend the process to others	218
Table 70: Survey 1: whether respondent would recommend the process to others: coded comment by ranked response.....	220
Table 71: Survey 1: most negative ranking of experience measures by respondent demographic profile	224
Table 72: Survey 1: association between respondent demographic profile and the most negative ranking for global experience measures (satisfaction outcome, satisfaction process, recommend process).....	225
Table 73: Survey 1: association between whether issues were addressed and the most negative ranking for global experience measures (satisfaction outcome, satisfaction process, recommend process).....	226
Table 74: Survey 1: association between satisfaction with the outcome and satisfaction with the process and whether respondent would recommend the process to others	226
Table 75: Survey 1: association between the most negative ranking for global experience measures (satisfaction outcome, satisfaction process, recommend process) and the most negative ranking for other experience measures.....	227
Table 76: Survey 1: association between respondent demographic profile and the most negative ranking (Rank 1) compared with all other rankings (Rank 2-5) for all experience measures and whether issues were addressed.....	228
Table 77: Survey 1: association between the most negative ranking for experience measures and whether the complaint/notification was managed in the national or NSW scheme.....	230
Table 78: Survey 1: most negative ranking for select experience measures where the subject practitioner was a medical or a nursing/midwifery practitioner	230
Table 79: Survey 1: association between summary outcome categories and the most negative ranking for global experience measures (satisfaction outcome, satisfaction process, recommend process) and whether issues were addressed	231

Table 80: Survey 1: association between major outcome types and the most negative ranking for global experience measures (satisfaction outcome, satisfaction process, recommend process)	232
Table 81: Survey 1: association between cases where a death or adverse event occurred and the most negative experience measure ranking	233
Table 82: Survey 1: most negative ranking for select experience measures where events occurred in a private hospital, in group practice and sole practice compared with public hospitals	233
Table 83: Survey 1: most positive ranking of experience measures by respondent demographic profile	234
Table 84: Survey 1: association between respondent demographic profile and the most positive ranking for global experience measures (satisfaction outcome, satisfaction process, recommend process)	235
Table 85: Survey 1: most positive ranking for process and outcome by summary outcome categories	235
Table 86: Survey 1: global experience measures: most positive responses (Rank 5) compared with all other ranked responses (Ranks 1-4) by major outcome categories	236
Table 87: Survey 1: experience measures most positive responses (Rank 1) compared with all other responses (Ranks 2-5) where subject practitioner was a medical or nursing practitioner	236
Table 88: Survey 1: what respondent wanted for the subject practitioner: 'very satisfied' respondents compared with all responses and responses where the subject was a medical or nursing practitioner	237
Table 89: Survey 1: most positive responses (Rank 5) for process and outcome by whether issues were addressed and respondent awareness of improvements	237

List of Figures

Figure 1: Regulatory mechanisms and patients as actors in a responsive regulatory pyramid	33
Figure 2: Decision-making entities involved in Stage 1 to Stage 5 of the complaint/notification process	56
Figure 3: Use of qualitative and quantitative methods in the study methods design, data collection and analysis	84
Figure 4: Survey 1: distribution and return rates	98
Figure 5: Survey 1: main reasons for making complaint/notification about the practitioner by subject profession (%)	120
Figure 6: Survey 1: what respondent wanted for the subject practitioner by profession (%)	122
Figure 7: Survey 1: what respondent wanted for themselves or their organisation by subject profession (%)	126
Figure 8: Survey 2: respondent profile	139
Figure 9: Survey 2: profile of the main target groups and service users of respondent organisations	139
Figure 10: Survey 2: whether agencies asked about the needs or ability of respondent members/service users to make a complaint	140
Figure 11: Survey 1: complaints/notifications referred for investigation and disciplinary action	150
Figure 12: Survey 1: when events were reported to have happened, management times and reported delays	151
Figure 13: Survey 1: summary outcome categories by subject profession (%)	153
Figure 14: Survey 1: awareness of improvements by location of original events	156
Figure 15: Survey 2: improvements resulting from individual complaints/notifications	157
Figure 16: Survey 2: improvements resulting from policy or advocacy work	157
Figure 17: Survey 2: use of complaints to identify risks or practice issues	158
Figure 18: Survey 1: role and powers: comparing the proportion of ranked responses (Rk) to comments (Com)	161
Figure 19: Survey 1: role and powers: comment themes by agency	162
Figure 20: Survey 2: respondent understanding of agency roles, by proportion identifying each role as a 'primary' role, a 'secondary' role, 'not' an agency role or 'unsure'	167
Figure 21: Survey 2: identification of agency roles by respondent type (%)	168
Figure 22: Survey 1: assessment criteria: comparing the proportion of ranked responses (Rk) to comments (Com)	169

Figure 23: Survey 1: assessment criteria: comment themes by agency.....	169
Figure 24: Survey 1: how well the respondent was kept informed: comparing ranked responses (Rk) and coded comment (Cm).....	173
Figure 25: Survey 1: how well respondent was kept informed: comment themes by agency	174
Figure 26: Survey 1: how well reasons for decisions were explained: comparing ranked responses (Rk) and coded comment (Cm)	178
Figure 27: Survey 1: how well reasons for decisions were explained: comment themes by agency	179
Figure 28: Survey 1: how fair was the process: comparing the proportion of ranked responses (Rk) and coded comment (Cm).....	187
Figure 29: Survey 1: how fair was the process: thematic comment by agency	188
Figure 30: Survey 1: was the respondent treated respectfully: comparing the proportion of ranked responses (Rk) and coded comment (Cm)	195
Figure 31: Survey 1: was the respondent treated respectfully: comment themes by agency.....	196
Figure 32: Survey 1: coded comment for impact on health excluding ' <i>not affected at all</i> ' responses: comments about agencies compared with comments about original events or subject practitioner.....	202
Figure 33: Survey 1: comment themes: health impact by agency	203
Figure 34: Survey 1: comment themes: ' <i>very significant</i> ' and ' <i>significant</i> ' health impact by AHPRA and NSW	203
Figure 35: Survey 2: factors affecting the willingness of respondent members/service users to make a complaint/notification	206
Figure 36: Survey 1: satisfaction with the process: comparing the proportion of ranked responses (Rk) and coded comment (Cm)	209
Figure 37: Survey 1: satisfaction with the outcome: comparing the proportion of ranked responses (Rk) and coded comment (Cm)	213
Figure 38: Survey 1: whether prepared to recommend the process to others compared with satisfaction with process and outcome.....	218
Figure 39: Survey 1: whether respondent would recommend the process: comparing ranked response (Rk) by comment (Cm).....	219
Figure 40: Most significant factors moderating respondents' perceptions	253

List of Boxes

Box 1: Information provision in the national and NSW schemes	57
Box 2: Interview extract: complaints involving communication.....	111
Box 3: Select responses to interview questions: disciplinary action.....	123
Box 4: Select responses to interview questions: legal action for compensation.....	130
Box 5: Interview extract: taking other steps before approaching the regulator	132
Box 6: Interview extract: experience of professional responses to reporting error.....	136
Box 7: Select responses to interview questions: error.....	137
Box 8: Interview extracts: practitioner refusal to meet	146
Box 9: Interview extract: resolution attempted without outcome.....	147
Box 10: Select responses to interview questions: about the role of complaints processes.....	163
Box 11: Interview extract: being kept informed	176
Box 12: Interview extract: raising profession-wide as well as individual practice issues in complaints; adequacy of reasons for decisions	183
Box 13: Interview extract: barriers to making complaints: practitioner	205
Box 14: Interview extract: barriers to making complaints: consumer.....	208
Box 15: Interview extract: positive Likert scale ranking notwithstanding 'no further action' outcome	210
Box 16: Interview extract: dissatisfaction with voluntary relinquishment of registration as an outcome	215
Box 17: Interview extract: dissatisfaction with lack of reasons for decisions and the outcome notwithstanding regulator action	216
Box 18: Interview extract: dissatisfaction with the process and outcome notwithstanding regulator action.....	217
Box 19: Interview extract: negative effects of not providing feedback on willingness to report and confidence in the regulator	221

Acronyms

AE or adverse event	An incident resulting in harm to a person receiving health care, where harm is an impairment or a deleterious effect which may be physical, psychological or social (including financial) *
AHMAC	Australian Health Ministers' Advisory Council Provides support to the Australian Health Ministers Conference Designed to support nationally coordinated health arrangements
AHWMC	Australian Health Workforce Ministerial Council A specific function of the COAG Health Council, it oversees the National Regulation and Accreditation Scheme (NRAS or the 'national scheme') Role is designated through the Health Practitioner Regulation National Law
AHPRA	Australian Health Practitioner Regulation Agency Established by the national law
COAG	Council of Australian Governments Peak inter-governmental forum of Australia, representing the Australian (Commonwealth), States and Territories
COAG Health Council	Advisory body to the AHMAC Remit includes health policy, services and programs and involves the Australian Commonwealth, State and Territory and New Zealand Governments
HCCC	NSW Health Care Complaints Commission
HCCC Act	Health Care Complaints Act 1993 (NSW) No. 105
HCE	Jurisdiction health complaint body Referred to as a Health Complaint Entity (HCE) under the national scheme The term 'commission' is used in the text
HPCA	NSW Health Practitioner Councils Authority
HPCA Act	Health Practitioner Regulation National Law (NSW) No 86a The Health Practitioner National Law as applied in NSW by the Health Practitioner Regulation (Adoption of National Law) Act 2009 (NSW) Governs the practice of registered health practitioners in NSW
Jurisdiction	A State or Territory of Australia These include the states of New South Wales (NSW), Queensland (QLD), South Australia (SA), Tasmania (TAS), Victoria (VIC), Western Australia (WA) and the Australian Capital Territory (ACT) and the Northern Territory (NT)
National Law	Health Practitioner Regulation National Law 2009 (Qld) as enacted in each Australian State and Territory Governs the practice of registered health practitioners in Australia, including accreditation and registration standards
National Law NSW	Health Practitioner Regulation Amendment Act 2010 (NSW) No. 34 Health Practitioner Regulation (Adoption of National Law) Act 2009, (NSW)
Notification	A complaint under the National Law
Open Disclosure	An open discussion with a patient about an incident(s) that resulted in harm to that patient while receiving health care*
NRAS	National Registration and Accreditation Scheme (the national scheme)

* Taken or adapted from the Australian Commission on Safety and Quality in Health Care

Definitions and key terms

Complaint	Any expression of concern or dissatisfaction and for the purposes of this study includes 'notification' under the National Law The term complaint is used in the text, and complaint/notification is used in headings
Consumer	Used interchangeably and to represent (unless otherwise indicated) patients or a general member of the community In Survey 1 tables consumer (CONS) is used for individual respondents not identified as a health practitioner
Notification	A complaint under the National Law
Practitioner	One of five registered health practitioners under study, including dental, medical, nursing and midwifery, pharmacy and psychology practitioners Subject practitioner or subject refers to the practitioner who is the subject of a complaint or notification In tables: • Subject practitioners are abbreviated as: DENT, DR, NMW, PHARM and PSY • Survey respondent practitioners are abbreviated as: PRACT
Regulatory agency/agencies	Refers to the bodies under study For the purposes of this Study: • AHPRA refers to both the Australian Health Practitioner Regulation Agency and one or more national health profession Boards that the agency acts for unless indicated otherwise • HPCA refers to the NSW Health Practitioner Councils Authority and one or more health profession Councils that the agency acts for unless indicated otherwise • HCCC refers to the NSW Health Care Complaints Commission • NSW is used to refer to combined responses relating to the HCCC and HPCA
Source or Survey Respondent	Category of survey respondent In Survey 1 these are the source of the complaint and include: • Consumers, who are individuals and who did not identify themselves as a registered health practitioner (abbreviated as CONS in tables) • Practitioners, who identified themselves as one of the five registered practitioners under study; abbreviated as PRACT in tables • Individuals, used to refer to both consumers and practitioners combined; defined in the survey as including patients, relatives, member of the general public, a health professional; abbreviated as IND in tables • Organisations, defined in the survey as third party professionals (e.g. lawyers) who are not registered health practitioners or an organisation (e.g. health service, government agency, community group); abbreviated as ORG in tables In Survey 2 these are: • Population organisations, which are non-Government organisations that represent particular population (cultural or demographic) group interests including providing policy and advocacy (advice or support on individual matters) services • Consumer organisations, which are non-Government consumer and consumer health organisations that represent consumer interests including providing policy advice • Community organisations, used to refer to both population and consumer organisations • Professional organisations, which include associations and insurer and defence organisations that represent registered health practitioners either at a policy level or through providing advice, support or defense on individual matters

Presentation of data

This Study involved two regulatory complaint systems, three agencies, five health professions and three respondent types in each of the two surveys used in the Study; with responses about medical practitioners and from consumers dominating Survey 1 responses (the main research instrument).

The following strategies are used to manage these dimensions and asymmetry of data and to maintain the flow for the reader.

Tables:

Tables are colour coded with 'total' responses highlighted in blue and AHPRA and 'all NSW' responses highlighted in beige.

Summary tables are used in the body of the thesis, with fuller tables in the Appendices:

- References to tables in the body of the thesis appear in (brackets)
e.g. (Table 3)
- References to supplementary tables contained in the Appendices are in [brackets] with the prefix 'A'
e.g. [A5.1] is Appendix 5, Table 1
- Chapter and Appendix numbers correspond
e.g. additional tables relevant to Chapter 5 are in Appendix 5

Figures are consistently colour coded for agency and practitioner type:

Agencies

- AHPRA: 
- HPCA: 
- HCCC: 

Practitioners

- Medical: 
- Nursing and midwifery: 
- Pharmacy: 
- Dental: 
- Psychology: 

Introduction

If a core measure of 'quality' is '*fit for purpose*', what does a quality health practitioner complaint process look like, what ends should it serve and what role can or should complaints and complainants play in health practitioner regulation?

This thesis seeks to answer these questions from the perspective of those who made a complaint or notification ('complaint') to the Australian Health Practitioner Regulation Agency (AHPRA), or in NSW the Health Professional Councils Authority (HPCA) or the Health Care Complaints Commission (HCCC).

Multiple factors bear on whether a complaint is made about a health professional, how a responsible agency responds, and how the complainant perceives the process and outcome. Influential factors are available law and policies; how the regulatory framework is interpreted and administered; the remit, skills and capacity of organisations tasked with the responsibility of managing matters; the age, location, nature and consequences of events that give rise to a complaint; the perceived severity and likelihood of recurrence; and the intent, knowledge, demographics and previous history of both the source and subject of complaint. These will in turn be influenced by the broader social, economic and political landscape in which they occur.

Claims about the value of complaints and health complaint mechanisms are diverse; potentially serving the interests of patients, the general public, practitioners, the broader health system, funders and insurers. These claims include providing accessible and low-cost pathways to resolve grievances; providing a means of holding practitioners and services accountable for the quality or suitability of care; restoring trust in a profession by demonstrating problems are addressed; providing a signal or predictor of risks for safety purposes; providing an opportunity for learning and quality improvement; informing education and practice standards; and aiding efficiency gains by helping to identify under-, over- or mis-use of services and resources, whether unintentional or deliberate.

Why complaints are made and the appropriate focus, powers and efficacy of complaint management and mechanisms has been subject of extensive public debate and scrutiny both nationally and internationally. Interest has been driven particularly by the rate and cost of errors and harms and the capacity of complaints to signal risk.

Previous studies and Australian government reviews indicate thinking and policy have evolved but not yet resolved key issues in the deployment of regulatory tools in responding to complaints. This includes the appropriate role and relative balance between 'learning' and 'sanctions' to achieve desired goals; providing transparency while respecting privacy and

confidentiality; and allocation of individual and 'systems' accountabilities. Studies indicate a mix of 'technical' and 'non-technical' factors give rise to complaints, but there are differences between regulators, professionals and consumers in how these factors are defined and the relative weight of their importance. Australian reviews have identified differences in expectations about the extent to which individual and public interests should be served; and the role of complainants in complaint processes.

Studies also tell us 'escalation' to complaint bodies and legal remedies is driven by a lack of open disclosure and responsiveness by practitioners and health service managers.

Complainants communicate a moral dimension to the process- both in relation to practitioners 'doing the right thing' in addressing errors and harms; managers responding appropriately to complaints and complainants 'doing the right thing' in raising their concerns. They place great value on practitioners and external mechanisms which acknowledge and address issues raised and implementation of changes leading to demonstrable improvements in healthcare practice and outcomes; both for themselves and others.

Notwithstanding efforts to make complaint processes accessible, literature indicates a significant proportion of users consistently express negativity about both process and outcome and under-representation of vulnerable populations in these processes. Identified factors include operational issues such as barriers to making complaints, adequacy of communication and timeliness. Important also have been perceived justice of process and outcomes; and managing an expectation 'gap' between what is sought and what is achievable.

Receiving and managing complaints is a core function of Australian health practitioner regulators; and engendering confidence in the appropriateness and efficacy of process as well as outcomes an important role. Current Australian arrangements provided a unique opportunity to assess complainants view on contemporary complaint processes and the implications these views have for regulatory practice.

Australia was an early adaptor of innovative regulatory practices and is a world- leader in complaint management, having translated mechanisms originating in the public sector as citizen protections and private sector as business improvement strategies to arrangements specific to regulated health practitioners and services. Significant human and financial resources have been directed towards establishing, overseeing and refining complaint processes that sit at the nexus of quality improvement and regulatory compliance and enforcement.

A federation of five states and two territories, Australian Health Ministers through the Council of Australian Governments (COAG) made a decision in 2008 to establish a single national registration and accreditation scheme to provide a streamlined and nationally consistent

approach; these responsibilities originally acquitted through individual jurisdictions. From the outset, however, the most populous state (NSW) made a decision to join the registration and accreditation components of the national scheme, but retain its 'co-regulatory' complaint system then in place for two decades.

These developments provided an opportunity to compare and contrast a mature and newly established system operating at scale in a single country environment. Further, most studies to date have focused on single-profession studies. The Australian arrangements enabled cross-profession analyses of responses to complaints to be undertaken.

Thesis objectives

The objective of this thesis on the management of complaints about health professionals by the Australian national and NSW state regulators are to:

1. Describe developments in regulatory and complaint management theory and practice, and their influence on the national and NSW systems.
2. Gain an understanding of the motivations, expectations and experiences of individuals and organisations that have made a complaint to one of the agencies under study.
3. Compare and contrast study participant responses; identifying points of similarity and difference between:
 - a. the national and NSW systems (primary focus of study); and
 - b. the five registered profession types, representing the majority of registrants and subjects of complaint in Australia (secondary focus of study).
4. Analyse and report on perceptions of purpose, efficacy and suitability of the processes; and the factors that underpin these perceptions, to inform future regulatory practice.¹

Practitioner regulation, like healthcare itself, is complex, requiring a mix of capabilities to address recurring and emerging problems, minimise perverse impacts, effectively communicate intent and manage interests and expectations. This is especially challenging because of the scale and diversity of the sector; mix of personal and public impacts; complexity of care arrangements; speed of technological transformation and the array of participants and issues; all played out in an evolving social landscape regarding the nature of professionalism and expectations of the practitioner-patient relationship.

Complainant perceptions are equally complex and this mixed-methods study found no single factor can fully account for complainants' expectations and responses. The most significant

¹ Thesis parameters were informed in part by the study being one of a set of five cohort studies funded through an Australian Research Council Linkage Grant. Each compares and contrasts the Australian national and NSW complaint and notification systems; each adopting a different perspective to come to an understanding of these two systems; and in so doing, providing insights to their effectiveness, efficiency and impacts. The four cohort studies included analyses of complaint data; internal complaint management; decision-making processes; and legal and structural aspects of the regulatory schemes.

factors moderating respondents' perceptions and experiences were power and transparency. These factors were relevant in accounting for views about operational processes and underlying assumptions of the regulatory model.

Most complainants saw themselves as a stakeholder in the process with only a minority thinking 'flagging' issues was sufficient. The majority reported a duty to raise concerns, the effort and risk involved and importance of issues raised. Respondents expected those managing complaints to carefully investigate their concerns, act in a timely and fair manner, and provide information about the process, reasons for decisions and changes made. Equally important is transparency about the principles, reasoning and assumptions that underpin processes and decisions. In essence, respondents sought the same level of accountability and responsiveness from regulators as expected from practitioners subject of complaint.

Two other factors are notable. One is the institutional shift away from 'rules based' regulation to 'responsive' and 'risk' approaches offered the advantage of more flexible and nuanced responses to the particular circumstances of cases. However, this flexibility can increase the risk of opacity and perceived lack of accountability (absent clear operational principles and reasoning); a weakness of agencies identified in this study. Depending on how the model is implemented, this change in regulatory approach may also prove challenging when 'authoritative' intervention is sought. Also significant is the proportion of respondents that tried to resolve their matter before approaching the regulator. Dissatisfaction in these cases was compounded by a lack of timeliness and communication on the part of agencies. However, escalation and reported dissatisfaction with responses to complaints by practitioners or employers appear a core problem; indicating a continuing need to improve management at the point of original contact.

Thesis structure

Chapters 1-3 are introductory, providing the context for the study. Chapter 1 provides an historical overview of regulatory developments both to understand the design of the systems under study and in which to situate the findings. Discussion includes factors influencing regulatory and complaint practice in general; background on the evolution of regulatory approaches to health professionals; and key features of the national and NSW schemes today.

Market liberalisation and an increased focus on risk and outcomes resulted in a general shift away from rules based regulatory practice. More specific factors influencing the historical model of self-regulation established principally by the medical profession were quantitative and qualitative evidence of the cost of error and regulatory failures coupled with unacceptable

standards of care and behaviour raised by consumers. However, the establishment of government-sponsored independent statutory commissions in Australian jurisdictions affected but did not displace professional control in regulatory frameworks. Their development was marked by contested views about the appropriate breadth of remit and their powers; the extent to which individual and public interests should be served, including providing compensatory relief for harms; and the role of consumers. Across their history, Commissions were routinely criticised for being both too 'soft' and too 'hard'; and by consumers for a narrow and clinical definition of harms. The national model positioned complainants as passive reporters, and unlike jurisdictional bodies, limited information that could be provided and rights to review.

Chapter 2 summarises the literature on the experience of and views about health complaint processes by people who have made complaints about registered health practitioners; as well as those who did not complain notwithstanding a belief they had cause to do so.

Studies identified an under-representation of more vulnerable populations in the complaint processes. Complainants typically sought more than one outcome and expressed a moral obligation to raise issues. Responses and conduct of the complaint process as well as outcomes were important to complainants. Preventing recurrence, followed by desire for an explanation or apology dominated reasons given for making complaints. Seldom were clinical issues alone at issue; most common prompts including clinical issues or treatment associated with a poor (insensitive) response and/or poor communication. The poor quality of responses by health providers contributed to complaint escalation and medico-legal claims that might otherwise have been avoided.

Chapter 3 describes the study methods, which included two surveys and interviews. A mixed methods approach was adopted; quantitative methods used to provide sufficient statistical power to give confidence in key findings of the study as a whole and the systems and professions under study. Qualitative data strategies were used to provide a more fine-grained understanding of motivations and experiences.

The main study instrument was an anonymous self-completed survey of all cases closed by the national and NSW regulators over a 12-month period. Data included reasons for making a complaint; outcomes sought and obtained; perceived fairness, adequacy of communication; and satisfaction with process and outcome. Semi-structured interviews were undertaken, seeking views on the purpose of health complaint processes, mistakes and accountability. A second survey of community and professional organisations probed general knowledge about the regulators; experience of complaint handling and its contribution to practice improvements

The results are presented in Chapters 4-6. Chapter 4 describes the profile of those who have made a complaint and the professions subject of complaint; the issues involved and where events occurred. It reports on steps taken to resolve matters before approaching the regulator; the reasons for making a complaint and what was sought from the process. It describes barriers to making complaints and views about errors and harms in healthcare, and accountability when they occur.

Respondents were primarily consumers, but included practitioners, primarily peer or senior to the practitioner subject of complaint; and organisations, primarily health services and employers. Per previous studies, key population groups were under-represented including Aboriginal and Torres Strait Islander peoples; Australians from culturally and linguistically diverse communities; and people with mental illness. Barriers to raising concerns identified by peak organisations included lack of knowledge and understanding of the right to complain and the process; the need to be identified and fear of reprisal (to service or employment); stress of the process and confidence in achieving desired outcomes.

Respondents reported a duty to raise concerns, the effort and risk involved and importance of issues raised. Consistent with available literature, they wanted an explanation, an apology, improvement in standards and action by the practitioner or regulator to ensure events would not recur. The majority attempted to first address their concerns through other means. Regulators were approached to 'bring to account', raise the standards of or stop practitioners regarded as unsafe, not competent or not responsive to concerns raised directly.

Chapter 5 describes the complaint management process, including whether matters were accepted or declined for investigation or other action; management times and reported delays and outcomes. It also reports on whether respondent issues were addressed; awareness of any improvements arising from the complaint and if any further actions were planned or taken.

Most did not know about the regulators or what to expect prior to approaching them. A significant level of referrals was reported; over half from one complaint body to another; adding to respondents' confusion. Reported delays appear related to both referrals and attempts to resolve matters directly; and, once received, lack of agency communication about process and reasons for decisions.

In contrast with their stated interests and intentions, the majority reported issues were either not or only poorly addressed; and less than ten percent were aware of any resultant changes. Over half resulted in 'no further action'; less than one-quarter that wanted an explanation and only ten percent that wanted an apology received one. Resolution occurred in less than ten percent of matters, three-quarters not proceeding or attempted without result. Conversely,

many not offered resolution felt it would have been helpful; some thought it should be mandatory.

Chapter 6 reports on rankings of key experience measures and reasons given by respondents for those rankings. Measures encompassed understanding of the system (clarity of agency roles and of criteria used to assess complaints); engagement and communication (how well respondents were kept informed during the process and how well reasons for decisions were explained); balance (fairness and respect); impact on health; and overall ('global') experience (satisfaction with process, satisfaction with outcome and whether or not the process would be recommended to others).

Respondents frequently report the experience of the complaint process, even where resulting in outcomes sought, to be stressful and challenging. Effects include development or exacerbation of significant physical and psychological conditions. One-third to one-half ranked their experience 'very negatively' in relation to clarity of assessment criteria, whether decision reasons were provided, fairness and overall satisfaction with process or outcome. Responses were similar for the two systems. Medical practitioners attracted the majority of complaints and more negative responses compared with all other professions. Absence of information undermined respondent's understanding or acceptance of decisions made and their confidence in the regulatory system. Fairness was the most significant indicator for overall satisfaction with the process, the outcome and whether or not the process would be recommended to others. Respondents reported asymmetries of knowledge and influence; and identified an inconsistency, perceived as bias, between their standing and treatment relative to that of practitioners' subject of complaint.

A Chapter summary is included at the end of each of Chapters 1-6. Because of its size, section summaries are also included in Chapter 6.

Chapter 7 discusses the key findings from the study. Respondent expectations of quality complaint processes appear congruent with the literature on best practice regulation and complaint management. Sound operational processes are important, including efficiency, good communication and given the complexity of Australian arrangements, well-integrated structures and roles – all identified as requiring improvement.

However, the most significant factors moderating respondents' perceptions and experience include power and transparency. While approaching agencies as a moral stakeholder articulating issues of value; in its most negative manifestation respondents experienced roles of unpowered and diminished actors; alienated from the resolution of events both deeply personal and painful. While this is most acutely expressed by patients and relatives, professional and organisational respondents report similar effects. There is no complainant

equivalent to the assumed 'good practitioner', and in the process of raising concerns many experience a transition from raising a problem to being perceived as one.

Dissatisfied respondents expressed anger or disappointment with regulators failure to exercise (or exercise sufficiently) their authority and powers; and adequately account for their activities and decisions. Notably, responses indicate a lack of or mixed understanding about the purpose of complaint processes and the role of regulators; the nature of error; how accountabilities, improvements or sanctions are determined; or the efficacy of regulatory choices at either an individual or systems level. This, combined with information from agencies focusing on the 'mechanics' of steps possible or taken undermined respondent's understanding or acceptance of decisions made and their confidence in the system.

Chapter 8 (Conclusion), discusses the implications of findings for future practice and makes recommendations for further work.

Chapter 1. Background

This Chapter addresses study Objective 1, describing developments in regulatory and complaint management and arrangements currently in place in Australia.

Part 1.1 discusses current and historical thinking about good regulatory and complaint practices; and factors influencing changing arrangements for health practitioners. Medical practitioners feature as the profession with the primary influence on regulatory developments and the model for other professions. I include discussion of safety and quality mechanisms that have developed concurrently with complaint processes.

Part 1.2 describes the establishment of NSW and other jurisdictional complaint commissions and Part 1.3 describes the national scheme, including comment on the issues and concerns of consumer representatives in its development. Part 1.4 is an overview of provisions of the current national and NSW schemes. I also discuss the reviews undertaken in relation to the national scheme over the course of this study. Part 1.5 briefly discusses risk based regulation which underpins the approach of the Australian national regulator.

1.1 Regulatory theory and practice

Four factors have been attributed to the changing nature of regulation of health practitioners and growth in complaint mechanisms.(1-16) First, market liberalisation and evolving views on the role of government and regulation more broadly. Second, a growing body of quantitative evidence on the cost of healthcare error and associated litigation concerns. Third, qualitative evidence on unacceptable standards of care and behaviour on the part of health professionals and services combined with regulatory failures, garnered through a series of high profile public inquiries following consumer complaints. Fourth, changes in social attitudes towards health professionals' authority. Each of these factors is underpinned by an extensive body of literature, but it is beyond the scope of this thesis to discuss all of them. My purpose is to highlight key issues and developments to situate the current Australian systems; and the issues raised by 'system users' in their design.

1.1.1 Best practice regulation, complaint management and care quality

Receiving or making a complaint about health care in Australia brings individuals into contact with different regulatory, complaint and care quality frameworks expressed through statutory instruments, directives, codes, standards and guides. 'Best practice' regulation, complaint management and quality frameworks share common features and principles. However, even if their intent aligns, the powers and remedies available in each vary as do the role and standing of individuals within them. Poorly articulated or integrated, they can give rise to confusion and dissatisfaction.

1.1.1.1 Common characteristics

There has been sustained scrutiny and a global convergence of thinking on the constituents of good regulatory practice. Central concerns are clarifying the necessity for and purpose of regulation; the efficiency and effectiveness of interventions and the capacity of regulatory authorities. While the focus and scale differ, at the highest level core principles of good regulatory practice (17-22) are shared with strategic business (23, 24) and good complaint management frameworks.(25-27) These include clarity of objectives and role; good governance and leadership; internally coherent systems, policies and procedures to support objectives; information and knowledge systems to capture results and inform future practice; internal capacity building to ensure requisite skills and capabilities are in place; and stakeholder engagement to engender acceptance and confidence. An international comparison of regulatory arrangements for health and social care identified common characteristics of effective regulators. These include flexibility and adaptability; engagement with stakeholders in setting standards; a mixture of formal and informal strategies; and balancing independence and impartiality with accountability.(28)

The benchmark for complaint management principles for public sector agencies and statutory authorities is provided by internationally agreed standards and Ombudsmen, the latter established in Australia to undertake independent and impartial reviews of complaints made and with responsibility for promoting good administration and service improvements.²(29-31) Although slightly variable, the fundamental principles and definitions for good complaint management practice are consistent across Australia and internationally.(32-43) In Australia this convergence has been advanced through institutions such as the Australian and New Zealand Ombudsman Association (ANZOA) and collaboration on the development of guidance which has involved jurisdictional health complaints Commissions ('commissions').(44)

Good complaint management principles include accessibility, fairness and responsiveness. Processes should be timely and transparent, with clear and informative communication to all parties involved. This includes informing the public about who can lodge a complaint or concern, how complaints are managed, what outcomes could be expected and any broader (systemic) learning that has resulted. The value proposition for good complaint management is consistent internationally, being improved accountability, consumer confidence, consistency

² Providing an efficient and relatively low cost alternative to court action, the Ombudsman model was first established in 1809 in Sweden to oversee government administration [referred to as '*Justitieombudsman*' - 'citizen defender' or 'representative of the people']. The International Ombudsman Institute currently lists over 170 institutions in 90 countries amongst its members. The first Australian Ombudsman was established in Western Australia in 1972 following the passage of the *Parliamentary Commissioner Act 1971* (WA), the Commonwealth and remaining jurisdictions following suit in the 1970s and 80s.

and integrity in decision-making, and opportunity to identify trends, take corrective action and make systemic improvements.(32, 34, 37, 39-42, 45-49)

The most recently published Australian jurisdictional Ombudsmen frameworks reflect the 2014 Australian-New Zealand Standard *Guidelines for complaint management in organisations* (AS NZS 10002-2014) ('the ANZ Standard').³ The ANZ Standard gives a sharper focus to managing and not simply 'handling' complaints. Its premise reflects quality cycles (i.e. act, review, learn and implement improvements) (50), that are achieved through effective complaint management systems and processes. Of note is the shift in objectives - from 'customer satisfaction' of the previous standard to public confidence in and satisfaction with the complaint process.⁴(51)

National guidance for healthcare delivery is provided by the *Australian Safety and Quality Framework for Health Care* ('the Care Framework') and the *Australian Charter of Healthcare Rights* ('the Charter'); both endorsed by Australian Health Ministers. The Care Framework sets out actions and is organised into three domains: '*consumer centred*'; '*driven by information*' and '*organised for safety*'.(52) Actions within these domains are presented in terms of expectations and actions for consumers and care providers and encompass decision-making, communication, open disclosure in the event of error or incidents and learning from patient experiences. The seven Charter rights include safety, the right to information, participation in decision-making and the right to raise complaints or concerns and have them addressed.⁵(53) Also relevant is the *Australian Open Disclosure Framework*, containing principles traversing similar ground- good governance, open communication and timely action following adverse events.(54)

Variations between frameworks can be attributed to the nature of the document, purpose and audience for which they were designed. Importantly however, the role and/or expectations a member of the public may have within each framework vary; as is the extent to which these expectations are communicated; which can give rise to confusion and dissatisfaction. The Care Framework and Charter explicitly identify consumers and patients as active health care partners with rights and responsibilities. While the complaint standard and guides reference the constraint on principles associated with the legal regime in which they are applied, their

³ This updated the 2006 International Standard (*Customer satisfaction—Guidelines for complaints handling in organizations*). In July 2014, the International Organisation for Standardization released *Quality management-customer satisfaction- Guidelines for complaints handling in organizations* (ISO 10002:2014 – 'the ISO Standard'), making relatively minor revisions to the 2006 Standard.

⁴ The ANZ Standard provides expanded principles (e.g. no detriment to complainant; good communication); and detailed information about executive and managerial responsibilities for implementing and monitoring effective complaint systems. Practical direction includes how to improve access and provide effective apologies; data collection and its use; and implementing a root cause analysis system. Members of the Joint Technical Committee that prepared the standard included the Consumers Federation of Australia and the NSW Ombudsman.

⁵ The seven rights include access, safety, respect, communication, participation, privacy and comment.

substantive thrust is one of participation, resolution, open communication and learning. However, while stakeholder 'engagement' is a staple in regulatory frameworks, its form is less prescribed and generally tempered by concerns of capture by specific interest groups.

The introduction of the national regulatory scheme in Australia has been marked by the contested nature of the role and power of professionals and consumers. While acting in the 'public interest', its statutory design keeps the public at arm's length unless they are deemed essential to its purpose. It accepts and utilises complaints, but gives no formal recognition to the role of those bringing issues forward; and the national scheme itself has no formally articulated role in their resolution. Until its introduction, people using jurisdictional commissions experienced a direct and active relationship with the bodies. These expectations have no doubt been carried through to the national scheme. The potential for confusion is amplified with the retention of some complaint functions at jurisdictional level, including in jurisdictions that are part of the national scheme. While similar, governance arrangements and legislative provisions between jurisdictions vary.(1, 55)

While the framework principles are broadly consistent, they are open to interpretation and can give rise to conflicts associated with different interests. Where regulatory trade-offs are involved the process and reasoning behind the final outcome should be transparent.(19, 56) However, there may be no immediate guidance for the resolution of such conflicts.⁶(12) The most relevant is how transparency and access to information are understood and in turn relate to privacy and confidentiality. The latter appear in all complaint management; safety and rights frameworks referred to above and are underpinned by legislation.⁷

Transparency is critical for public understanding and confidence (57, 58), and relevant to how complaints and inquiries involving health practitioners are managed. Yet its interpretation is wide-ranging:

"The term "transparency" is itself non-transparent, being understood to mean quite different things by different groups... [ranging] from simple notification to the public that regulatory decisions have been taken, to controls on administrative discretion and corruption, better organisation of the legal system through codification and central registration, the use of public consultation and regulatory impact analysis and actively participatory approaches to decision-making."

OECD (2002) *Regulatory policies in OECD countries: From Interventionism to Regulatory Governance*, p.65

⁶ This can be seen for example in the *Open Disclosure Framework* Principle 8. This requires the privacy and confidentiality of patients and clinicians to be protected and for agencies to establish policies for this purpose; but also indicates "*this principle needs to be considered in the context of Principle 1: Open and timely communication*". Australian Commission on Safety and Quality (2013) *Australian Open Disclosure Framework*

⁷ In Australia this includes both Commonwealth and jurisdictional legislation and statutory offices. At the Commonwealth level, the Office of the Australian Information Commissioner is an independent statutory agency with responsibility for the *Privacy Act 1988* (Cth), the *Australian Information Commissioner Act 2010* (Cth) and the *Freedom of Information Act 1982* (Cth) relating to privacy, information and access to information held by public agencies. At jurisdictional level there is corresponding legislation and these functions are often separated.

At its most complex transparency can be understood as relational - at the highest level “*between state, market and society*” or in operational terms as “*the capacity of regulated entities to identify, understand and express views on their obligations under the rule of law*”; its value seen in addressing regulatory capture or bias and less arbitrary decision-making.(58) In the context of accountability and participation, transparency can be understood as:

“the degree to which information is available to outsiders that enables them to have informed voice in decisions and/or to assess the decisions made by insiders.”

Florini, A. (2007) *The Battle Over Transparency in The Right to Know: Transparency for an Open World*, p.5

This goes to the question of the power of information and associated asymmetries - who holds it; who may have access to it and under what terms; whether this is voluntarily provided or compelled. Florini says that to hold decision makers accountable requires decision makers to release information.(59) Scaling this back to complaints and actors in the regulation of health practitioners, consumers may want details, but for a range of reasons, professionals’ prioritise confidentiality when “*discussing and learning from cases of less than optimal practice*”.(12) These reasons may include claims that confidentiality is necessary to protect them from medico-legal consequences (real or imagined) or in peer review processes to encourage openness essential to learning to improve practice.

The above example raises different and layered questions relevant to complaint handling. One question relates to concerns about which actors have decision-making rights on what information is available; how competing rights and interests of actors are balanced, and the extent to which individual (patient or professional) or broader (public or profession) interests are constructed and factored into the decision. Another concern is the extent to which there is evidence of ‘what works’ (12, 60-63) and what perverse impacts might arise in terms of learning and improvement when information is or is required to be made available; and how influential this evidence should be in the calculus relative to ‘rights’. Another core question for this study is how (and how well) any of these dimensions are communicated by agencies with regulatory responsibilities to the sources and subject of complaint or the public more broadly.

1.1.2 Developments in regulatory thinking

The Australian government endorsed frameworks above reflect an evolution of thinking about regulatory approaches. These have been informed by experience with the limits of traditional approaches; emerging social challenges and concern with both efficiency and cost containment.(9, 64-66)

Traditional regulation concerns hierarchies and rules; state power exercised and enforced through civil and criminal laws and sanctions.(64, 67) Alternate definitions encapsulate concepts more fluid and dispersed in terms of controls (policies or other instruments that may be formal or informal) and actors (government or non-government organisations).(18, 22)

Rather than 'directing' these are 'influencing', 'behaviour shaping', or 'overseeing' strategies (7, 12, 64, 68, 69); using 'principles' rather than 'rules' to achieve specific ends.(64, 65) In this context, regulation may be understood as:

"the sustained and focused attempt to alter the behaviour of others according to defined standards or purposes with the intention of producing a broadly identified outcome or outcomes, which may involve mechanisms of standard-setting, information-gathering and behaviour modification."

Black, J. (2002) *Critical Reflections on Regulation*, p.20

The change reflects reforms associated with market liberalisation and a reconceptualisation of the role of governments in the second half of the 20th century. In the words of Osborne and Gaebler, governments and their agents should be "catalytic" - their role is to "steer, not row"; to be problem and result oriented; to empower communities to solve their own problems.(70) In Australia, trade and financial deregulation in the 1970s and 1980s were followed by a series of reviews identifying regulation as a key barrier to economic reform.(71-74) New principles adopted by government introduced public interest tests in relation to the introduction or scope of any regulatory restrictions.⁸ The Australian review that led to the establishment of the national scheme followed a decade or more of productivity reforms (70, 71, 75, 76) and allied initiatives concerned with health workforce sustainability. However, concerns with regulatory failure resulted in countervailing pressure for greater accountability and improved regulatory practice.(57, 58)

Responsive regulation theory provides a strategic response to polarised views of strong state regulation and free market deregulation; while addressing the limitations of rule-based approaches. It proposed a rethink of the relationship between regulator and regulated, applying a graduated hierarchy of approaches and responses having regard to the activities, motivations and context of those regulated; and core principles to manage the complexities facing regulators.(77) The now-ubiquitous pyramid visually emphasised the precept that legal sanctions and other 'stern' measures constituted (or were required as) only a small proportion of regulatory effort; the more substantive 'base' concerned with self-managed behaviour and persuasion in various guises:

"for the responsive regulator, there are no optimal or best regulatory solutions, just solutions that respond better than others... [recognising] regulatory styles... may operate at cross purposes...[and] achievement of regulatory objectives is more likely when agencies display both a hierarchy of sanctions and a hierarchy of regulatory strategies."

Ayres, I. and Braithwaite, J. (1991) *Responsive Regulation*, p.4

⁸ These included that any regulatory restrictions must clearly demonstrate they were in the public interest and where applied, the restrictions were no more than necessary to secure the public interest.

Using game theory, the authors further proposed ‘tripartism’ (empowering public interest groups) as a mechanism to address the risks of regulatory capture and corruption by specific interests; as well as the asymmetry of knowledge and power of the public.(77, 78)

The flexibility offered by ‘responsive regulation’ paired with ‘networked governance’ was thought valuable for managing risk in the complex health sector. Networked governance recognised a range of actors and institutions contributed to safety.(12, 79-82) Healy argues that the complexity and risks of healthcare are such as to both mandate a “*duty of stewardship*” to the state and broaden the responsibility of safety to multiple regulators and strategies given:

“One single regulatory actor cannot expect to have all the knowledge, to have command over all actions and still less have the necessary cunning to implement change in a complex system. Making health care better and safer involves everyone: politicians, administrators, doctors, nurses... as well as patients and families.”
Healy, J. (2011) *Reluctant Regulators*, p.xiv

Healy has further extended the regulatory pyramid to include patients and consumers as actors. (Fig.1) More recently, use of patient complaints in the regulatory process has been suggested as one form of tripartism (83) and legislative provisions for ‘lay’ representation in regulatory processes may be seen as another.⁹

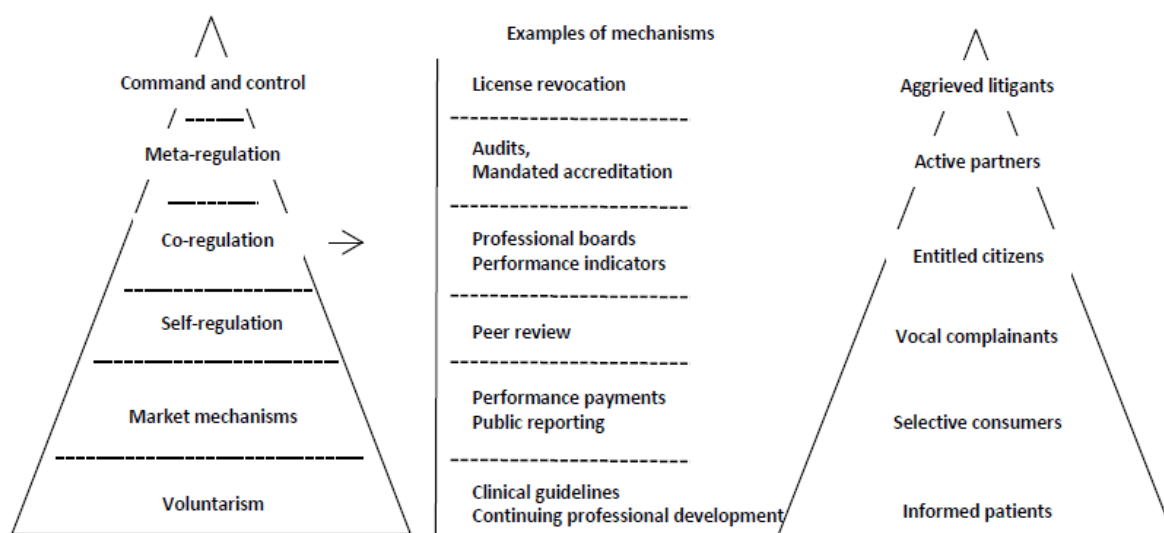


Figure 1: Regulatory mechanisms and patients as actors in a responsive regulatory pyramid
Source: Healy, J. (2013) Regulation Workshop Crawford School ANU

⁹ As part of the development of the national scheme (discussed in chapter 1.3) a Public Interest Assessor was unsuccessfully proposed as part of the complaint process. However, the idea was never substantively developed and even consumer groups who found it theoretically attractive indicated they would not support it without further work; which did not eventuate (The Senate Community Affairs Legislation Committee (2009) *National registration and accreditation scheme for doctors and other health workers*). The concept has been advanced for use in other sectors in response to regulatory failures, such as a ‘Public Interest Council’ to oversee financial services regulation. See for example Omarova, ST. *Bankers, Bureaucrats, and Guardians: Toward Tripartism in Financial Services Regulation*. Journal of Corporation Law. 2012;37(3)

Notwithstanding the inclusion of patients and consumers as significant actors, for much of the twentieth century autonomous professional control of entry and standards - commonly called 'self-regulation' - dominated health practitioner, and more specifically medical, regulation.(1, 6, 8, 84, 85)

Colonial Australia drew its professions, educational institutions and traditions primarily from the United Kingdom (UK) and similar arrangements to the UK were established.¹⁰(86, 87) The NSW Medical Board, the second oldest in the world after Tasmania, was established in 1838 through legislation to define the qualifications of medical witnesses in proceedings before Coroners and Justices of the Peace; and empowered to maintain a single register of practitioners.¹¹ Subsequent legislation extended the Board's regulatory responsibilities to the profession more generally; followed by statutory arrangements for other professions, commencing with those most closely aligned to or in competition with the medical profession.^{12,13}

Most accounts of regulatory developments for the medical profession reference self-interest in the form of anti-competitive boundary protection and autonomy.(1, 6, 8, 88) The *Medical Act 1858* (UK) centralised professional control of title and entry and created a Council comprised wholly of practitioners empowered to maintain a public register of practitioners. Understood in terms of strategic collegiality (3), the legislation established a regime whereby accountability was to peers and the focus of regulation primarily relating to conduct rather than performance:

"the rules of professional conduct and misconduct were dominated by a concern with how doctors should treat each other, rather than with their conduct towards patients ... [within this culture]... detailed control over the professional judgement of the doctor, once admitted to the collegial community, was inappropriate."

Moran, M. (2003) *The British Regulatory State: High Modernism and Hyper-Innovation*, DOI:10.1093/0199247579.003.0003

Allsop proposed a more complex 'regulatory bargain' for regulatory developments in which protectionism and public responsibility were "*interwoven in the history of the profession*".(80) Similarly, Dixon-Woods et al. suggest a social contract with autonomy balanced by professionalism; the latter predicated on a willingness and ability to address individual patient interests through the care relationship and the profession's interests in addressing individual practitioner failings.(11) Positive features of self-regulation are also recognised - efficiency; flexibility; acceptability and therefore greater compliance by members.(89) Nonetheless the

¹⁰ "Medical politics were intense"; the suggested drivers for the profession being similar to those in the UK- competition from untrained practitioners and lay-controlled societies that funded and contracted basic care. Lewis MJ. (2014) *Medicine in Colonial Australia 1788-1900*. MJA. 201(1): S5-S10

¹¹ An Act to define the qualifications of Medical Witnesses at Coroner's Inquests and Inquiries held before Justices of the Peace in the Colony of New South Wales, 1838 [2 Victoria, Act No. XXII]. The Tasmanian Medical Council was established in 1837; legislation in other jurisdictions following in subsequent decades.

¹² An Act to provide for the Registration of Legally Qualified Medical Practitioners 1855 (NSW)

¹³ Legislation for the regulation of pharmacists was first enacted in 1876 (Victoria); dentists in 1887 (Victoria); nurses 1912 (Queensland); midwives 1915 (Victoria); and psychologists 1965 (Victoria).

privilege of the profession - control of *"task related behaviours"* combined with claims of *"specialised knowledge"* discouraged external intervention.¹⁴(1, 89, 90) It was not until the *Medical Practitioners Act 1938* (NSW) was enacted that disciplinary hearings involved any actors beyond the Board; and a further fifty years before registration included the maintenance of high practice standards. More immediate responses were to extend the well-established model of professional self-management and tools of peer-review.

The adequacy of the self-regulatory regime was tested with two concurrent developments - international studies providing rigorous quantification of the cost of harms from care paired with qualitative evidence of harms played out through a series of scandals arising from patient and 'whistle-blower' complaints. These occurred in a complex environment. Technological advances; growing rates of chronic disease and costs; and concerns with sustainability were already taxing governments and insurers; amid evidence of high expectations but concomitant consumer dissatisfaction with health services.(91-93)

Comparing responses to these challenges, Thomas notes that while governments in the UK and United States (US) responded with adjustments to existing disciplinary mechanisms, in Australasia a *"two pronged attack on medical autonomy"* was launched.(1) This involved extensive reworking of definitions of professional conduct to include incompetence and negligence; and establishment of complaint mechanisms, whose activities affected both individual practitioners and the autonomous operations of profession Boards. Arguably however, the interventions did not necessarily result in a commensurate transfer of power or substantive recognition of patients in the model.

1.1.2.1 Care induced harms; safety and quality responses

Major reports on the burden of iatrogenic injury (unintended harm caused by health care) were released in the 1990s.

The Harvard Medical Practice Study found adverse events (AEs) occurred in nearly four percent of hospitalisations, of which 2.6 percent caused permanent disability and nearly 14 percent death.(94) Most AEs were found to be preventable, particularly those due to error or negligence.¹⁵(94, 95) Testing speculation about the rate of medico-legal claims, the study also found negligent injuries far exceeded claims at a rate of 7.6 to 1 (96); subsequent work pointing to both the inequity and inefficiency of the malpractice system in distributing

¹⁴ In an appeal involving deregistration by the Medical Board NSW for "infamous conduct" Pring J commented that while the Court was not bound by the Board: "... *this court is very loath to disturb the finding of professional men whose knowledge of what may be termed as professional conduct must be very much greater than the court can possess*" *Clune v Medical Board* (1917) 34 WN (NSW).

¹⁵ In the review of 18,000 medical records, error was identified in over half of AEs studied and negligence in over one-quarter. Variations in each were associated with age, location of events and error type. Negligence defined as error plus failure to meet an accepted norm, i.e. *"failure to meet the standard of practice of an average qualified physician practicing in the specialty in question"* per *Brune v. Belinkoff*, 354 Mass 102 (1968).

compensation to those harmed.(97) An Australian study found over 16 percent of admissions to be associated with an AE; of which half were considered highly preventable.¹⁶(98) Extrapolating the data to all Australian hospitals, it concluded 470,000 admissions and 3.3 million bed-days could be attributable to AEs in 1992. Subsequent studies in a range of countries showed an overall rate of 10 percent of hospital admissions associated with AEs.(99)

In response to these findings the Australian government established a Taskforce (1995) and National Expert Advisory Group on Safety and Quality (1997). The Advisory Group identified the need for additional measures to advance a safety and quality agenda and support learning from incidents, adverse events and complaints; and recommended the establishment of an Australian Council for Safety and Quality in Health Care ('the Council') to provide leadership and a coordinated national approach. Proposed measures included strengthening clinical practice; developing information systems and metrics to capture and monitor trends; providing education for quality and safety; and strengthening the consumer voice and participation in care.(100, 101) In making its recommendations, the Expert Group noted that health providers had indicated that:

“the outcomes of improved consumer involvement from their perspective included better functioning of teams within the hospital, creation of a more open culture and more pro-active behaviours by service providers in seeking and using consumer feedback.”

National Expert Advisory Group on Safety and Quality in Australian Health Care (1999) *Implementing safety and quality enhancement in health care*, p.6

Notably, consultations undertaken as part of this work also found consumers viewed care 'quality' broadly – i.e. not understood solely in technical terms, but including the process of care delivery and entailing:

“effective communication, opportunities for active participation as partners in care, continuity of care and respect for human needs such as dignity and privacy.”

National Expert Advisory Group on Safety and Quality in Australian Health Care (1999) *Implementing safety and quality enhancement in health care*, p.5

Australian policy directions drew on and reached similar conclusions to parallel initiatives in the US, UK, New Zealand (NZ) and Canada.(102-107) The dominant focus of these and similar reports was understanding the variability of care; the service environment; and systems as well as individual factors that promote or undermine safety and quality. This work was paired with establishing infrastructure suited to support safety and quality. A key platform was facilitating a cultural shift from 'individual blame' to an organisational or systems 'learning' approach:

¹⁶ Examining over 14,000 records in 28 hospitals, the study found 13.7% of AEs resulted in permanent disability; 4.9% in death; and on average accounted for an additional 7.1 days in hospital.

“These quality problems occur typically not because of a failure of goodwill, knowledge, effort, or resources devoted to health care, but because of fundamental shortcomings in the ways care is organized”

Institute of Medicine (2001) *Crossing the Quality Chasm*, p.25

The systems approach reflects efforts at the time to examine and understand how other high risk industries such as aviation approach errors and safety.(106, 108-112) Its adaptation to healthcare as described in ‘*An organisation with a memory*’ indicates safety is strongest in organisations with “*informed cultures*”; key cultural dimensions including reporting, justice, flexibility and learning:

“[a] reporting culture [being] an organisational climate in which people are prepared to report their errors or near-misses... [a] just culture [being] not a total absence of blame, but an atmosphere of trust in which people are encouraged to provide safety-related information – at the same time being clear about where the line is drawn between acceptable and unacceptable behaviours.”

Department of Health (2000) *An organisation with a memory*, p.35

Consistent with these directions, definitions of error distinguished intent (inadvertent and deliberate actions); acts of both omission and commission; and that significant risk can be present regardless of outcome (i.e. potential as well as actual harms).¹⁷(113, 114) Through this lens, blame and punitive responses should not be directed at people involved with the error, which would happen to most providers over the course of their career.(113)

Identified barriers to implementing safety and quality initiatives were deficiencies in governance, leadership and communication, including an historical lack of preparedness but concurrent need to listen to patients and other external sources of warning.(100-103, 106, 112, 115) Response strategies included encouraging patients to ‘speak up’; establishing or strengthening complaint mechanisms and extending opportunities for consumer and community involvement. These aligned with trends towards ‘patient centred care’; partnered decision-making; consent law reform and the broader consumer rights movement.(116-122)

The Commonwealth Government of Australia through the ‘*Consumer Focus Collaboration*’ and jurisdictional agencies funded initiatives to understand the evidence for and facilitate consumer participation.(123-126) Health Ministers established the Council¹⁸ as recommended; which subsequently funded *Turning Wrongs into Rights: learning from consumer reported*

¹⁷ These include “the unintentional use of a wrong plan to achieve an aim, or failure to carry out a planned action as intended”. Runciman et al (2003) *Error, Blame, and the Law in Health Care-An Antipodean Perspective* p.975 and “an act of omission or commission in planning or execution that contributes or could contribute to an unintended result”. Grober and Bohnen (2005) *Defining medical error* p.42

¹⁸ The organisation was succeeded in 2006 by the Australian Commission on Safety and Quality in Health Care (ACSQHC); which was given a statutory basis under the *National Health Reform Act 2011* (Cth).

incidents.(127) Managed by the HCCC¹⁹, the project included research into complaints management in Australia and internationally; surveys and broad consultation with interest groups. This resulted in guidelines and a handbook to assist services to better understand the potential of complaints for safety and quality purposes and to establish or improve their complaint systems and practices.(44, 128)

Australian Health Ministers also endorsed an Open Disclosure standard to facilitate communication following AEs.(129) The Standard was subject to extensive review and consultation with patients and providers; with supporting resources and systems developed (130-133) and action taken to provide protections from medico legal claims.²⁰ The current standard includes an “*apology or expression of regret which should include the words I am or we are sorry*”.(54) While there is no statutory duty of disclosure, the standard explicitly states open disclosure is a patient and consumer right; a core professional requirement and an institutional obligation.

Reviews have highlighted the positive benefits to the health system and patients from greater openness and trust. However, the literature indicates a continuing gap in disclosure, which is relevant to complaint processes. Health professionals indicate a continued concern with potential liability arising from disclosure, both legal (financial) and disciplinary; as well as reputational damage; and the need for support to give effect to the directions.(131, 132, 134) Patients have indicated the experience is often more one of ‘information disclosure’ rather than the dialogue or exchange they are seeking; with apologies falling well-short of their expectations and disclosure guidance.(132, 135, 136)

1.1.2.2 Accountability in a ‘just culture’

‘Just culture’ thinking is relevant to complaint management when considering how to appropriately determine individual accountability and when and what type of sanctions should be applied.

Marx identifies four categories of behaviour; differentiated on the basis of intent to help inform thinking about culpability and deterrence in healthcare; including when punitive sanctions may be appropriate.(137) *Error* involves inadvertent harm from acting other than one should; while *negligence* is a failure to identify a risk that resulted in harm that should have been identified - the test being exercising the skill, care and learning of an equivalent reasonable professional. Neither of these two categories involves intentional harm, although negligence raises the issue of compensatory action. Whether it is more beneficial to punish the negligent or

¹⁹ Working with the Victorian Health Issues Centre (acting on behalf of the Australasian Council of Health Care Complaints Commissioners) and the Royal Australasian College of Physicians (acting on behalf of the Committee of Presidents of the Medical Colleges)

²⁰ While not uniform, jurisdictions have statutes to address liability concerns e.g. *Civil Liability Act 2002* (NSW).

encourage them to report remains a live issue. Experience in other high risk industries led him to conclude the latter is more efficacious. In contrast, *reckless* conduct involves a conscious disregard of risk and punitive sanctions should be reserved for this and *intentional rule violation*. He suggests sanctions are also more likely to act as a deterrent in these cases.

Rivard argues causality is over-attributed to individuals and events temporally and spatially proximate.(138) In a 'blame culture' individuals are held accountable for adverse events; and resolution sought through sanctions and/or retribution is 'normalised', making learning difficult. The historical emphasis in health care on 'error free' performance and individual responsibility have resulted in both an over-emphasis on individual accountability and an incentive to downplay one's own errors or blame others. He suggests a 'just culture' provides both an antidote to 'blame' and a means for assigning and categorising accountability and culpability as they apply to - and across individuals, teams and organisations; managed through "*fair, objective, and explicit decision rules*" (Ibid, p.4).

There are risks for complainants if a 'don't blame' framework is applied without careful consideration and adaptation to how complaints are conceptualised or responded to. The most immediate is by default a complainant can readily become a 'blamer' with all its negative connotations rather than one raising a legitimate question or point. Blame is not necessarily negative - "[to] assign responsibility for a fault or wrong" but its synonyms for common use suggests otherwise - "*indict, point the finger at, finger, incriminate*".²¹ Similarly, complaints can be considered more neutrally as an objection or problem - "*a statement that a situation is unsatisfactory or unacceptable*". Again however, common usage suggests a patina of unreasonableness - "*grouse, cavil, quibble, grumble, whinge*". As Friele et al. observed, the key difference between complaints and open disclosure "*lies in the initiative*" - one emanating from a practitioner, the other a patient.(139) Here historical cultural relationships and differences in agency and power are influential. If providers are still challenged by giving effect to care partnerships with their patients (140, 141), complaints present an even more acute 'initiative'.

From a complainant perspective, potential limitations include the extent to which Rivard's '*explicit decision rules*' are established and applied; are clearly communicated or are concerned with their interests. Approaches to the appropriate allocation of responsibility and determination of suitable regulatory responses (106, 142) includes development of decision tools (137, 143) or downscaling the divide between individuals and entire systems such as concepts of 'collective accountability'.(144-146) Others suggest moral agency as a means of encouraging self -reflection, -regulation and disclosure.(147) Agency websites contain legal

²¹ Google www.google.com

judgements. However, how agencies operationalise their 'decision rules' in the context of complaints of wrongs and harms from a complainant's perspective is unclear and appears unresolved still.

There is the sense too, that 'blame' is assumed to be negative, problematic or wrong. Yet compensatory arrangements are relevant and may be entirely reasonable. Factors contributing to a 'blaming' approach include lack or inadequate consent; and the adversarial legal processes required to secure support and compensation.(113, 148) As in other studies, Duclos et al. found the nature and quality of communication influenced whether patients defined an event as an 'honest mistake' or 'error'. They also found significant financial stresses and harms, a facet under-reported in the literature:

"the participants all mentioned the devastating impact of financial problems following an incident. This type of trauma in some cases was the salient issue that seemed to affect the impact of the other trauma.... Participants reported that the financial impact became especially overwhelming when it threatened or negatively affected personal credit reports."

Duclos et al. (2005) *Patient perspectives of errors*, p.481

Ocloo also challenges the construction of 'just culture' on the grounds it remains predicated on a medical model that has yet to fully reflect patient concerns and notions of harms and accountability.(149) This perspective is congruent with reviews finding divergent patient and practitioner reports of what constitutes an AE. Consistent with earlier research on quality, these studies found patients interpret and report communication and quality issues beyond more narrowly and clinically defined definitions of AEs; with 'mistakes' identified by patients re-characterised as 'miscommunication' or 'misunderstandings' in a substantial number of cases.(150-152)

Levinson and Pizzo suggest the "*science of quality improvement*" be applied to communication 'errors'. They propose the use of metrics, reporting on their occurrence and funding to drive improvement as mechanisms to elevate recognition of their importance and incentivise desired responses.(153)

Applying a 'patient safety lens', Gallagher and Mazor (154) propose treating a complaint as an AE to drive improvements that matter to patients, whether harms of a physical or other nature have occurred. Emphasising the need to systematically collect and collate these data, the authors also raise the potential of treating reoccurring complaints (even absent obviously reckless behaviours) as requiring disciplinary action:

"If providers are generating multiple complaints through what could be construed as at-risk behaviour, especially in the face of feedback and coaching about how to modify the at-risk behaviour, this pattern itself represents recklessness that would merit disciplinary action"

Gallagher and Mazor (2015) *Taking complaints seriously: using the patient safety lens*, p.354

1.1.2.3 A series of scandals

In parallel to efforts to reduce adverse events, a series of high-profile domestic and international events had a significant impact on public attitudes towards health services and their regulation, placing pressure on governments to respond. Prompts included a mix of egregious individuals and systemic deficiencies; issues ranging from experimentation without consent to sexual assault; deliberate harm; murder; and inadequate or sub-standard practice, including care resulting in avoidable deaths and harms.(155-164) The scale and cost of subsequent inquiries were substantial. [A1.1]²²

If the quantification of error drove more standardised approaches to quality and safety, the scandals and inquiries highlighted their failings and the inadequacy of practitioner, service and regulatory responses to substantial and ongoing harms and risks. While not without their critics or limitations²³ (165-168) inquiries focused the public gaze on long-standing problems unresolved through existing processes; raised by patients, families and select staff, who persisted:

“in the face of reluctance on the part of health care organisations ‘to do the right thing’. In most cases ... [they] persisted ... largely because no one was willing formally to admit to errors and apologise”

Hindle, D., Braithwaite, J., Travaglia, J., Iedema, R. (2006) *Patient Safety: a comparative analysis of eight inquiries in six countries*, p.6

Features commonly identified by inquiries included those previously discussed in relation to iatrogenic harms - long-standing problems of poor governance; poor standards; an absence of or inadequate quality and safety systems; and an unwillingness or failure on the part of services or regulators to listen, believe or respond to complaints or concerns expressed by staff and patients.(1, 11, 12, 92, 93, 165, 168-177) While resources were a factor in some cases, it was not the sole or necessarily dominant feature.²⁴

Inquiries highlighted the fact that clinicians and managers were often long aware of problems before any substantive action resulted; and exhaustively documented a range of factors constraining both patients and practitioners in voicing concerns.(156-158, 161, 170, 173, 178-180) For the former, factors included: vulnerability; isolation; guilt; embarrassment; disbelief associated with a long-standing relationship with a ‘trusted professional’; fear or experience of repercussions; concern with being perceived as a ‘troublemaker’ or ‘habitual complainer’; lack

²² Supplementary tables contained in appendices appear in brackets e.g. [A1.1] being Appendix 1, Table 1.

²³ This includes lack of rigour and standardisation of inquiry processes, limiting generalisability of findings; lack of mechanisms to translate findings to implemented actions; the significant cost and length of time many take; these factors compounded by fragmentation of investigative efforts. Walshe, K. and Shortell S.M (2004) *When Things Go Wrong: How Health Care Organizations Deal With Major Failures*

²⁴ Poor governance was typically associated with one or more of the following: dysfunctional leadership; fragmented organisational or accountability arrangements; deficient teamwork or isolated practice; poor communication and a culture that was secretive and/or bullying. Issues with safety and quality included poor clinical governance or review arrangements; absent or outdated policies and procedures, reporting systems or registers; and lack of systems to collect, integrate or optimally use data.

of knowledge about, existence or adequacy of a complaint process; defensive, disbelieving and unsupportive responses; and relative power and knowledge imbalances.

Factors identified by these same reports as constraining practitioners included absent or unclear complaint processes; failure to credit hearsay evidence; and unwillingness by some patients to complain or specific direction that the matter not be taken further. Other factors included inherent uncertainties of healthcare; defensiveness; in places a 'closing of ranks'; and professional and cultural norms against 'judging' others practice particularly if relating to a dominant senior or working in another speciality or area. Managers adopting a 'them and us' mentality also played a role in complaints:

"The impression I received was that complaints from individuals were suspected of being, in some way, unreliable... Also, there was resistance to any action which might be seen as "assisting complainants" and therefore as "unfair to doctors."

Smith, J. (2004) *The Shipman Inquiry Fifth Report, Investigating the Circumstances of a Complaint*, s.18.128, p.579

Kingdom's framework for the formation of public policy proposes a 'policy window' opening when three streams align - a problem stream (events/crises requiring a solution); a policy stream (alternate solutions for resolution) and a political stream (jostling interests and agendas).(181) Pacey et al. use this framework to situate the factors leading to the establishment of the national scheme.(182) The framework is also useful for conceptualising the multiple roles occupied by the Australian inquiries. These are both used to manage 'hot' political issues and called for because of their powers to compel witnesses and information; bringing people and institutions 'to account'. Critical events gave rise to the establishment and shaped the terms of reference of the health inquiries; but circumstances and problems were generally long standing and well known. Outcomes included a mix of legislative, systems and policy reforms, including the establishment or strengthening of complaint agencies or processes in the interest of individuals concerned and the broader public.(159, 170-176, 183-185) I discuss this in the following sections.

1.2 Establishment of Commissions and the NSW scheme

In Australia, the *Medicare Agreements Act 1992* (Cth) required the development of a Public Patients' Hospital Charter and establishment of an independent complaints body in each jurisdiction (Commitment 2 "*making improvements in the efficiency, effectiveness and quality of hospital service delivery*").(186)

The impetus if not the full reality for all jurisdictions in establishing bodies ('commissions') was well established by that point. The factors previously described all played their role - harms, litigation and failure of professions, health services and regulatory institutions to adequately respond to patient concerns. However their establishment; powers and approaches taken by

early commission leaders varied although all contained a mix of 'public watchdog' and 'resolution' functions. All attracted opposition from medical associations (187-191) who argued that they were unnecessary; divisive; unsuitable (lacking practice understanding and expertise); would undermine the doctor-patient relationship and were unlikely to deliver improvements.(187-191) These responses came from a profession already sensitised following disputes with Australian governments over insurance and remuneration arrangements.(192)

1.2.1 NSW developments

NSW was the first jurisdiction to introduce an independent scheme with the establishment of the NSW Complaints Unit (the Unit) in 1984 as an administrative unit of the NSW Department of Health.

The impetus for establishing the Complaints Unit came from the Health Minister, Laurence Brereton MP, who was responding to public disquiet about money (in the form of substantial medical fraud and over-servicing); but also anticipated the Unit would act as a systemic quality control mechanism by reviewing complaints and making recommendations.(190) The Complaints Unit transformed into the Health Care Complaints Commission in 1993 as a result of recommendations by the Royal Commission into Deep Sleep Therapy (the 'Slattery Commission') findings; which included some 24 preventable deaths occurring as a result of the controversial treatment that had been conducted in NSW from 1963-1979.(12, 160)

A feature of the Unit's early operations was an emphasis on individual practitioner accountability, achieved through a 'legal prosecutorial' approach. Thomas defines this as the routine use of investigative and legal powers to enforce accountability and achieve discipline; highlighting both individual and system shortcomings in the process.(190) This contrasts with a 'conciliation' approach which is primarily concerned with resolution and restoration of trust; legal powers being exercised only as a last resort. The philosophical underpinnings for the prosecutorial approach were drawn from Public Interest Law (PIL) which had its antecedents in community legal centres in the US and Australia; representing the less powerful and 'under-represented'.(193) Importantly, PIL can be applied to a 'community of interests' as well as individual interests.

A second feature of the Unit's approach was to focus on the broader public interest and systems reform that could be leveraged from complaint trends and issues. While both individual and broader public interests may be pursued, maintaining both can be difficult; an early review of the Units' operations noting:

"While there are many occasions on which individual and public interests coincide, they can diverge when a complaint about the manner of delivery of a professional service is considered. If individual consumers and providers have difficulties, these can

be resolved to their individual satisfaction without the public interest necessarily being protected... the fault may remain within the system."

Fox, P. (1989) *Review of Complaints Unit for the Department of Health* in Thomas, D. (2002) *Medicine Called to Account*, p.7

Bills to establish a statutory basis for the NSW Complaints Unit introduced over 1992-93 highlighted the tensions between broader 'public interest' advocates and those more concerned with the process as an accessible means of addressing individual interests through resolution or redress.^(193, 194) Criticisms included a failure to include a charter of consumer rights or provision for an advocacy role for the Commission; and exclusion of a recognised role for assisting individuals to pursue compensation.⁽¹⁹⁵⁾ The latter appears exacerbated by unsuccessful legal challenges to bring the 'Chelmsford' practitioners to professional account; similarly with efforts to secure compensation to those harmed.²⁵ Assistance to secure compensation was not included in the final legislative framework and has been excluded since, although recompense may result from resolution processes.

Critical of the failure of the Department and other institutions to act in the Chelmsford case, recommendations from the Slattery Commission were a significant driver for the *Health Care Complaints Act 1993* (NSW) (the HCCC Act) and distinguishing features of the scheme. In addition to resolution functions that were articulated as a patient right²⁶, this included powers to undertake independent investigations and prosecutions of individual practitioners (previously requiring the prior approval of the Secretary of the Department); and a parliamentary oversight body (the 'Joint Committee').²⁷

The NSW Medical Board had argued that it could not take disciplinary action against the Chelmsford practitioners on the grounds its' legislative remit did not include 'poor performance'.²⁸ The *Medical Practitioners' Amendment Act 1987* (NSW) addressed this, introducing a definition of 'professional misconduct' as including "*any conduct that demonstrates a lack of adequate (i) knowledge, (ii) experience, (iii) skill, (iv) judgement or (v)*

²⁵ While the Slattery Commission recommended charges be laid, the three doctors in question obtained a permanent stay of disciplinary proceedings on the grounds of excessive delays in bringing the complaints forward. Decision by the NSW Court of Appeal upheld by the Australian High Court in *Walton v Gardiner* [1993] HCA 77; (1993) 177 CLR 378; (1993) 112 ALR 289; (1993) 67 ALJR 485 (29 April 1993). The full decision is available at <http://www.austlii.edu.au/au/cases/cth/HCA/1993/77.html> and the history is set out in *Herron v McGregor* (1986).

²⁶ The objects (s3) being: (a) to facilitate the maintenance of standards of health services in New South Wales; (b) to promote the rights of clients in the New South Wales health system by providing clear and easily accessible mechanisms for the resolution of complaints; (c) to facilitate the dissemination of information about clients' rights throughout the health system; and (d) to provide an independent mechanism for assessing whether the prosecution of disciplinary action should be taken against health practitioners who are registered under health registration Acts.

²⁷ The Joint Parliamentary Committee on the Health Care Complaints Commission; a particular impetus for its establishment was to address concerns about the powers of investigation and prosecution being invested in a single body.

²⁸ The *Medical Practitioners Act 1938* (NSW) limited grounds for complaints to be investigated or referred for disciplinary action to conviction of a felony or misdemeanour; habitual drunkenness, addiction to a 'deleterious' drug and 'infamous conduct in any professional respect'; 'infamous conduct' including the use of unqualified assistants undertaking roles requiring 'professional discretion or skill' and misuse of title [s27(1)-(2)]. Grounds for refusal of registration were similar [s17(6)].

care". The legislation reconstituted the Medical Board,²⁹ requiring four members (of 18) to be nominated by the Minister for Health "*not less than 2 of whom shall be persons who, in the opinion of the Minister, are conversant with the interests of patients as consumers of medical services*"³⁰ and for a lay person be included on Tribunals.³¹ The HCCC Act and *Medical Practice Act 1992* (NSW) also formalised 'co-regulatory' arrangements for the joint assessment and referral of complaints between the Board and HCCC that had been established informally from the outset of the Unit. The 1992 Act also articulated a protective objective (public health and safety).³²(196)

To fulfil its broad remit, the HCCC established a system of engaging expert health reviewers to support assessments and investigations; provided complaint investigation courses for health services and support officers to assist consumers to directly resolve issues; and made recommendations for systemic improvement arising from investigations. Inquiries instigated by the Joint Committee included conciliation and alternate dispute resolution approaches undertaken internationally (197-202) and in the early 2000s the HCCC led the national *Turning Wrongs Into Rights* project to improve complaint management. Problems with HCCC practices identified in Joint Committee oversight reports of the early 2000s relate to adequacy of the agency's powers and operational issues. The latter included significant delays; and concerns about the quality of investigations and education of investigators, expert reviewers and panel members.(199, 203) Two subsequent investigations and public inquiries had a substantive impact on the commission.

Reflecting approaches to safety and learning of the time, regulatory responses to harms (actual or potential) had regard to intent and whether system failures, error, incompetence or wrongdoing associated with neglect or wilful misconduct were involved. In NSW, the approach had been given effect by the Medical Board through a Performance Program implemented in 2000 focusing on remediation and support absent indications of unethical behaviour or deliberate misconduct.(204)

Views of accountability and appropriate remedies however were not uniform, reflected in the response to a 2003 HCCC investigation into clinical care in two NSW hospitals. The investigation followed patient complaints made over several years, media attention and subsequent 'whistle-blower' reports by nurses to the then Minister for Health. While finding serious patterns of inadequate treatment and care, the HCCC investigation focused on the hospital service as a whole.(205) The Commissioner was dismissed and a Special

²⁹ Under Pt II s5(4) *Medical Practitioners Act 1938* (NSW) only registered practitioners could be members.

³⁰ Sch 1 pt II s5(g) *Medical Practitioners' (Amendment) Act 1987* (NSW).

³¹ Ibid s32M(5)(c). However, this requirement did not extend to committees of the Board.

³² The Act introduced an extensive definition of unsatisfactory professional conduct; made arrangements for impaired practitioners and provided further protections for complainants. *The Nurses (Amendment) Act 1992* No 95 introduced similar provisions for impaired practitioners as its medical counterpart.

Commission of Inquiry established.³³ (206) The Inquiry report was highly critical of the HCCC for not investigating allegations as they pertained to individual professional conduct, commenting in the interim report on the perceived unfairness of the approach and in the final, accountability:

"The very notion that a public regulator such as the HCCC could prepare a report which substantiates ... allegations of inadequate care etc. on the part of identifiable doctors, without regarding those allegations as a complaint against that doctor is offensive to a sense of fairness."

New South Wales (2004) *Interim report of the Special Commission of Inquiry into Campbelltown and Camden Hospitals & Walker, Bret*, p.9

"I wonder if too much credence has been given, in the commendable reformist zeal of applying new approaches, to a spurious antinomy between improvement-oriented enquiry and individual accountability inquiry... the chimera of no-fault in health care should be banished."

New South Wales (2004) *Final report of the Special Commission of Inquiry into Campbelltown and Camden Hospitals & Walker, Bret*, p.88

The Inquiry was criticised both for its failure to not go far enough (207) and for adopting a retrograde and punitive approach.(208, 209) Hindle et al. suggest the distinction drawn is false and the Inquiry failed to adequately grasp the idea of a 'systems approach'.(169) If accurate however, the Inquiry was not alone in one respect, its report noting a senior Health executive observation that *"we need a whole new and special set of skills to be able to untangle what is a systems issue as opposed to an individual issue"*.³⁴(Ibid p.152)

In drawing its conclusions, the Inquiry recommended the HCCC focus on the investigation of serious complaints, working closely with but leaving leadership of quality improvement initiatives to other institutions such as the NSW Clinical Excellence Commission.(159, 210) The recommended directions were reflected in subsequent legislative reforms including changing the Objects for the HCCC³⁵; strengthening powers to obtain (compel) information; and creating within the agency an independent role of Director of Proceedings responsible for decisions to take disciplinary action. At the same time, and consistent with the Inquiry's

³³ In announcing the decision, the then NSW Premier advised *"The report does detail in great length instances of clinical failure, deficiencies in management systems, and the failure to ensure appropriate supervision, but for an investigation that took 13 months to compete, the HCCC simply doesn't go far enough in terms of finding anyone accountable for these failures."* Sydney Morning Herald, 11 December 2003, available at <http://www.smh.com.au/articles/2003/12/11/1071086182495.html>

³⁴ That the concept has cycled through various incarnations is reflected in a recent observation by Professor Reason that *"a just culture ... is neither excessively punitive as it was in the past, nor excessively liberal as it might have been in the recent past with the so-called blame-free culture."* Reason, J. (2016) *Error Models* PMCID: PMC1117770 (International Federation of Airworthiness)

³⁵ The Objects were changed to: "(1) The primary object of this Act is to establish the Health Care Complaints Commission as an independent body for the purposes of: (a) receiving and assessing complaints under this Act relating to health services and health service providers in New South Wales, and (b) investigating and assessing whether any such complaint is serious and if so, whether it should be prosecuted, and (c) prosecuting serious complaints, and (d) resolving or overseeing the resolution of complaints. (2) In exercising its functions under this Act, the Commission is to have as its primary object the protection of the health and safety of the public." In 2009, (2) was amended to: "...Act, the protection of the health and safety of the public must be the paramount consideration."

recommendation, the definition of '*unsatisfactory professional conduct*' was changed so that only significant departures of skill, judgement or care would result in disciplinary action.

Further substantial changes followed in 2008 consequent to reviews (176, 177, 211) undertaken into and critical of the handling of multiple and serious complaints.³⁶ *The Medical Practitioner Amendment Act 2008* introduced mandatory reporting requirements ('reportable misconduct') for medical practitioners; strengthened investigation powers and made provision for immediate action powers (suspension or conditions) to protect the public. Professional Standards Committees were required to be chaired by a legal practitioner, to be open to the public unless otherwise directed and make statements of decisions public.(212)

Notwithstanding criticism of how specific matters were handled, by the time the national scheme was proposed, consensus among the community, professions, regulators and Parliament was that the NSW model had served the community well and reforms over time had resulted in "*strong, accountable and transparent disciplinary and complaints systems*".(213, 214) Concern was expressed about the loss of independence and accountability with the profession-led model proposed under the national scheme as well as knowledge and experience built up over time.(214)

1.2.2 Other Australasian jurisdictions

The establishment of the NSW Unit was followed by statutory arrangements in Victoria (1988); Queensland (1991); the ACT (1994); Western Australia (WA, 1996); the Northern Territory (NT, 1998) and South Australia (SA, 2004). I refer to these complaint entities as commissions although titles vary. Similar arrangements were also made in New Zealand (NZ, 1994) although that country is distinguished by a universal 'no fault' financial compensation scheme for personal injuries established in the 1970s.³⁷ However, it shared a common feature with NSW and Queensland in being preceded by a profound breach of trust; involving experimentation (late or non-treatment) of women with carcinoma in situ without consent over a twenty year period.(215) The independent Office of the Health and Disability Commissioner subsequently established has wide-ranging powers (advocacy, mediation, investigation). Unlike Australia, NZ also established a statutory Code of Patient Rights and a network of patient advocates.³⁸

³⁶ This included Graeme Reeves, infamously dubbed 'the Butcher of Bega'; a former obstetrician and gynaecologist who was deregistered; issues including practice without registration; genital mutilation; and sexual and indecent assault of patients.

³⁷ Initially established by the *Accident Compensation Act 1972* (NZ); since replaced by the *Accident Compensation Act 2001*(NZ).

³⁸ The Code of Rights is a regulation under the *Health and Disability Commissioner Act 1994* (NZ). Paterson also makes the point the rights are not absolute, including a 'taken reasonable actions' defence- Paterson, R. (2006) *The Patients' Complaints System In New Zealand*. Health Affairs 21:3. A nationwide system of ethics committees also followed; as did the precursor to what is now the National Cervical Screening Program.

Some Australian jurisdictions carry dual roles, including community service (SA, NT), disability (WA) and human rights (ACT); which impact on their statutory focus and powers. Common legislative features include provisions for who may make and grounds for complaint and pathways for management, including conciliation.(216) Others include responsibility for monitoring and reporting on trends in and causes of complaints; and assisting to minimise these and respond more effectively. [A1.5] Most contain principles that reference patient rights and responsibilities and providers establishing and informing patients about complaint resolution mechanisms. [A1.5] However, unlike NSW, the remaining jurisdictions, led by Victoria, initially adopted more ‘conciliation’ based models with investigations referred to jurisdictional registration boards.

Queensland might have been expected to initially follow the NSW lead given similar health scandals. Long-standing complaints alleging abuse of patients and inappropriate treatment practices including excessive medication during the 1970s-1980s in a psychiatric unit at Townsville Hospital resulted in a Commission of Inquiry (‘the Carter Inquiry’); findings leading to reform of psychiatric services in that state.³⁹ Ameliorating effects for the model chosen include the establishment of the Commission as part of broader health system reforms which were grounded in “*quality assurance and peer review*”; and the ‘conciliation’ approach of the initial Director of the statutory office.(188) This model continued to be pursued on the basis that it was regarded as an accepted alternative to litigation; delivering financial compensation in over 20 percent of cases as at 2002. However, a separate scandal involving negligence and patient deaths resulted in another Commission of Inquiry (‘the Davies Inquiry’).(173) This was followed by the establishment of the Health Quality and Complaints Commission in 2006; with investigative powers akin to those in NSW.(217) Further substantial changes were made in Queensland and Victoria following the establishment of the national scheme, discussed in the following section.

The type of complaints made to the commissions are similar (216) and irrespective of investigational or prosecutorial functions, until the establishment of the national scheme the commissions worked closely with registration boards. In addition to process, the commissions faced common challenges and criticisms in their first years. This included insufficient resources relative to demand; limitation of powers; challenges in balancing individual complaints with service and system reviews; dissatisfaction in places with the lack of support for compensatory relief; and mixed perceptions on the appropriateness of informal resolution being used in lieu of formal corrective or disciplinary action.(155, 187, 188, 190, 191) Reviews

³⁹ Queensland Commission of Inquiry into the care and treatment of patients in the psychiatric unit of the Townsville General Hospital between 2nd March, 1975 and 20th February, 1988 & Carter, WJ (1991). *Report*. Queensland Government Printer

also pointed to variable confidence in arrangements expressed by consumers and professionals.

1.3 Establishment of the national scheme

In 2008 the Council of Australian Governments (COAG) signed an Intergovernmental Agreement (IGA) to implement the National Registration and Accreditation Scheme ('the national scheme') for health professions. While 'coming with the territory', complaint functions were not the primary driver. The direct antecedent occurred four years previously with the commissioning of a review from the Productivity Commission on the Australian health workforce ('the review'). The terms of reference were wide-ranging; addressing workforce needs, planning and supply and demand; including consideration of issues arising from regulatory or other factors in the health and educational sectors.(218-222)

Regulatory limitations identified by the review included inefficiencies associated with fragmentation, duplication and professional role rigidities; formal institutions including more than 20 bodies involved in accrediting workforce education and training and over 90 jurisdictional profession-based registration boards.⁴⁰(221) Reform recommendations included establishment of a single national registration board for (all) health professions; and a single national accreditation board with uniform national registration standards. The IGA delegated responsibility for managing implementation of the scheme to Health Ministers, including consultation on the details of the final legislative framework.⁴¹(223)

A series of consultation papers on specific dimensions of the proposed scheme were issued, including one on arrangements for handling complaints ('the consultation paper').(224) At the time of its release the proposed scheme had departed from a number of recommendations and included profession specific boards (219) Principles for the regime included that it provide a robust system to protect public safety. It would manage complaints through three pathways depending on whether they pertained to a practitioner's competence (performance stream), impairment (health stream) or behaviour (conduct stream). Consistent with developments in regulatory thinking, the scheme was to focus on prevention and early intervention; build on the best aspects of jurisdictional schemes; balance the rights and interests of consumers and health practitioners; and be compatible with nationally and internally accepted standards.

[A1.2]

⁴⁰ Previous reviews had pointed to workforce inefficiencies and regulatory fragmentation; and a range of initiatives to address workforce sustainability preceded the Productivity Commission report. These include establishment of the Australian Medical Workforce Advisory Committee in 1995 and the Australian Health Workforce Advisory Committee in 2000 relating to nursing, midwifery and allied health professionals which released over 40 reports prior to being disbanded in 2006 (<http://www.health.gov.au/internet/publications/publishing.nsf/Content/work-res-ruraud-toc~work-res-ruraud-lis~work-res-ruraud-lis-b~work-res-ruraud-lis-b-4>); and release of the first *National Health Workforce Strategic Framework* by the Australian Health Ministers' Conference in 2004.

⁴¹ A timeline of developments is at [A1.3].

Assumptions included that national profession Boards, largely through delegated committees, would be responsible for assessing, investigating and determining the most appropriate course of action for complaints. They would adjudicate most matters with the exception of serious conduct which would be heard by jurisdictional tribunals; with the resources of the national scheme responsible for prosecuting these cases. The tribunals would also review Board decisions. Resolution of matters through conciliation or similar means was not contemplated on the assumption these functions would be retained by jurisdictional commissions. The consultation paper outlined the intent of provisions and posed a series of options for comment.⁴² The following briefly summarises responses relevant to this study - focusing on issues and rights for those raising complaints; and provisions for community engagement and representation.⁴³

Consumers were highly critical of the proposed regime, perceived as retrograde for its grounding in a peer-review/self-regulation model; and for failing to adhere to its stated principle of balancing consumer and professional interests. Complainants were “invisible” while professions had a central role and powers without concurrent accountability mechanisms.(225-231) The paper was criticised further for a lack of evidence that the proposals were modelled on ‘best practice’ complaint handling or reflected experience gained through jurisdictional commissions; and its lack of clarity regarding the role, powers and decision-making influence of those bodies.(225-227, 229, 232) The commissions were uniformly opposed to the reintroduction of professions as ‘gatekeepers’; reiterating past failings of such models and dismissive of their characterisation in the consultation paper as simply ‘conciliation’ bodies.(233-239) The value of the NSW co-regulatory model was raised in submissions by NSW Boards (240-242) and others proposed using the jurisdictional commissions to initially assess complaints.

Consumers stressed the need for a model demonstrating engagement with and recognition of their role as partners and decision-makers; greater transparency and separation of powers (between accreditation and standard setting functions with those relating to the assessment and management of complaints); and inclusion of measures to ensure the process was accessible. This included a ‘one stop shop’ approach; plain English information; clear points of

⁴² This included definitions; nomenclature for complaints and concerns; who, in what form and relating to what matters they could be made, and whether a report should be required in some circumstances (‘mandatory notifications’); the processes and powers of relevant bodies to consider, make decisions and act; and the rights of those making and responding to complaints to provide or receive information, appear before bodies, be represented or appeal decisions. Over 100 submissions were made, including responses from consumer and community organisations, professional and indemnity bodies and those with a regulatory or complaint management role; the proportion of these groupings similar to those received in subsequent inquiries (A1.4).

⁴³ For simplicity, the term ‘consumer’ will be used in this section to refer to submissions by and interests of both consumer and community organisations.

contact; and a status tracking system. Emphasis was also given to the use of data collected to inform continuous improvement, education and practice requirements.(225-232, 243)

Submissions proposed that the Charter of Healthcare Rights should be recognised as part of the arrangements (225); and practitioner behaviour should be assessed against community values as well as professional standards.(226) Another submission proposed inclusion of community standards, criticising the definitions proposed for performance and conduct as too narrowly focused; and not clearly defining behaviour:

“understood by the community to be abhorrent, negligent or unacceptable. It is this community standard that needs to be included in the offered definitions of ‘unsatisfactory professional conduct’. It is out-dated for the professional standard to be the only reference for conduct that is unacceptable. Exclusive reference to peer standards, particularly in the area of economic exploitation, merely extends the luxury of self-regulation to the profession instead of reducing this emphasis.”

Health Consumers Council Western Australia (2008) *Submission*, p.4

Consumers were concerned perceived or unconscious bias would inhibit complaints.(225, 226, 229) Many emphasised the need for protections against adverse or retaliatory impacts, especially for vulnerable persons dependant on care (225, 226, 229, 243); complex or lengthy processes; and the potential for abuse of process through delaying tactics by practitioner representatives.(228) The consultation paper reasoned conflicts would be avoided by a total separation between commissioning boards and review/adjudication panels. This was rejected by consumers who argued the level of contact in the professional community generally and local nature of decision-making assumed by the model would enable a significant level of professional ‘influencing’ and ‘conflicts’ to occur.(226, 227)

The consultation paper proposed the use of the term ‘notification’ *“because it encompasses matters referred from a range of sources, not just clients or patients”*. Without exception consumer groups supported retention of ‘complaint’ on the grounds that it was a commonly understood term not confined to consumers and ‘notifier’ was alienating and unfamiliar; although some had no reservations about using multiple terms. In contrast, professional groups generally although not always favoured ‘notifier’.⁴⁴

The role contemplated for complainants in the consultation paper appeared passive; with only minimal information being made publicly available and advice to complainants confined to information on the public register. This was reinforced in a second paper released on information arrangements.⁴⁵ Consumers stressed the importance of having access to

⁴⁴ For example, the Dental Board of NSW responded: *“The essential process is a Complaint, whatever or whoever the party involved in the reporting of an event or concern. The investigation process is designed to resolve the Complaint and, historically, all parties on both sides have recognized the issue as a complaint. The Board sees no need, advantage or purpose in changing the terminology.”* Dental Board NSW (2008) *Submission* p1

⁴⁵ See Table A1.2: Practitioner Regulation Subcommittee on behalf of the Australian Health Ministers’ Advisory Council (December 2008) *Consultation Paper: Proposed arrangements for information sharing and privacy*

information (including being given reasons for decisions); review rights (including preliminary assessment decisions) and openness of procedures, including panel hearings. While the position of professional and regulatory respondents varied on these points, the tendency of submissions from these sources was to restrict information, consumer standing and openness of proceedings.(244)

Consumers might be present at panel hearings (if required by a board) and speak with the leave of the panel but would have no right to seek a review. Options proposed were for all panel hearings to be closed to the public; or alternatively, to close 'performance and health' matters with 'conduct' matters open unless the panel chose to close proceedings (all or in part). The most extensive consumer submission on this point argued that:

*"if the panels are to deal with serious allegations about competence and unsatisfactory conduct, then the panels should be open unless there are compelling reasons not to do so. Any exceptions to a panel being open should be set out in the enabling statute. The reasons for a panel's decision should also be made public. A recording of the proceedings of the panel should be made, and a transcript be made available to the parties."*⁴⁶

Public Interest Advocacy Centre (2008) *Maintaining Consumer Focus in Health Complaints: the key to national best practice*, p.11

In terms of adjudication bodies⁴⁷, consumers advanced the principle of consumer representation on all bodies, proposals ranging from a minimum of one or two persons to 50 percent representation, rejecting a proposition in the consultation paper that the consumer voice was adequately represented through the inclusion of a lawyer.(225-227, 245)

Following consultations, the Regulatory Impact Assessment for the national scheme outlined three options.(246) [A1.2] These were for a new national agency based on the NSW model; establishment of an Independent Public Interest Assessor to make determinations on how a case should be handled at assessment and after investigations, leaving investigation and prosecution functions with the boards; or use of jurisdiction commissions to help determine with the Boards how a matter should be handled, but again leaving investigation and prosecution functions with the boards. Selected and implemented (except in NSW) was the third 'pragmatic' option.(55)

While consumers had argued for a 'nothing about us without us' approach; most progressive features proposed were not included with the result that self-regulation was not displaced,

⁴⁶ It was suggested this approach would increase public confidence – "Complainants/notifiers would have a full picture as to how the issues that they raised were dealt with. It provides other health practitioners with clearer guidance with regard to standards and ethical issues." PIAC (2008) *Maintaining consumer focus in health complaints: the key to national best practice*.

⁴⁷ The paper proposed panels contain no members of a board or committee that referred the matter and be comprised of at least one registrant from the profession concerned; at least one who has never been a registered practitioner; with no more than half of members registrants from the profession concerned. Tribunals were to consist of three members, at least two from the profession concerned, and on the probability that it would be chaired by a legal member "community standards are likely to be reflected in the determinations." (s10.6)

even though it had been substantially modified by other regulatory developments. In addition to education, standard-setting and registration, health professionals maintained a central role in complaint assessment, management and adjudication.

1.4 The national and NSW schemes today

The statutory focus of the national and NSW schemes is public protection. Complaints may be voluntary or required ('mandatory') for practitioners and specific institutions in circumstances associated with risk to public health and safety. Neither scheme is designed to provide compensation for harms, which must be pursued through administrative or civil proceedings.

The national scheme is overseen by a Ministerial Council⁴⁸ and an Agency Management Committee; each health profession having a national board. The *Health Practitioner Regulation National Law Act 2009* (Qld) was adopted in each state, in NSW with substantial modifications related to complaints.⁴⁹ Boards are responsible for establishing requirements and standards for registration, qualification and continuing education and for managing complaints about students and practitioners. Boards investigate and have panel hearings in all but the most serious matters that may result in suspension or cancellation of registration. These are referred to tribunals; which also hear reviews or appeals of board decisions.

The national law provides the framework for consistency of process and decision-making, but it is a matter for boards and jurisdictions to determine what form these take. Day to day operations including complaint management is undertaken by AHPRA on behalf of the boards; all activities met through registrant fees.⁵⁰ Roles of and relationships between AHPRA and jurisdictional commissions are established through a Memorandum of Understanding.⁵¹

In NSW the *Health Practitioner Regulation Amendment Act 2010* (NSW) ('the national law NSW') enabled NSW to join the national registration and accreditation components of the scheme, but retain management of its independent complaint process. Under the new arrangements the (previous) NSW profession-specific Boards transitioned to statutory Councils (with functions similar to the national Boards) and are supported by the Health Professional Councils Authority (HPCA); an administrative unit under the *Health Administration Act 1982* (NSW). As in the national scheme, complaints are dealt with in three

⁴⁸ The Australian Health Workforce Ministerial Council (AHWMC)

⁴⁹ The Commonwealth government does not have constitutional power to enact the legislation directly.

⁵⁰ Under the national law Boards cannot employ staff. Staff employed by AHPRA undertake investigations and perform other functions for Boards such as maintaining the national register; the boards being the regulatory decision-makers.

⁵¹ Commissions are called health complaint entities or HCEs in the national law. Statutory obligations of registrants include undertaking continuing professional development, maintaining insurance and providing notice of certain events; which include being charged or convicted of certain offences; restriction or removal of privileges (practising, prescribing, billing); being subject of a complaint; or having conditions placed on registration, suspension or cancellation in a domestic or international jurisdiction.

streams (impairment, conduct and performance). However, while the definition of impairment is common to both schemes, different definitions apply in relation to conduct and performance.

Table 1: Summary of select legislative provisions of the national and NSW schemes

	NATIONAL LAW [1]	NSW [2]
Nomenclature	Notification	HPCA: Notification; interpreted as complaint HCCC: Complaint
Funding source	Profession funded (registrant fees)	HCCC: budget provided by the NSW Government HPCA: Regulatory portion of national registration fees from registrants practising in NSW and NSW Government
Objects	Provide for the protection of the public	Protection public health and safety paramount consideration
	Fees: have regard to efficient and effective operations; Practice restrictions: only to ensure safety and quality	Complaint component of fees to be separately identified [3]
Role	Profession Board receives, investigates & prosecutes (AHPRA acting for Boards)	HPCA or HCCC receives Independent body (HCCC) investigates section 23 matters and prosecutes [4]
	Must consult with health complaint entity (HCE) in each state <i>if</i> matter relevant to their role	HCCC must consult with profession Councils (HPCA) HCCC must refer to HPCA impairment and performance matters Most serious view of either body prevails
Definitions	Notification: Public at risk due to impairment; significant departure from professional standards; intoxication; sexual misconduct Voluntary: conduct, knowledge, skill or judgement of a lesser standard, impairment, contravened law, condition of registration Mandatory: alcohol, drugs, sexual misconduct, risk of substantial harm - impairment or significant departure from professional standards	Complaint HCCC: Professional conduct; impairment; lack of competence; criminal conviction; not suitable person to hold registration HPCA (National law NSW): criminal offence, unsatisfactory professional conduct or professional misconduct, not competent, impairment, otherwise not suitable
Limits to functions	Practice restrictions may be imposed only if necessary to ensure safety and quality	HCCC Director of Proceedings must take into account public protection; seriousness; likelihood of proving conduct; practitioner submissions
Assessment timing	Preliminary assessment within 60 days – whether within purview (registered practitioner, recognised ground), if relevant to HCE role	Assessment within 60 days – whether to accept and if so, how to manage (e.g. investigate, conciliate)
Engagement with complainant/notifier	X	Unless decline- must as part of assessment: Identify allegations and subject Confirm with complainant matters identified consistent with information they provided
Resolution Conciliation	X but can refer to HCE to exercise its resolution or conciliation functions	Resolution Conciliation
Information to complainant/notifier	Assessment – if NFA- reasons ‘as soon as practicable’ Investigation- update at least 3 monthly Investigation outcome – notifier- only what is available on public register	Assessment – notify decision or action within 14 days Investigation- update at least 3 monthly Investigation outcome – decision, action, reasons (HCCC only), may seek review
to employer	Notify if decide to take health, conduct or performance action	Notify of complaint (excl. complainant at risk; subject employment prejudiced); decision to investigate
Power to compel	May require information for health, performance assessment; only in investigation stage	May require information
Review	X	Must if requested (if Council- referred to HCCC)
Monitoring	Functions include monitoring conditions, undertakings, suspensions	Following performance review, monitor conditions, effectiveness of orders [2]
Public role	Provision for minimum representation on Boards and Board committees	HPCA: Provision for minimum representation on Boards and Board committees HCCC to consult on complaint process
Accountability and oversight of regulator	Agency Management Committee Australian Health Ministers Advisory Council National Health Practitioner Ombudsman and Privacy Commissioner	HCCC: NSW Minister for Health; NSW Joint Parliamentary Committee on the HCCC HPCA: Secretary, NSW Health HCCC + HPCA: NSW Ombudsman; NSW Privacy Commissioner; NSW Information Commissioner; Independent Commission Against Corruption

[1] *Health Practitioner Regulation National Law Act 2009* (Qld) as adopted in each jurisdiction

[2] *Health Care Complaints Act 1993* (NSW). *Health Practitioner Regulation National Law* (NSW) No 86a applied (with modifications) through the *Health Practitioner Regulation (Adoption of National Law) Act 2009* No. 86

[3] National Law NSW provision

[4] s23 includes complaints raising significant issues of public health or safety, appropriate care or treatment; or if substantiated would provide grounds for disciplinary action, or involves gross negligence or an offence under provisions of other legislation

The HCCC Act includes a Commissioner appointed by the Governor of NSW; a Director of Proceedings that is appointed by but exercises functions independent of the Commissioner; and a Registrar of a Health Conciliation Registry, staff of which are not subject to the Commissioner's direction or control when dealing with a referred matter. Reporting to the NSW Minister for Health, oversight is provided by the NSW Joint Parliamentary Committee. HCCC roles include assessing complaints; investigating complaints relating to professional conduct, a health service or other matters referred by a Council; assisting resolution, referral (to conciliation or elsewhere); and prosecuting complaints. This may be before Councils, professional standards committees of Councils and tribunals. It also has powers to make complaints in serious matters; add to, substitute, amend or delete complaint particulars and take action against non-registered practitioners. A Council does not have powers to investigate misconduct - this is done by the HCCC, but the HCCC must refer performance and health matters to the relevant Council.

The process under both schemes is similar. (Fig.2) On receipt, a complaint is assessed and consultation occurs on how it should be best managed; however, there are differences in law. In NSW the HCCC has 60 days to carry out an *assessment*, which is to determine whether a complaint is to be investigated, referred or declined. Unless declined, the assessment is to identify the specific allegations and best endeavours made to confirm with the complainant the relevant issues. In contrast, a national Board must undertake a *preliminary assessment* within 60 days to determine whether the notification is a recognised ground for notification and relates to a registered practitioner or student,⁵² although it can of course manage this more expeditiously. If it receives the complaint the HCCC is required to notify the relevant Council; and if the Council does, both the HCCC and relevant national board. They must consult; including consultation on any associated complaint, with the most serious view prevailing. Likewise, if it receives the matter, a national Board must notify the relevant jurisdictional commission but only if the matter is relevant to the latter's remit; whereas a commission must notify the Board if it relates to a registered practitioner. As in NSW, the most serious view prevails. However, while the HCCC has powers to require records or other materials during the assessment stage, these powers apply only after an investigation commences under the national scheme.

If the NSW decision is to not investigate or refer the complaint (to NSW Health, a Council or other body), the HCCC is required to provide both parties with reasons and advice that the complainant may seek a review of the decision; which the Commission must undertake if the request is made within 28 days. Similar information and review provisions apply following investigations, with opportunity for the practitioner to make submissions on any proposed

⁵² 'Practitioner' will be used for registered practitioner and student for convenience.

actions. No equivalent requirement to give reasons or provide a review to the complainant exists in the national scheme. (Box 1)

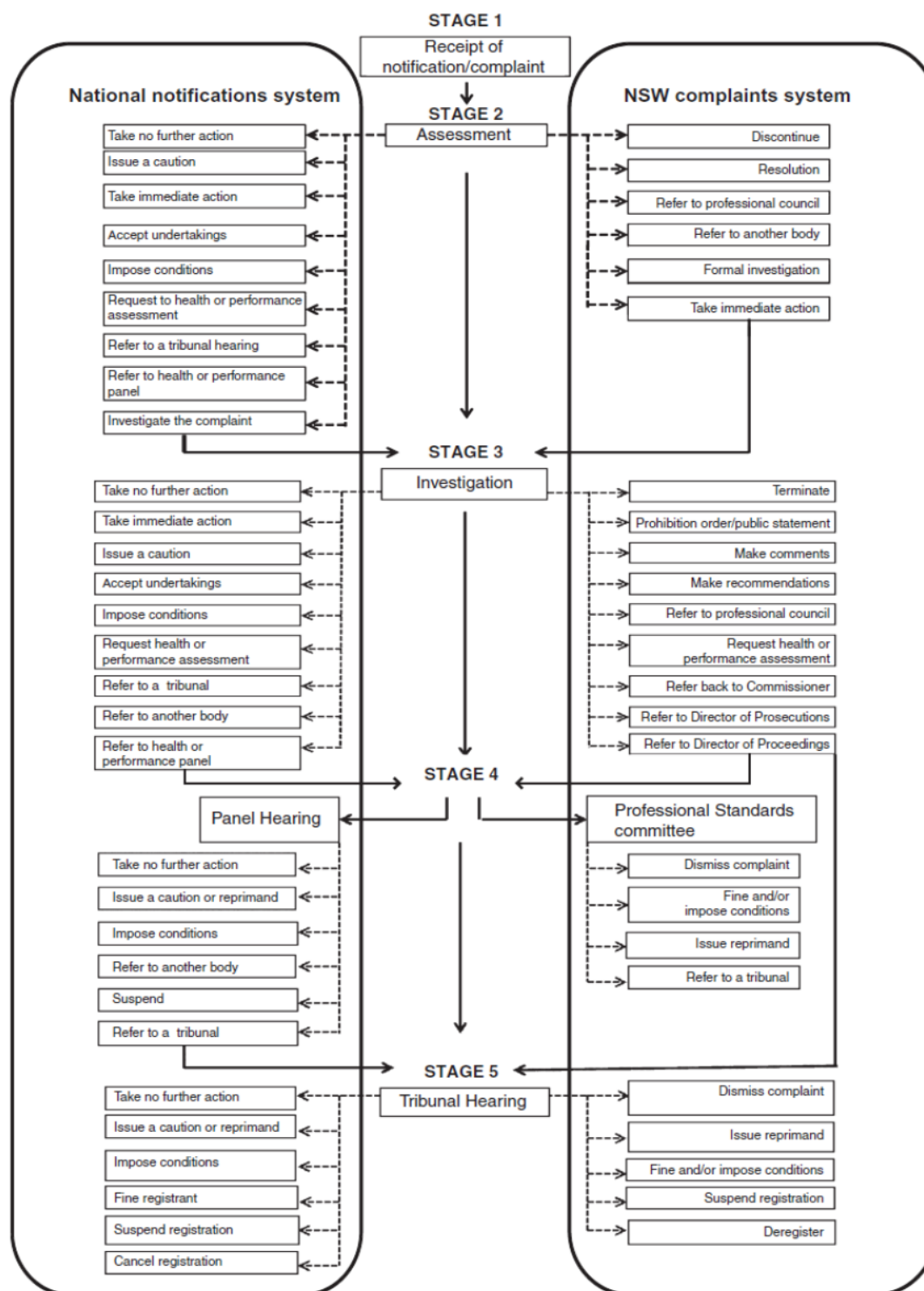


Figure 2: Decision-making entities involved in Stage 1 to Stage 5 of the complaint/notification process

Source: Satchell et al. (2015) *Approaches to management of complaints and notifications about health practitioners in Australia*, AHR doi. 10.1071/AH15050

In the most serious cases, there is power in both the national and NSW schemes to take immediate action to protect the public. Barring this action, decline or referral of the complaint, inquiries will proceed in both schemes having regard to the particulars made out; the relevant definitions that apply in each regime and which stream (health, performance, conduct) they are deemed most relevant to be managed in. At the completion of inquiries, a decision is made as to what, if any action will be taken by the responsible body. (Fig.2, Stages 4-5)

While similar, there is some variation in actions and powers available; and the HCCC must apply particular tests in determining whether to proceed with a prosecution, including likelihood of proving the alleged conduct. Provision is made in both systems for 'community' representation on inquiry and disciplinary processes.⁵³ This is in addition to representation on Councils and Boards proper. The proportion varies according to the type of body and profession. [A1.3]

Box 1: Information provision in the national and NSW schemes

Information in the national register includes the fact that a practitioner has been reprimanded; the fact (and if applicable, the timeframe) of a suspension; the fact and details of conditions or undertakings. However, a board may decide to not include these details if necessary to protect the practitioner's privacy and there is no overriding public interest for their inclusion; or the practitioner asks the board not to and the board reasonably believes inclusion would present a serious risk to the health or safety of the practitioner. A board may also remove notice of a reprimand when its continued inclusion is no longer necessary or appropriate.

From November 2015, legislative changes require councils to inform complainants of the outcome. Results of inquiries of a meeting of Council; actions arising from assessment decisions and other actions taken by a Council, its committees or panels in exercising complaint functions (including imposition of conditions) are to be notified.

However, Councils must not disclose confidential information unless the public interest in providing it outweighs the public interest in protecting the confidentiality of the information or privacy of affected individuals.

The November 2015, legislative amendments also require Councils to provide employers with information about the imposition, alteration or removal of conditions concerning health, conduct or performance, including details of conditions. However, information about conditions associated with impairment may only be provided to specific individuals nominated by employers for this purpose and used by employers for the purposes of supervision or to ensure patient safety only.

1.4.1 Reviews of the national scheme

This Study was undertaken at a time of ongoing review and improvement. Since 2010 there have been nine major government sponsored reviews of the national scheme as well as AHPRA-commissioned external reviews of its own practices. (Table 2) Reviews indicate the national scheme encountered similar start-up challenges experienced by the commissions, exacerbated by problems with transitioning registration arrangements that appear to have consumed it in the early years. Unsurprisingly, reviews also found the model itself poorly received by not only consumers but jurisdictional governments and agencies. Until its introduction, people using commissions experienced a direct relationship with complaint bodies; had information and review rights; and these bodies reported to jurisdictional Ministers. The following section discusses reviews preceding and in train during the course of this Study.

⁵³ These are selected from a panel appointed by a relevant Minister.

1.4.1.1 Early reviews of the national scheme

An Australian Senate inquiry undertaken in 2011 was primarily concerned with challenges and delays associated with transitioning registration arrangements for over 500,000 practitioners to the national system.(247) Other issues subject of recommendations (and raised in subsequent inquiries) included delays and lack of consistency in complaint management; lack of accountability to jurisdictions and professions; concerns about mandatory reporting; and that some complaints by other practitioners or family members were not made in good faith.

Table 2: Major Australian reviews relevant to the national scheme from 2010 – present

Year	Review [1]
2016 - 2017	<i>The complaints mechanism administered under the Health Practitioner Regulation National Law</i> Senate Community Affairs References Committee referred by the Australian Senate on 1/12/16; submissions close 24/2/17 (to draw on 2016 'medical complaint process' inquiry submissions); reporting date 10/5/17 Focus: implementation of the complaints mechanism, with a particular focus on medical complaints; adequacy of the regulatory framework; roles and relationships between regulatory, health complaint and professional organisations
2016	<i>Inquiry into the performance of the Health Ombudsman's functions pursuant to section 179 of the Health Ombudsman Act 2013</i> Queensland Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee Report No. 31 referred by the Committee on 27/6/16; report 16/12/16 Focus: operation of the complaint system under the Health Ombudsman Act; performance of National Boards, Agency Further work: factors adversely impacting on statutory timeframes (why not met); role of AHPRA and national Boards
2016	<i>The medical complaints process in Australia</i> Senate Community Affairs References Committee referred by the Australian Senate on 2/2/16; ceased (lapsed) on dissolution of Senate 9/5/16; readopted on 15/9/16; report 16/11/16 Focus: prevalence of bullying and harassment in the medical profession; barriers to practitioner reporting; operation of complaint process; potential of benchmarking complaints against practice outcomes particularly complication rates; potential of 'good faith' declarations as part of lodging complaints Recommendation 6: establishment of a new inquiry (elements reflected in the 1/12/16 complaints mechanism referral)
2015	<i>Independent review of the notifications systems and processes in the AHPRA Victorian office</i> KPMG report commissioned by AHPRA (report not publicly released) Focus: followed potentially preventable baby deaths in hospital; 28 month investigation by AHPRA into one practitioner Recommendations: improve risk assessment and management of high risk matters; assess delays in high risk, complex cases; improve transparency and communication; address culture and perception that 'pro practitioner'
2014	<i>Independent Review of the National Registration and Accreditation Scheme for health professions</i> 'Snowball' Report commissioned by the Australian Health Ministers' Advisory Council Focus: statutory three review of the national scheme (Inter Governmental Agreement cl 14) Response: COAG communique 14 August 2015, accepting most of the consumer-related recommendations
2014	<i>Setting Things Right Report</i> Victorian Health Service Commission, commissioned by AHPRA Focus: Improve consumer experience, address interface between AHPRA and the Victorian Health Service Commission Response: Action plan to improve customer service
2014	<i>Inquiry into the Performance of the Australian Health Practitioner Regulation Agency</i> Victorian Legislative Council Legal and Social Issues Legislation Committee Report No. 2 Recommendation 11-12: Victoria consider amending the National Law to become a co-regulatory jurisdiction for Part 8 (health, conduct and performance matters), having regard to regimes in place in NSW and Queensland
2012 - 2014	<i>Queensland Chesterman Report Recommendation 2 Review Panel Final Report</i> 'Forrester' Report following the Queensland Parliamentary Crime and Misconduct Committee A report on the Crime and Misconduct Commission's assessment of a public interest disclosure ('Chesterman' review) Findings: lack of timeliness, consistency and predictability of outcomes, management of matters that may constitute criminal misconduct by the Queensland Medical Board Response: Queensland Health Minister issues 'show cause' to Queensland Medical Board – majority resign; Health Ombudsman Act 2013 (Qld) - introduction of 'co-regulatory' model
2011	<i>The administration of health practitioner registration by the Australian Health Practitioner Regulation Agency</i> Australian Senate Finance and Public Administration References Committee Primary focus: registration functions Recommendations 5-7, 10: Review complaints processing to ensure more accurate reporting of notifications and reduce the impact of vexatious complaints; establish mechanisms to improve accountability to jurisdictions; establish consultative groups with professional organisations and providers (urgently); review mandatory notification requirements having regard to arrangements in Western Australia
2010	Commencement of National Scheme; NSW retains independent Commission – 'co-regulatory' model

[1] Excludes reviews of jurisdictional health complaint entities (commissions)

One year later, the Victorian Legal and Social Issues Legislation Committee was asked to inquire into the performance of AHPRA “including the cost effectiveness, the regulatory efficacy of and the ability of the National Scheme to protect the Victorian public.”(248)

Particular points of dissatisfaction highlighted in the report findings included loss of jurisdictional control of functions; a reduction in rights to information, review and appeal available under the previous regime; costs and issues articulated in the 2011 Commonwealth review outlined above. Recommendations 11-12 of the review report were for Victoria to consider amending the National Law to become a co-regulatory jurisdiction, and examine arrangements in NSW and Queensland to this effect.

In parallel developments, an independent review of a public interest disclosure in Queensland (249) had resulted in a further review about the management of complaints about medical practitioners in that state.(250) Findings included a lack of timeliness, consistency or predictability of outcomes; the report noting in part that:

“the decision-making processes taken by AHPRA and the [Medical] Board are much more lenient in relation to medical practitioners than other regulated practitioners.”

Forrester, K., Davies, E., Houston, J. (2013) *Final Report Chesterman Report Recommendation 2 Review Panel*, p.xxiii

Queensland subsequently moved to a co-regulatory jurisdiction for the management of complaints with the introduction of the *Health Ombudsman Act 2013* (Qld).

In response, AHPRA commissioned the Health Issues Centre Victoria to undertake a review of its practices from a consumer perspective including the interface between AHPRA and the Victorian Health Services Commissioner. The action plan (251, 252) that followed the report (253) included establishment of a community reference group; changes to processes to better engage with and communicate to complainants; and strategies to improve the timeliness and management of complaints.⁵⁴ A consultation on regulatory principles was also undertaken, with a revised framework released in 2014 emphasising the risk based approach adopted by the agency.(254)

1.4.1.2 Statutory review of the national scheme

The 2014 review of the national scheme was a commitment of the 2008 Inter-Governmental Agreement. Review activities included release of a consultation paper (255); a comparative analysis of international regulatory regimes (including England, New Zealand and Canada);

⁵⁴ A commitment to establishing reference groups for health profession associations, practitioners and the community appeared in the AHPRA *Annual Report 2010-11* (p. 18). A Professions Reference Group was subsequently established (AHPRA *Annual Report 2011-12*; p.62); a community engagement strategy with national briefings commenced in June 2012 (Ibid p.62) and a Community Reference Group was announced in May 2013 (AHPRA *Community Reference Group Established To Advise AHPRA and National Boards* media release 21 May 2013; AHPRA *Annual Report 2012-13*; p.8

and a review of the cost effectiveness and efficiency of the national scheme was commissioned.

Consumer concerns expressed in response to the 2014 consultation paper reflect those flagged at the time consultations were undertaken in relation to the establishment of the national scheme. These include a lack of confidence associated with the system's complexity and opacity, and lack of meaningful engagement with consumers.(256-259) Inadequate or lack of information given to those making complaints combined with a predominance of 'no further action' outcomes left consumers with *"the perception that the Scheme exists primarily to protect health practitioners rather than consumer or public safety."*(256)

Other deficits identified were confusion and lack of information about referral arrangements between the national and jurisdictional commissions and how systemic issues arising from complaints were managed, if at all. Submissions emphasised the need for integration of national and jurisdictional processes, with a single point of entry and 'no wrong door' approaches.⁵⁵(256-259)

The consultation paper specifically asked whether the Queensland co-regulatory model (all complaints managed by a single independent commissioner) should be adopted in all jurisdictions. Given the Queensland reforms were still relatively recent, some consumer submissions concluded it was too soon to be definitive, although it was supported in-principle (256, 259); others commenting on the need to clarify existing arrangements between AHPRA and commissions.(257, 258) All agreed that irrespective of the model or to whom a complaint is made (a provider, complaint or regulatory body at state or national level), a coordinated 'back end' of the system needed to be in place to manage referrals between relevant entities. This required clarity of roles; pathways to ensure matters were referred to appropriate entities; capacity to manage cross-jurisdiction and cross-profession issues; and application of consistent criteria. Legislated timeframes to ensure timeliness were suggested. Comment was made about the need for improved communication with consumers to manage expectations, including the type of matters that may attract regulatory action; what joint assessment of complaints entails; and factors influencing where matters are directed and how they are handled.

⁵⁵ Many of these core issues were not confined to consumers, a joint submission of jurisdictional Commissioners stating *"[we have] concerns about a lack of transparency in relation to Boards' decision-making, whether Boards are truly independent in making such decisions and whether there are sufficient checks and balances in the scheme for handling complaints about practitioners... A scheme that provides an enhanced role for Commissioners... would address a number of concerns... This might be achieved by establishing a sole independent complaints handling body by giving function to HCEs or developing an equal partnership with joint consideration between Boards and HCEs (ACT model) would provide additional confidence that Boards are not making decisions without input from an independent body"* Australia and New Zealand Health Complaint Commissioners (2014) *Submission* p.5-6

Improved transparency was a priority, including reforms to require Boards to provide progress updates and information about (and including reasons for) outcomes. Measures proposed to improve accountability were supported, including reconstituting AHWAC to provide an independent reporting mechanism on the scheme (subject to consumer representation); and introduction of and public reporting against specified performance measures.

In terms of participation, opening appointment of Board Chairs to consumers was supported. Interest was also expressed in accreditation authorities partnering with consumers in delivering education.⁵⁶ Continuing Professional Development (CPD) was singled out as particularly important in this regard:

“because once a person qualifies as a health practitioner, it is the only way of ensuring that they are keeping abreast of the field in which they are practising. If CPD is not being done, or only being done half-heartedly without a commitment to quality improvement and patient safety, there are strong arguments for periodic reassessment of skills and competencies to allow continuation of registration.”

Health Care Consumers ACT (2014) HCCA Submission for the Review of the National Registration and Accreditation Scheme for Health Professionals, p.12

These issues were reflected in recommendations from the final report.(260) [A1.4] However, while recommendations were made for improving communication and engagement, a core challenge identified in the report was not explicitly resolved:

“notifiers commonly see themselves as party to their case and expect to have an active and ongoing role in the resolution of it, whereas the system views them as a witness to an allegation of misconduct.”

Snowball, K. (2014) Independent Review of the National Registration and Accreditation Scheme for health professions Final report, p.28

In its Communique of August 2015 (261), the COAG Health Council announced acceptance of most of the consumer-related recommendations made; with further work undertaken on other proposals. [A1.4]

In the same period, and following significant adverse publicity associated with potentially avoidable deaths of babies in a Victorian health service, AHPRA commissioned a further review of its Victorian operations in 2015, which reiterated the need to improve transparency and communication⁵⁷; and *“to address perceptions of being pro-practitioner”*.(262) Changes in the Victorian Office of AHPRA in 2015-16 included the establishment of a notification liaison officer role and a commitment to initial risk assessment of notifications being undertaken by

⁵⁶ Other proposals supported by consumers included a requirement that suspended practitioners be required to reapply for re-instatement and registration. Mandatory reporting exemptions for practitioners receiving treatment attracted in-principle support; with the suggestion that a probationary period of exemption be considered before a report is triggered where treatment is provided. Concern was also expressed about cases of practitioners seeking care being the target of unsubstantiated or vexatious complaints; with a recommendation that such behaviour be subject of increased penalties

⁵⁷ This was subject of discussion at the Australian Health Workforce Ministerial Council meeting of 8 April 2016, the communique stating in part: Ministers agreed to ask AHMAC to consult with AHPRA *“and provide advice on options for reform, including options to strengthen system linkages, facilitate early detection of impaired or poorly performing practitioners, and minimise the risk of regulatory failure.”*

senior staff.(263) While remaining within the national scheme, substantial changes to the Victorian commission also followed, including legislative reforms that took effect in early 2017.⁵⁸ As in NSW and Queensland, the new legislative objects emphasised public interest and safety. [A1.5]

In subsequent developments, the *Health Practitioner Regulation National Law Amendment Bill 2017* (Stage 1 Amendment Bill) includes provision to appoint Chairs of national Boards on merit (i.e. non-practitioners may be appointed as Chairs) and provides Boards with discretion to provide further information to complainants.(264-266) It is intended that:

“AHPRA and National Boards will develop a common protocol to ensure appropriate information is disclosed to notifiers at appropriate times, while also taking into account privacy concerns of practitioners and patients”

COAG Health Council (2017) *Summary of the draft Health Practitioner Regulation National Law Amendment Law 2017*, p.8

1.4.2. Risk-based regulation and challenges

In Australia, the work of the Australian Health Practitioner Regulation Agency (AHPRA) is informed by eight regulatory principles as well as the legislation.(267) The principles include giving primary consideration to public protection (Principle 3) and a risk-based approach to standard setting, policy work and management of individual practitioners (Principle 5). Principle 5 commits the agency to identifying risk, assessing its likelihood and consequences and *“responding in ways that are proportionate and manage risks so we can adequately protect the public.”*(267) Principle 8 commits the agency to working with stakeholders which are stated as including the public and professional associations *“to achieve good and protective outcomes”*. The principle is explicit in separating the regulator from professionals *“We do not represent the health professions or health practitioners”* but is otherwise silent on the role of the public. In 2014 the agency established a risk based regulation unit to analyse and better utilise the data to direct regulatory efforts.(268)

While there are standard guides to undertaking risk assessment (269, 270), there is no agreed definition of risk-based regulation; described variously as a set of tools, methodologies and systematised decision-making frameworks to inform priorities, resource allocation and activities.(14, 271-273) Ideal characteristics proposed by Lloyd-Bostock and Hutter include a:

“commitment to a risk-based philosophy, belief in the anticipation and manageability of risk... a more holistic view of regulation and risk management in which public and private sources of regulation co-exist, [with] integrated approaches to regulating risks... and the formalization of regulation/risk management through the employment of technical risk-based tools emerging out of economics (cost – benefit approaches) and science (risk assessment techniques).”

Lloyd-Bostock, S.M. and Hutter, B.M. (2008) Risk-based approaches to regulating the medical profession, p.70

⁵⁸ The *Health Complaints Act 2016* (Vic) followed; a new Office of Health Complaints Commissioner taking effect from 1 February 17, with greater powers, including ‘own motion’ powers; making public warnings and power to prohibit practices. Other changes included expansion of who could make a complaint (previously confined to patients).

The growth of risk-based regulation is attributed to government interest in minimising intervention and the administrative burden of regulation, while improving regulatory outcomes.(273-275) Risk-based approaches and tools are seen as scientific, objective and transparent - useful for managing interest group conflicts when making policy choices.(275) In the context of health care scandals and increased third party scrutiny, the approach has the additional values of representing a shift from reacting to errors and problems to proactively identifying, preventing or minimising their impacts; and as a means of restoring public trust in medical regulators.(14) At the same time, the task is a complex one, highlighted by Black and Baldwin who point to the interplay of factors (people, institutions and strategies) that are in a state of constant change and interaction.(276)

The requirements for and limits of risk-based regulation are documented extensively, most particularly in relation to its dependence on (and costs of) quality data, especially when drawn from different sources and collected for different purposes; the ability to quantify information; the simplification of inherently complex problems or risks; and underlying assumptions.(14, 271-273, 277) The need to both manage and communicate assumptions and uncertainties underpin a range of good regulatory practice guides.⁵⁹ The challenge in applying the concept to medical regulation, included public acceptance of risk-based approaches was recognised in the UK:

“The bottom line is that lighter-touch regulation of medical practitioners would mean that some ongoing risks to patients would have to be tolerated by society”

Department of Health (2006) *Good doctors, safer patients*, p.178

Significant effort has gone into utilising complaints and other sources of data to better identify risk and towards addressing deficiencies in data infrastructure to better utilise what is provided.(168, 278-286) In addition to their predictive value, the very immediacy of complaints may prompt behavioural change in ways that generalised information cannot (272), potentially mitigating the need for additional actions.

However, use of complaints are not without their own difficulties and limits - what is reported may not reflect substantial risks, while the unreported or ‘near-misses’ may; the predictive value may vary; how things are reported may mask underlying and serious issues; the focus may be on an individual when broader organisational or systemic issues are more pertinent and vice-versa.(272, 287-289) As previously noted, the level of reporting of AEs is low and while there is no way of knowing precisely, estimates of unvoiced complaints about health care issues or concerns are substantial.(290) Finally, while the concept of ‘taking on’

⁵⁹ See for example the US White House Office of Management and Budget and Office of Science and Technology Policy Directive (OMB OSTP Memorandum M-07-24) (2007) *Principles for Risk Communication* in OECD (2010) *Improving the Governance of Risk* p.41

complaints as a source of information has gained purchase, less clear is the role of the individuals that bring them forward.

Sparrow suggests the central purpose of regulation is controlling harms to society; its craft in 'picking important problems, fixing them and telling people'; utilising a problem-specific and risk-based approach.(291-294) He argues effective regulation requires competencies as well as strategies - including having the expertise to understand, define and prioritise problems; and the capacity to effect change (directly or through collaboration) and to measure impacts.

Sparrow's concerns (295, 296) include a lack of appropriate metrics for assessing the efficacy and efficiency of regulatory performance; the uncritical adoption of private sector strategies (customer service, business process and quality improvement) without translating their relevance to 'risk control activities'; and insufficient attention being given to strategies he regards more relevant to regulatory tasks such as:

"the challenges of operational risk-control, behavior modification, compliance management, or the structuring of enforcement discretion around specific harm-reduction objectives."

Sparrow, M. *Crime Reduction Through a Regulatory Approach*, p.356

Missing in this strategic lens is how and if complaints and complainants 'fit'. The evolution of regulatory thinking in the UK is a case in point.

Right Touch Regulation was published in 2010 by the UK Council for Healthcare Regulatory Excellence (CHRE) and refined by its replacement, the Professional Standards Authority (PSA) meta-regulator. The approach is outcome focused, based on problem identification and the quantification and evaluation of risk.(297, 298) '*Right touch*' is the application of regulatory powers sufficient to have the desired effect and used only when necessary.(298) Core principles remain unchanged as have values of 'independent', 'fair', and 'proportionate'. However '*patient and public centred*' (CHRE) is now '*focused on public protection*' (PSA) and the stated aims have been repositioned away from a 'rights' or advocacy 'voice'.⁶⁰ These reflect changes in regulatory thinking and concerns; one responding to a stream of public inquiries and reports on the failure of services and regulatory institutions to respond to inadequate care, harms and complaints.(156, 157, 161, 163, 164, 178, 277, 299, 300) The other recognises that constant 'escalation' is unsustainable; there is a paucity of evidence for its efficacy; and it (inappropriately) shifts responsibility for managing issues and service improvement from those regulated to the regulator.(62, 297, 298) In *Rethinking Regulation*,

⁶⁰ See for example: "*CHRE aims to promote the health, safety and well-being of patients and other members of the public and to be a strong, independent voice for patients in the regulation of health professionals throughout the UK*". CHRE (2011) *Patient and public participation in health professional regulation*; compared with "*The interests of patients and service users are at the heart of all our work, and this is clearly set out in our legislation*" Professional Standards Authority (2015) *Right Touch Regulation*

the PSA proposes a substantial overhaul of both regulatory thinking and practice, and a dialogue with both regulated professions and the public about this.(62)

As part of addressing Objective 4, this study includes a reflection on the extent to which complainants believe Australian agencies have undertaken or effectively engaged and communicated their priorities and operations to them.

Summary of Chapter 1

This Chapter addressed Study Objective 1, describing developments in approaches to regulation and complaint management, and arrangements currently in place in Australia.

Principles of good complaint management include accessibility, fairness and responsiveness. Processes should be timely, transparent, with clear and informative communication with all parties involved. These are consistent with internationally-recognised good regulatory practice, which is predicated on clarity of objectives and role; good governance and leadership; policy and infrastructure to support remit; and stakeholder engagement to engender acceptance and confidence.

'Responsive' and *'risk-based'* regulation have become cornerstones of regulatory practice; with requirements and limits well-documented. Challenges remain, such as how to resolve competing principles (e.g. balancing access to information with confidentiality); and appropriately allocating individual and system-wide accountability for errors and harms.

The historical model of practitioner self-regulation has been substantially affected by developments in regulatory thinking, but not displaced. In addition to education, standard-setting and registration, health professionals maintain a central role in disciplinary action and the assessment, management and adjudication of complaints. These provide information about practitioners of concern; and can impact on registrant's practice entitlements.

Australian government-sponsored independent statutory commissions are rare. NSW (followed by Queensland) are further distinguished by the possession of investigative and prosecutorial powers exercised independently of, although in consultation with professional boards. Commissions' establishment followed international evidence about the scale and cost of healthcare harms; examples of egregious practitioner behaviour and a growing consumer rights movement. The latter gained purchase through its alignment with a quality and safety movement that identified patient involvement in care was associated with improved outcomes.

Commissions experienced common challenges - managing the volume of complaints; limitation of powers and variable expectations on their role and approach. This included mixed perceptions on the appropriateness of informal resolution being used in lieu of formal corrective or disciplinary action. Commissions have been routinely criticised by practitioners,

consumers and reviewers for being both too 'soft' and too 'hard'. NSW developments particularly highlighted tensions between serving individual and broader public interests; and some dissatisfaction with its lack of role in compensatory relief.

The introduction of the Australian national scheme (except for NSW) brought with it responsibility for managing complaints. While acting in the 'public interest', its statutory design keeps the public at arm's length unless essential to its purpose. It accepts and utilises complaints, but gives no formal recognition to the role of those bringing issues forward; and the scheme itself has no formally articulated role in their resolution.

Reviews indicate the national scheme encountered similar start-up challenges experienced by commissions, exacerbated by problems with transitioning registration arrangements. Reports suggest regulatory actions in both the national and NSW schemes remain predicated on a clinical understanding of harms to the dissatisfaction of consumers. A 'gap' remains between expectation and experience of 'open disclosure' and acknowledgement of harms.

Unless well integrated, managed and communicated, the environment for the introduction of the national scheme was susceptible to confusion and dissatisfaction. Reviews found the national model poorly received by not only consumers but jurisdictional governments. Until its introduction, people experienced a direct relationship with complaint bodies; had information and review rights; and these bodies reported to jurisdictional Ministers. Commissions to varying degrees retain a role in the assessment and resolution of complaints and communication of broader learning for purposes of education, standard-setting and improvement. The national scheme also followed the introduction of government policy directives giving formal recognition to the rights and responsibilities of patients and consumers, including recognition as a partner in care decisions; and the right to make complaints and have them addressed. These expectations are no doubt carried through to the national scheme.

The following Chapter discusses the literature on complaint management, with a particular focus on the expectations and experience of 'system users'.

Chapter 2. Literature review

An initial search framework was established [A2.1]⁶¹ to provide an overview of the field.

Testing revealed an extensive literature on regulatory systems and complaints management both generally and in relation to health systems, services and professionals. A complicating factor in undertaking searches was the cross-over with literature on health conditions ('complaints'), their diagnosis and management. A schematic of identified domains from the initial search was established [A2.2] to support refined searches and manage results.

Searches of literature in English were then undertaken using Medline, Embase, Ovid and Web of Knowledge using the following key words and phrases as search terms, including combinations, synonyms and truncations of words and phrases: complaint, grievance; complaint process, handling, management, system; patient, complainant, health consumer, rights, expectations, experience, satisfaction, empowerment; health professional, provider, doctor, medical practitioner, nurse, midwife, dentist, dental practitioner, pharmacist, psychologist; error, accountability, competence, impairment, discipline; regulation, regulatory theory, practice, strategy. References and citation lists were checked and additional sources were identified. Secondary searches were undertaken using the following key words or derivations: apology, adverse events and open disclosure.

Annual reports of the Australian Health Practitioner Regulation Agency (AHPRA), the NSW Health Care Complaints Commission (HCCC) and the NSW Health Professional Councils Authority (HPCA) from 2010 were reviewed, as were reports from the NSW Parliamentary Committee on the Health Care Complaints Commission and the National Health Practitioner Ombudsman and Privacy Commissioner.⁶² Previous literature reviews, discussion papers, reports and submissions to major reviews undertaken during the course of the project were also sourced.

Studies on the type, frequency, location or profession subject of complaint; the value for or mechanisms to use complaints for quality and safety were noted but not included; the search focus being on complainants' perceptions and experiences.

Studies from the early 1990s sought to reconcile non-legal complaint mechanisms designed to be accessible and responsive and evidence of dissatisfaction with them. This occurred even where a complaint was found proved.⁽³⁰¹⁾ These studies foci included better understanding of the factors known to influence whether or not a complaint or claim is made; the accessibility of processes relative to demographic, geographic or socioeconomic factors; expectations of

⁶¹ Additional tables contained in the appendices appear in brackets e.g. [A2.1] is Appendix 2, Table 1.

⁶² 2010 was selected as the 'base' year on the grounds that the national scheme started in that year.

the process and association of complaints with errors or medico-legal action. Explanatory theories tested to explain expressed dissatisfaction included knowledge or expectation gaps i.e. lack of congruence between outcomes sought and the remit or powers of the bodies involved; and concepts of justice. The nature of complaining has also been scrutinised, including assumptions that attribution of blame is inevitable.(4)

Others studies expressed different concerns – that assisting individuals via an informal process may mask more substantive systemic or policy issues; particularly absent formal feedback or public accountability mechanisms.(302-304) This was the case if mechanisms were not well organised, resourced and empowered. While theoretically designed to empower consumers, complaint mechanisms paradoxically could serve to further empower professions instead. Even with a legislative base, these processes do not necessarily challenge the fundamentals of self-regulation and information emerging cannot be used for further action.(302, 305)

The primary focus of this literature review is the experience of complainants. Methods used in studies identified included one or more of the following: telephone and written surveys; structured and semi-structured interviews; focus groups; review of letters or claims; and retrospective data analyses. The scale ranged from less than 20 to hundreds of participants. Studies encompassed complaints to service providers, complaint and regulatory agencies and (compensatory) claims to providers and insurers.

Typically, multiple factors were involved in generating a complaint or claim. [A2.3] Seldom were clinical issues alone at issue; most common prompts including clinical issues or treatment associated with a poor (insensitive) response and/or poor communication.(287, 302, 306, 307) Where recorded the nature of emotions associated with events giving rise to the complaint were similar, including anger; shock or distress; betrayal and humiliation.(287, 306, 308)

Complainants usually sought more than one outcome.(301, 306, 308-313) Preventing recurrence of the events or circumstances giving rise to the complaint was the most common, followed by desire for an explanation or apology.(306, 309, 311) Studies indicate up to 90 percent of complainants wanted to prevent recurrence.(301, 306, 309, 310) A moral dimension; the complaint being '*the right thing to do*' or a '*duty*' was frequently ranked.(301, 308)

Given the significance attached to preventing recurrence, it is unsurprising that communication of change or a commitment to change was associated with greater satisfaction.(287, 310) Raising awareness also featured, but the meaning or intent of this varied; including making a practitioner aware of what they had done; making a broader array of staff aware of what

occurred and the impact on the patient; and making more senior staff or 'authorities' aware of events, their seriousness or impacts.(301, 306, 309) Sanctions or disciplinary action were included in the suite of outcomes sought, although in most cases this was significantly lower than other factors.(306, 309, 311, 312) A notable exception is the study by Daniel et al. in NSW, which found complainants wanted 'stern action'; findings including 43 percent being satisfied in cases of disciplinary action versus six percent involving no further action.(308) When sought, compensation was relatively minor compared with other factors; even in cases of medico-legal claims.(306, 308, 309, 311-313)

Comparing complaint and medico-legal claims in the 'two path' New Zealand system, Bismark et al. identified four categories of accountability sought by claimants- communication (including explanation and apology); correction (systemic or individual to prevent recurrence); restoration (compensation, intervention); sanction (discipline or punish).(311) Those lodging complaints placed a greater emphasis on communication and corrective action. Those seeking compensation were cost related (income loss; disability); deaths more associated with complaints than claims. The authors point to problems associated with systems designed with 'either-or' pathways, concluding sole 'claims' systems won't address non-monetary concerns, while sole complaint mechanisms won't address financial issues.

2.1 Responses, explanation and apology

Recurring themes are complainants want to be listened to, acknowledged and believed.(287, 307, 309) Yet complainants report feeling 'fobbed off'; not being taken seriously or receiving 'defensive' responses when raising their concerns.(287, 309, 314)

Lloyd-Bostock and Mulcahy found 41 percent of complainant letters about hospital care received an unsatisfactory explanation.(287) Bark et al. found 41 percent of respondents received an explanation; but only 43 percent of these fully understood the information, while 34 percent said they had no opportunity to ask questions.(306) The majority felt the explanation did not deal with the issue (59%), one-third that excuses were made and one-fifth that the explanation was vague or inadequate.(306) While nearly one-quarter received an explanation within days, Vincent et al. found 40 percent of respondents taking legal action never received any explanation for events.(309) Where provided, less than 40 percent felt this was done sympathetically; less than one-quarter were satisfied with its clarity, and a similar proportion with its accuracy.

Lloyd-Bostock and Mulcahy analysed letters of complaint to hospitals and responses received. Common features identified in letters were complainants making a case for the issues they raised being '*complaint worthy*'; and communicating that they were not '*customary*

complainants'. Proposing an 'account model' for the interaction, the authors found complainants were calling the hospital to respond or 'account' for itself and staff.(287) Hospital responses were judged to be defensive and mostly challenging these accounts; correcting (17%) or casting doubt (15%) on the contents. Where accepted as accurate, issues were deemed not '*complaint worthy*' (18%). While nearly two-thirds of responses contained some expression of regret, the authors found many did not meet the criteria of adequacy proposed by Goffman in assessing whether responses amounted to an apology or 'pseudo-apology'. These criteria include acknowledgement (something blameworthy has occurred); sympathy (with censure of others) and evidence of repentance (amends made, commitment to improve in the future).⁶³ The findings challenge assumptions about complaints solely being about 'redress'; and neat divisions between 'process' and 'outcome' insofar as a critical component of satisfaction with the response received related to being "*understood, believed and taken seriously.*"(Ibid, p.143) The authors further conclude that health service scepticism about non-material outcomes sought (apology, explanation, prevent recurrence) are both unfounded and may be counterproductive.

Daniel et al. found respondents were more likely to take legal action when clinical issues were involved.(308) Vincent et al. found nearly half the people making medico-legal claims had an independent expert report suggesting negligence and over 70 percent were severely affected by events.(309) Yet 43 percent of people taking legal action indicated they did so because of the attitude of staff post-event; and litigation could have been avoided by an explanation (41%), an apology (37%), correcting the error (25%) or compensation (19%). The conclusions synthesise critical issues identified in a range of studies about what complainants seek and experience:

"Communication assumes a special importance when things have gone wrong. Patients often blame doctors not so much for the original mistakes, as for a lack of openness or willingness to explain. A valued feature of the civil system.... [is] their case is reviewed by an independent expert ... Unlike the complaints procedures, the patient sees the clinical report, has access to the notes, and may be able to discuss their case with the expert. Many patients, after reading such reports, experience a feeling of relief that their suspicions were confirmed and that they were not wrong to persist in their complaints... where they have misunderstood ... an independent expert may be able to clarify matters for them... it is unfortunate that such independent experts cannot be brought in at an earlier stage, perhaps without incurring the emotional and financial costs (for both sides) associated with litigation."

Vincent, C., Young, M. and Phillips, A. (1994) *Why do people sue doctors? A study of patients and relatives taking legal action*, p.1613

⁶³ Goffman, E. (1971) *Relations in Public: Microstudies of the Public Order* in Lloyd-Bostock, S. and Mulcahy, L. (1994) *The Social Psychology of Making and Responding to Hospital Complaints: An Account Model of Complaint Processes*. Law & Policy Vol.16:2; p.139

As discussed in Chapter 1, despite literature on the accepted value of complaints for providing understanding and resolution, for identifying standards or competence issues and preventing recurrence; there exists a persisting gap between Codes and guidelines for apologies and open disclosure and what occurs in practice.

Comparing expectations of the general public (PB) with physicians (DR), Friele et al. found agreement between the respondent groups on the view that few practitioners are open when things go wrong (PB 5%: DR 25%). All other measures showed a significant disparity, including expectations that clinicians should be proactively checking whether things were going well or if patients had any complaints (PB 90%: DR 63%). Similar disparities were identified in terms of whether it was clear where complaints could be made (PB 41%: DR 71%); whether complaints were taken seriously (PB 37%: DR 89%); perceived fairness (PB 39%: DR 87%) and impartiality (PB 24%: DR 77%). Sixty percent of the public believed doctors “*cover each other’s back*” when things go wrong compared with 13 percent of doctors. Reflecting on the findings the authors’ note preconceptions about how a complaint will be managed may substantively inform the experience, and may be difficult to change.

Interviewing patients with cancer who believed that a preventable harm or wrong involving a breakdown in care or communication, Mazor et al. found apologies and genuine expressions of remorse were valued as were acknowledgement of responsibility and efforts to avoid recurrence and the importance of actions being congruent with the words of apology.(315) For some, these were more important than explanations. However, the study also identified key components (acknowledgement, expressed remorse etc.) were frequently missing.

2.2 Process and outcome expectations

Research shows people are more willing to accept decisions they believe were made through a fair decision-making process; and fairness can be more important than outcomes.

Dimensions relevant to procedural fairness include opportunity to participate; neutrality (impartiality) and trustworthiness of authorities; and whether people are treated with dignity and respect.(316)

Examining hospital complaints in the Netherlands, Friele and Sluijs (301) found complainants expected timeliness (44%), an opportunity to tell their story (52%) and the process being explained to them (59%). Procedural expectations of over three-quarters of participants included an investigation; adjudication of the complaints’ validity, being provided with reasons and for change to occur. A similar proportion expected complaint committees to be impartial and respectful; the hospital to raise issues and take corrective action and professionals to admit their errors. In a follow-up study at the completion of the process, dimensions of

expected fairness corresponding to justice theory were explored, relating to fair process (procedural justice); fairness in communication (interactional justice) and fair outcome (distributive justice).(310)

Friele et al. found less than one-third felt they received justice.(310) Four factors were identified as influential - whether the complaint was determined to be well-founded; and satisfaction with the conduct of the committee, the hospital and the practitioner involved. Sixty percent perceived the process as '*just*' if their complaint was substantiated ("*well-founded*"); 36 percent if '*partially*' substantiated and 21 percent in '*no grounds*' determinations. The most important factors for satisfaction with the committee were impartiality and recommendations for change. Dissatisfaction was associated with professionals (doctors) not admitting errors; and lack of information from hospitals on corrective measures taken. The authors identified significant 'gaps' between what the complainant sought and ranked important; and the outcome. This included being informed of change (94% ranked important: 53% *not* achieved); being given an explanation (83% ranked important: 42% *not* provided); and having errors disclosed (89% ranked important: 21% *received*). The authors speculate the 'disclosure gap' may relate to hospital/practitioner fear of liability. The study found it is often '*how*' rather than '*what*' is communicated that is most significant to complainants; and per other studies, the extent to which efforts are made to seriously make amends and to fully utilise available remedies to improve the situation.

In Sweden Skalen et al. found nearly three-quarters (72%) of complainants were dissatisfied with practitioner statements made to a hospital committee about their matter; one-quarter because the practitioner did not tell the truth and a similar proportion because the practitioner gave insufficient information. Conversely presence of two or more of the following was statistically significant for satisfaction: a mistake acknowledged or expression of regret made; and internal problems or intended changes were communicated.

Bismark et al. also examined the 'expectation gap' in a sample of consent related complaints made to the Health Complaints Commissioner (Victoria).(317) Categorisation of outcomes sought was replicated from previous New Zealand studies, being communication, correction, restoration and sanction. As the matters were conciliated it was unsurprising that most communication needs were met (94%). However the authors found less than one-third seeking restoration received it; less than one-fifth assurance of corrective action and less than one-tenth sanctions. The authors note that while the Commission possesses a range of powers, these may not be commensurate with what is sought; pointing to the need to better understand and manage complainant expectations.

The Victorian Commission subsequently surveyed complainants following an identified outcome 'satisfaction gap' between complainants (58%) and health providers (90%).⁽³¹³⁾ Complaints 'escalated' to the Commission due to providers not taking responsibility for events or admitting mistakes; and ignoring or not taking seriously complaints made. Complainants wanted system or practice changes to avoid recurrence (44%); an apology (21%) or compensation (19%). The majority (86%) had realistic expectations of the Commission; but high levels of dissatisfaction (65%) or ambivalence (22%) with the outcome, with 42 percent dissatisfied with both outcome and process; and 70 percent regarding the process as unfair. The authors speculate poor understanding of reasons for decisions may contribute to dissatisfaction; identifying 'gaps' between complainant reports for closure (told couldn't be assisted, were referred elsewhere or 'gave up') and Commission records for declining matters ('not warrant investigation'; 'insufficient detail'; 'reasonable steps not taken'); and for any changes achieved (44% sought; 7% achieved). Views were divided on the process (51% negative) but 66 percent indicated they would recommend the Commission, either because of a positive experience or in-principle for the importance of its availability. Identified areas for improvement included improved quality and frequency of communication; explanations; timeliness and increased powers to act in the public interest.⁶⁴

In addition to the reviews commissioned by AHPRA into its processes (discussed in Chapter 1), three studies of complainant experience of regulatory agencies in the Netherlands and the UK were identified.

A study of complaints to the Dutch Health Inspectorate (DHI)⁶⁵ pursued the themes of procedural, distributive and interactional justice that informed prior studies (310), adjusted for the regulator's role. Comparing complaints that were accepted or declined for investigation by the DHI, the study found respondents had a strong sense of duty to raise issues; a desire to contribute to improvement and saw themselves as a stakeholder in the process.⁽⁸³⁾ As in other studies, what respondents deemed serious and important was broader than (the clinical) criteria used by regulators; and related to issues other than personal physical harms.

The authors in the DHI study identified the following three aims sought by complainants, in order of importance. These were broader benefit for care quality (prevent recurrence, safety, quality); personal benefit (justice, resolution, prevent recurrence); and consequences for providers. Less rigorous measures (e.g. a 'hard hitting conversation') were more favoured

⁶⁴ As noted in Chapter 1, in 2017 the *Health Complaints Act 2016* (Vic) took effect, providing the Commission with additional investigative and resolution powers.

⁶⁵ In the Netherlands, the *Quality Act 1996* (NTH) vests primary responsibility for complaint management with providers. The DHI, part of the Ministry of Health, Welfare and Sport is responsible for monitoring compliance. Complaints may be made directly to the DHI, but these are used for risk purposes not resolution, those not accepted being referred elsewhere. Criteria for acceptance and investigation include severe deviation from standards; severe harm to health, high probability of recurrence and absence or failure of quality systems at institutions. The DHI may ask the provider to first investigate, or commence its own investigation.

than 'sterner' measures (e.g. punishment or being stopped from practising). Personal benefits and consequences for practitioners were slightly less important in complaints to the regulator compared with complaints to hospitals.

Those whose complaints were accepted (27%) felt their aims were achieved more than those whose complaints were not; however, only half felt the desired broader benefits were achieved; and less than 40 percent that the other two aims were (personal benefit and consequences for the provider). Less than 20 percent of complainants whose matter had not been accepted felt their aims were achieved. However, the majority of complainants, whether their complaints were investigated or not felt they had achieved their aim of '*doing their duty*' by making the complaint. The authors conclude better reporting on the regulatory value of complaints (at an aggregate level); attention to issues beyond clinical standards; and more flexible and strategic responses would be helpful.⁶⁶

The UK General Medical Council (GMC)⁶⁷ commissioned a study of people who had made a complaint that was accepted.(318) Interviews found reasons for complaints included seeking justice following injury or a death; to gain answers to outstanding questions about an issue or incident; and to protect other patients. Making a complaint was not taken lightly; some participants having approached other bodies first including the hospital, Trust, Ombudsman or a lawyer. Most had expected the GMC to be independent, fair and impartial; some expressing doubts of impartiality from the outset, others following their experience. The authors found a lack of understanding of the role or remit of the GMC; concluding many initial expectations were therefore unlikely to be met through the process. Views on the process were mixed; identified areas for improvement being timeliness; support through a complex process; improving poor, insensitive or jargon-laden communication; and providing reasons for decisions.

A separate evaluation was undertaken of a pilot project involving meetings with patients whose complaint was investigated by the GMC.(319) Complainants regarded the meetings helpful; feeling 'listened to' and their complaint taken seriously. While most reported having an understanding about the GMC's role and purpose, when discussed, they mainly referred to processes rather than the 'role' per se. Complainants regularly reported a lack of understanding about how decisions were reached or why they were prevented from receiving reports arising from the process.

Deliberative workshops commissioned by the UK meta-regulator, the Professional Standards Authority also found most participants assumed professionals are supervised; and only those

⁶⁶ The authors also propose consideration be given to a 'no fault' insurance scheme as operating in NZ.

⁶⁷ In the UK the GMC is responsible for setting standards for medical practitioners and investigating more serious complaints through the *Fitness to Practice* (FTP) process; which may relate to behaviour, health or performance.

aged 31-55 had a good understanding of how regulation works, although this group also showed knowledge gaps.(320) Discussion of regulatory complexities stimulated interest in more information on the subject. The potential to use patients as '*experts by experience*' in regulatory processes was well received by workshop participants.

2.3 Who doesn't complain and why

Studies show the general population do not complain even in the presence of grievances, with vulnerable populations under-represented including people with disabilities, older people, minority populations and people from low socio-economic backgrounds; suggesting specific efforts are needed to hear from these populations.(321) As found in major inquiries, absent, uncoordinated and unpublicised complaint processes combined with a lack of leadership or support impact on their use and perceived efficacy.(307, 322, 323)

Surveying the Swedish general public, Wessel found while nearly three percent of the population had made a complaint, 19 percent with cause did not pursue a complaint on the grounds that they lacked the strength (to deal with the process), didn't know how and/or believed it would make no difference.(290) Kent also found while institutions have been established to manage complaints, all but three percent are dismissed.(324) The process is perceived as biased and patients report:

"their complaints provoked collegiality among their care providers, including leaders, who rallied around the reported colleague rather than objectively examining the complaint's merits... [and] the patient who complains also risks debarment from care."
Kent, A. (2007) *Dismissing the disgruntled: Swedish patient complaints management*, p.492

In national phone surveys comparing people under 65 with those over 65, Doron et al. found only 23 percent of the Israeli population with cause to complain did so, with a higher rate of non-complaining by older people (76%) compared with those under age 65 (66%).(325) Those aged 75 and over and having below average income were 2.5 times less likely to complain than people aged less than 65. Reasons given for not complaining included lack of motivation or time; low expectations of getting a response; not knowing how or being unaccustomed to complaining; and ill health. In a separate study in Israel Gal and Doran found 25 percent of health service users had cause to complain but only nine percent did so. Three-quarters of complaints were made locally and informally; with only 17 percent being made to the official complaint bodies.(326) Rates were similar for age, gender and education but immigrants and minorities were less likely to complain - people living in Arab residential areas were half as likely, and those living in Jewish areas up to four times more likely to make a complaint. Davis and Vincent found surgical patients, particularly less educated or unemployed males were less willing to challenge healthcare staff regarding their care.(327)

In Australia, Anderson et al. found congruence between the demographics of older people and representation in the proportion of hospital complaints; however, three-quarters were made by someone else on their behalf. A second analysis also showed a high proportion of complaints made by advocates.(328) In New Zealand, Bismark et al. found older people, people of Pacific origin and people from lower socio-economic backgrounds were less likely to complain.(311) In Taiwan Wu found urban living to be the only independent factor for both making a complaint and taking legal action, speculating urban living may be associated with higher socio-economic status.(329) Jones et al. found rural and low socio-economic residents in Victoria under-represented in complaints; associated with a lack of knowledge about and scepticism of the efficacy of process.(314) Nearly half felt they had cause but did not complain thinking it futile; with 27 percent concerned about repercussions. Other reasons were they did not know how (15%) or it was too hard or time-consuming (7%). Of those who had made complaints 58 percent indicated it had no effect.

Gal et al. expected that people with disabilities would show a higher rate of complaint congruent with a higher level of service use.(330) However, only one-third of people with a grievance were found to complain, the rate only slightly higher for people with a disability. Of those who had, three-quarters had a physical disability, and nine percent a mental impairment. The majority of complaints were submitted locally or informally. In Finland, Valimaki et al. found that while the rights of psychiatric patients to complain about care are embedded in law and policy, process complexity, combined with lack of information, power imbalances and cognitive impairments inhibit exercise of these rights.(331)

Summary of Chapter 2

Studies from the early 1990s sought to reconcile non-legal complaint mechanisms designed to be accessible and responsive; and evidence of dissatisfaction with them.

Complainants typically sought more than one outcome and saw raising their concerns as a moral obligation. Preventing recurrence, followed by desire for an explanation or apology dominated reasons given for making complaints. Seldom were clinical issues alone at issue; most common prompts including clinical issues or treatment associated with a poor (insensitive) response and/or poor communication. The poor quality of responses by health providers contributed to complaint escalation and medico-legal claims that might otherwise have been avoided. A 'gap' remains between official directions for open disclosure and complainants' experience.

While some wanted 'stern' action from the complaint process, most commonly people sought acknowledgement, an apology and information about changes made. Studies indicate that to

a large extent this does not occur; or in a way that is not understood or acceptable to the complainant.

'Thin' responses experienced in the complaint process appear to reinforce dissatisfaction associated with the original events and provider responses. The literature points to under-representation of more vulnerable populations in complaint processes.

The literature informed the methodology and tools selected for this study, discussed in the next chapter.

Chapter 3. Methodology

Multiple methods were used to address Objectives 2-4; being to understand and explain perceptions of the complaint process from the perspective of 'system users' who have reported concerns; to compare and contrast responses between systems and professions; and to identify factors that underpin these perceptions to inform future regulatory practice.

An historical concern of methodological pluralism is the need to locate an epistemological position to inform both methodology and methods.(332, 333) Quantitative (numerical based) research is located in a positivist epistemology; social reality conceptualised as objective and externally 'knowable'; and historically associated with deductive reasoning or 'theory testing'. The stated advantages include reliability, reproducibility and potential for scale.(334, 335) Qualitative (text based) methods are grounded in inductive reasoning or 'theory generating'; are concerned with understanding social reality as created and interpreted; advantages including depth, nuance, detail and researcher reflexivity.(333, 336)

This study uses methods associated within a positivist epistemology; and draws on developments in pragmatism (337-339) but is located in an interpretivist position; one concerned with the socially constructed nature of knowledge and the importance of understanding individual actions and perspectives in context.(333, 335, 340, 341)

Interpretative phenomenological analysis is relevant insofar as the study focuses on the lived experience and 'sense making' of the individuals involved. However, the primary focus of this study is on the explanatory value of individual accounts at a higher systems level rather than psychosocial processes.(342-345)

3.1 Grounded theory

Qualitative analysis was undertaken using grounded theory methods to generate an account of expressed respondent views, not predicated on but which could be compared with previous studies.

Evolution of grounded theory research tradition and practice has been both influenced by and contested on ontological, epistemological and methodological grounds; with claims made for its place in both positivist and interpretivist paradigms and application in both objectivist and constructionist theory development.(335, 346-357) This is notwithstanding that at its inception there was no explicit claim to specific philosophical positions, and disciplinary claims have been resisted by one of the original authors.(353, 358, 359)

In *The Discovery of Grounded Theory* Glaser and Strauss set out a dynamic process and strategies for qualitative analytical practice and theoretical development. In so doing, they

responded to and sought to reverse the dominant sociological focus in the United States at that time on deductive quantitative research methods and of gathering data to test and validate theory. Instead, they proposed an inductive and emergent approach that could lay equal claim to rigour and authority; discovering and generating theory from data *“systematically obtained and analyzed”*.(347, 359)

The value proposition was theory generated from data both ‘fits’ and ‘works’ - providing relevant concepts able to be readily operationalised; with strong predictive and explanatory power accounting for complex social phenomenon. This addressed then-observed limits of deductive theorising that appeared abstract, weak, impressionistic and opportunistic; with poor resonance with actual data.(347, 357, 359) The authors proposed strategies of methodological rigour that challenged assumptions about qualitative research being unsystematic, biased, merely descriptive or unable to give rise to theories. Per Strauss, the methods were *“explicitly formulated, reliable and valid”*.(360) Also dismissed was the antimony of quantitative and qualitative data collection, suggesting both are useful and sometimes necessary as complementary sources of data to generate and verify theory.

Core elements include simultaneous data collection, coding and analysis; with conceptual categories of meaning built inductively. Both diversity and eventual synthesis of categories are central to the process, with categories developed, integrated and refined as new data are added; supported by the use of tools such as reflective memos and diagrams. (341, 356, 361, 362) Systematic theoretical sampling is undertaken, conceptually directed by the data and towards an emergent theory.(350, 354, 359)

Discovery was informed by the theoretical traditions from which its’ authors emerged; its systematic approach and codified methods analogous to quantitative methods reflecting (Glaser’s) positivism; the emphasis on human agency, subjective meaning and process that of (Strauss’s) pragmatism, particularly symbolic interactionism, and ethnographic field research.(346, 347, 357, 361, 363, 364) Theoretically relevant also is the priority given to social process and interpretation in the research process; a response to the dominance of structural functionalism in sociology in the United States at that time.(347)

Symbolic interactionism asserts individual development, behaviours, actions and meaning are socially constructed processes. Action is informed by meaning, which is language-dependant and dynamic; a result of constant social interaction and interpretation of how others perceive us and the environment. Individuals’ subjective perspective and interpretation also give rise to multiple possible meanings.(335, 365-367)

As part of the movement away from positivism, grounded theorists extended this perspective to encompass the researcher; their account also understood as a construction; both central to

the research activity and presenting only one of many possible interpretations of the phenomenon under study.(335, 357) Researcher subjectivity in this context may be recognised as part of, rather than an impediment to, the process.⁶⁸

More recently, Clarke, while retaining the orientation of symbolic interactionism, has enlarged the focus of research effort beyond individual actors to encompass the situation of inquiry and, drawing on the work of Foucault and others, relations of power.(368, 369) While not adopting the mapping strategy in this study, the concept of discursive positions and analysis of power were salient to reflections on the data and the findings of this study.

A focus of grounded theory literature has been to define its parameters and 'salient characteristics' relative to other approaches.⁶⁹ (335, 346, 347, 350, 357, 364, 370)

Considerations for study design these raise include approaches to sampling; concepts of saturation and validation of data collected; and the appropriate location of existing theory in the research process.(336, 349, 354, 356, 357, 359, 361, 371)

This study is located in an interpretivist and constructionist position, one concerned with the social creation of knowledge and meaning, understood through the contextualised and subjective experience of the individuals concerned. My position of researcher in this process was not immersive (333), rather one of '*empathic neutrality*'.(336) This approach offered a practical median between concepts of objective- and value-mediated observation during the interview process.

A constructionist approach does not naively negate or minimise objective reality or the particular environment and circumstances shaping meaning; in this study being a relational encounter within the context of how the agencies administered their operational remit and practices.(335) Study products were individual constructions and recollections of events, experiences, exchanges and feelings as reported at a specific point in time.

However, when establishing the scope of work, also important for the agencies was understanding the pattern of ranked responses and their scope, including the extent to which qualifying comments are commonly expressed or relative 'outliers'. Both frequencies and detailed descriptions of responses are included for this purpose; and in part informed the decision to adopt a mixed methods approach.

⁶⁸ Charmaz proposes the term 'constructivist' to emphasise the researchers role in interpreting and constructing an account of the data, and to explicitly recognise the subjectivity researchers bring both *to* the work and *in* the work through their interpretive shaping of data (Charmaz, K. (2014) *Constructing Grounded Theory 2nd Edition*.

⁶⁹ For example, in *Discovery* the authors assert that although replication is part of the evidentiary process, it is not 'facts' but conceptual categories or properties developed through the process of sampling and constant comparative analyses on which theory is generated. In subsequent writings, Strauss identified verification as part of the inquiry process whereas Glaser explicitly rejected this.

3.1.1 Coding

Terminology, coding processes and procedural terms vary between grounded theorists, some more prescriptive about the stages of coding (335, 338, 349, 356, 357, 359, 371); but broadly involve:

“a movement from generating codes that stay close to the data to more selective and abstract ways of conceptualising the phenomenon of interest”
Bryman, A. (2008) *Social Research Methods 3rd edition*, p.543

In the first stage, coding involves descriptive labelling and notation of data based on the words or phrases contained in the text. These categories are then systematically integrated into ‘lower level’ groups. Properties and dimensions are explored and refined, with categories in turn developed and combined to create interpretive or analytical categories of theoretical abstraction. Each new piece or ‘slice’ of data is selected for its theoretical relevance and importance. Categories are tested and retested and iteratively revised as further data are gathered. Additions are compared with existing codes and categories and the inter-relationships between the categories reviewed.

In this study, a process of initial coding followed by of selective coding was undertaken to provide flexibility and maintain a focus on comparisons and emergent categories.(350, 354, 357, 372, 373) Both word by word and line by line coding and analysis of comments accompanying rankings for experience and satisfaction measures in Survey 1 was undertaken to identify and develop categories; the approach adjusted according to the nature of the question or responses. Line by line coding and analysis of comments in Survey 2 was undertaken for similar purposes. A line by line analysis of extracts from interviews was undertaken for specific purposes, such as understanding what survey respondents meant by ‘disciplinary action’. This also assisted with a comparison of the temporal dimensions and narrative whole of respondent reports of their experience with the operational model of the agencies. These activities are described further in Section 3.7.

3.1.2 Sampling and saturation in theory development

Early grounded theorists emphasised development of one or more central or ‘core’ categories with strong explanatory power; able to condense and best describe the phenomenon under study.(349, 353, 359, 360) Key is the saturation and ‘richness’ of categories and their properties, achieved by the iterative process of sampling, identifying, comparing and refining; and seeking the greatest possible variation to both limit and broaden the boundaries (or generalisations) that might be made. Adequacy of theoretical sampling:

“is judged on the basis of how widely and diversely the analyst chooses his groups for saturating categories according to the type of theory he wished to develop.”
Glaser, G. and Strauss, A.L. (1967) *The Discovery of Grounded Theory*, p.70

A number of approaches to sampling were adopted in this study. Statistical sampling approaches were used to capture the extent to which respondents' profile was congruent with and representative of categories of complainants, complaint types and profession. Both stratified random- and purposeful theoretical- sampling were undertaken for interviews to help develop a substantive account for views expressed in survey responses, including capturing variability.(333, 359)

Broadly, theoretical saturation is deemed to have been reached in coding when the value of re-categorisation has been exhausted and in the analytical phases when no new data emerge to challenge the existing conceptualisation of the data or bring fresh insights.(361, 374)

Inherent in the concept is that categories or concepts have been "fully explored".(335)

However, a number of analyses highlight challenges of interpretation and application of the concept; resulting in the inappropriate use of quotas, claims made without evidence of achievement, and conversely, continuous collection not adding conceptual value.(375-377)

Useful in this study was Hood's guidance on retaining focus on the theoretical concern.

Elements of the initial interview schedule were deemed 'saturated' when no discernible explanation for variation in understanding of the role of complaints or concepts of error emerged; the focus not to capture every possible description, but the extent of understanding and implications of this finding.

Theoretical sampling is purposeful sampling but it's purposeful sampling according to categories that one develops from one's analysis and these categories are not based upon quotas: they're based on theoretical concerns.

Hood, J. in Charmaz, K. (2006) *A Practical Guide through Qualitative Analysis*, p.101

3.1.3 Existing theory and literature

Central to the grounded theory approach proposed by Glaser and Strauss is enabling outputs of the process (concepts, categories, properties and hypotheses) to emerge from the data without preconceived theories dictating these; assessment of similarities or divergences from established literature occurring only after analytical categories are established.(359) Past criticism of this approach included the extent to which this is feasible, either in practice or due to funding and ethics requirements; subsequent commentators rejecting the naivety this suggests.(378)

Available literature and survey instruments informed the development of interview questions and survey instruments used in this study (Fig.3). In part, alignment with previous studies, while not deterministic to the design, anticipated the value of subsequent comparisons to be made. Categories from data were generated, and after this a more in depth comparative reflection with previous studies and reviews was undertaken; during this reflective process moving between "*everyday concepts and meanings, lay accounts and social science explanations.*"(336)

3.2 Use of multiple methods

There is no single definition of multiple- or mixed-methods research. At its most basic it involves the combined use of qualitative and quantitative methods, although it is also used to refer to the combination of multiple qualitative methods.(379) Various frameworks conceptualise activities and inter-relationships.(380, 381) Leech et al. propose a taxonomy relating to the extent of mixing, timing and emphasis of approaches.(382) The combination of qualitative and quantitative methods may be phrased in the negative as when one paradigm is not adequate to answer a study question.(361, 382) Phrased more positively, and congruent with the intention of this study, the complementarity of approaches provides a means of obtaining a fuller picture to better understand the social world and observed phenomenon.(380) It may also address validity threats or corroborate findings through triangulation. Johnson et al. identified 19 definitions.(383) Key to theoreticians is the *purposeful* use of the methods, whether used during some or all of the research phases.(334, 361, 384-387) The definition by Creswell et al. includes questions that call for real-life contextual understandings and rigorous quantitative and qualitative research; with multiple methods that are intentionally integrated.(385)

The choice of methods and development of my research strategy (Fig.3) were designed to address the study objectives and obtain as rich an understanding of the phenomena as possible. In addition to managing the relative strengths and weaknesses of data collection methods, the approach was influenced by pragmatic factors, as described below.

Qualitative methods used to design instruments that contain quantitative and qualitative elements

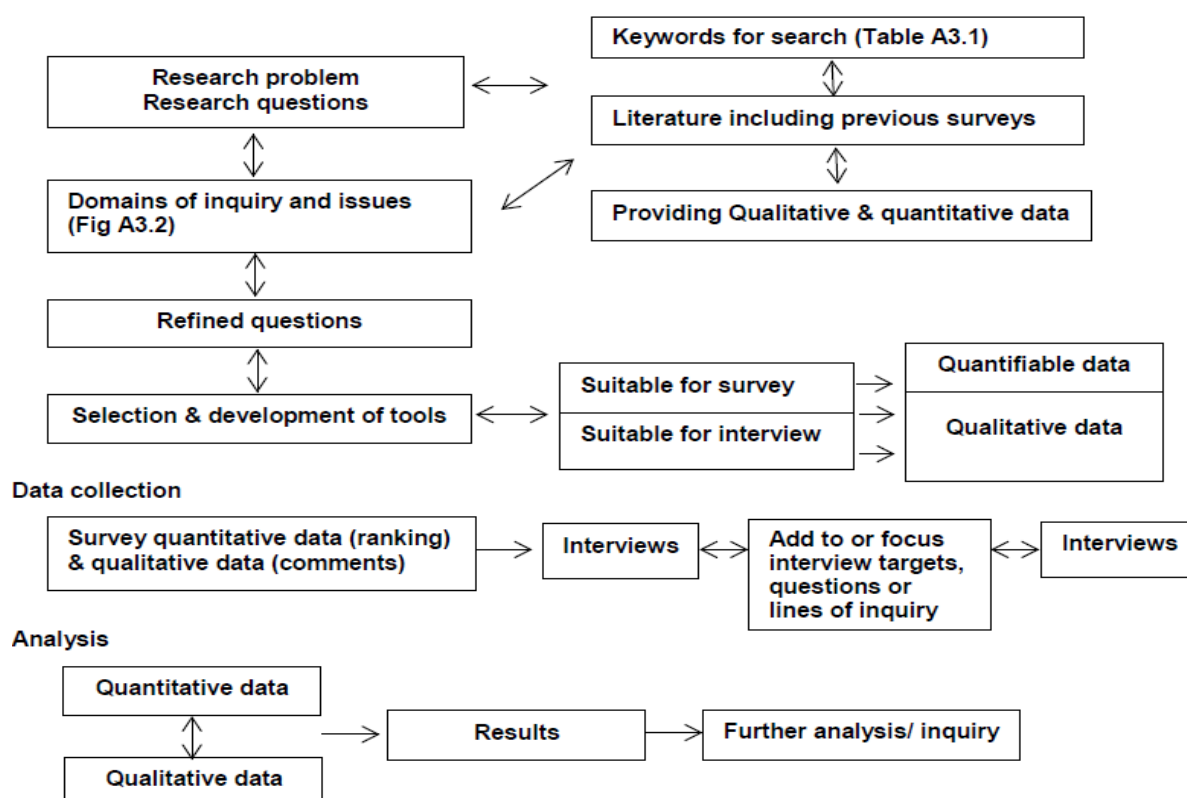


Figure 3: Use of qualitative and quantitative methods in the study methods design, data collection and analysis

The three agencies and five professions were selected as part of the approved Australian Research Council Linkage Grant application for five separate but inter-related studies. The professions selected were highly representative of the two systems and registered profession types, accounting for 88 percent (N=542,525) of all registered health practitioners in 2013-14; 95 percent (N=6449) of national and 96 percent (N=3,098) of NSW complaints received that year; and a similar proportion of matters closed.(388)

For Objectives 2 and 3 - to measure and report on experiential views and identify trends about the processes - an unbiased and robust data set representative of complainants; complaint types; professions; and processes within and across the three agencies; and of sufficient scale to enable comparisons to be made was sought.

A self-completed questionnaire (Survey 1) conducted over a 12 month period was selected as the primary means of achieving these ends; a survey instrument also identified as the only feasible means of reaching the national target audience. The survey also addressed design considerations identified in the literature - maximising participant convenience while maintaining anonymity; providing consistency of approach; and minimising direct researcher effects.(335, 389, 390) Making the instrument available in hard-copy and on-line was financially possible and anticipated not all potential participants had computer access or felt

comfortable using that medium. The 12-month timeframe was chosen to achieve sufficient numbers; having reviewed return rates in comparable surveys. Known pitfalls of survey design, such as ambiguous, double and negative questions; technical terms; respondent fatigue and over-use of particular response modes was managed through a piloting process.(333, 335, 391-393)

Objectives 2 and 3 also required capturing individual subjective accounts of participants' lived experience with the processes. The research tasks included gathering insights about the factors and expectations that actors brought to the process; and their understanding of and reflections about the process. Two data collection strategies were used for this component; designed to address the limits of survey instruments and quantitative research more generally. These limits include amenability of instruments to certain types of questions; abstraction; the static and single-dimensional nature of responses; limited insight to the meaning of or how meaningful responses are; variability in respondent interpretation of terms and questions; and assumptions about respondents' knowledge.(333, 335, 357, 391)

First, comments were invited about reasons for numerical rankings in questions where this was amenable to a survey format. Second, recognising the limitations of survey instruments, telephone interviews with a stratified random sample of self-nominated participants who completed Survey 1 were included to maximise variability; provide a more fine-grained understanding of their motivations and responses; and to explore more complex issues not feasible in a survey instrument.(340, 361, 390)

Telephone interviews were identified as the only means of reaching a national audience in a country the size of Australia, thereby avoiding geographic bias. Semi-structured interviews were selected as the most appropriate approach; scheduled questions providing a comparable baseline for analysis of responses to select issues, while retaining flexibility to pursue themes arising from survey responses or other interviews using theoretical sampling techniques.(361, 391) This included matters particular to a complainant or aspects of the complaint process.

Objective 4 involved exploring the implications and higher level explanatory value individual accounts had for the design and management of processes at a systems level. Comparable insights into the complaints handling process were sought through surveys of organisations that have a role in the processes under study or were expected to enrich the understanding of processes from a meso- or macro-level perspective. This survey (Survey 2) also identified gaps in knowledge and engagement amongst significant community actors that may be conduits of knowledge and information between the agencies and the broader community or community segments. The number of potential organisations was so large that individual

interviews were not deemed within the capacity of the study. A survey emailed in Word format was utilised as the most efficient and effective means of achieving national reach and seeking responses from all relevant organisations.

3.3 Ethical issues

Particular ethical challenges in research design, analysis and reporting associated with this project included potential bias in terms of instrument design and case selection; questions of privacy, confidentiality and anonymity; informed consent and honesty of interactions; interpretation and representation of responses; and adverse impacts arising from the subject matter for both research participants and researcher.(333, 335, 394, 395)

Particularly useful for managing these challenges was the principle of researcher responsibility for ongoing reflexivity about ethical dimensions of process and activities (as opposed to simple procedural adherence to ethical codes of practice); underlying assumptions and whose interest they serve.(333, 357, 394, 396) Charmaz highlights the tensions between expectations of Institutional Review Boards (IRBs)⁷⁰ to identify and establish responses to ethical issues and potential conflicts in advance, and the essentially iterative ('emergent') nature of issues and decision-making in practice.(397) Charmaz also suggests a greater agency for participants, challenging preconceived assumptions about their vulnerability and harms.

3.3.1 Bias

A risk of survey design is 'leading' or 'directing' respondents through questions asked and unasked; and how those included are framed. This was managed by incorporating both quantitative and qualitative measures in both surveys; inviting ranked responses for quantitative measures; including both focused questions and an invitation for 'open' comment more than once in Survey 1 (on 'process', 'outcome', 'areas for improvement' and 'any other comment') and in Survey 2; and using a semi-structured interview design that allowed issues arising to be further tested. The surveys, particularly Survey 1, were extensively tested for content (coverage), framing, participant understanding and consistency of interpretation.

Sampling bias was managed by a one hundred percent sample; offering on-line and hard-copy response options to Survey 1 (involving consumers, where variability in computer or internet access would be highest); and surveying organisations (Survey 2) representing populations most likely to be not captured or less responsive due to language and other factors. Interviews were conducted by telephone to manage geographic bias and undertaken by a single interviewer, providing consistency of approach. Potential interviewees were asked to indicate if they required interpreter assistance. Some responding in the affirmative were

⁷⁰ In Australia these are called Human Research Ethics Committees

found subsequently to possess English language skills that appeared strong or did not impede the interview.⁷¹ Others however, had no English language proficiency when contacted and interpreter arrangements were not able to be made.

Substantive bias could also occur through how responses are analysed and interpreted. Potential influences include conscious or unconscious researcher values and assumptions; and cultural, language and power differentials between researcher and participants; practice challenges including coding inconsistencies and selective reporting. (333, 335, 340, 386, 391) These risks were managed by establishing a coding guide tested with a quantitative and qualitative researcher; careful attention to the coding and analysis process; maintenance of a diary to capture issues; continuous reflection on the data; and review of data by colleagues.

The thesis reports on common and exceptional responses. Inclusion of supplementary tables in the Appendices enables readers to assess the content and scale of material underpinning conclusions drawn as well as demonstrating in greater detail how these were categorised. A decision was made to include interviews in whole or part to illustrate and expand on key issues and themes raised by participants or observed by the researcher. While the circumstances are unique, the themes are typical of views expressed in multiple interviews on the same subject. *Which* interview or extract selected to present was essentially a pragmatic decision e.g. it elegantly or forcefully communicated a specific issue; or covered several issues relevant to the study. Additional steps were taken to protect the anonymity of participants (discussed below). Unchanged however, is the order of discussion in the interview. Relevant to this decision was respect for interviewees and the methodological import of capturing the narrative whole. In places this helped to contextualise remarks that would otherwise not be fully understood. Reflecting on the flow and sequence of descriptions, including repetition of issues, was important in analysing features of the complaint model that explained the content and strength of participant views otherwise lost in the detail of specific words or phrases.

Interview experience highlighted the need for constant awareness and reflection, both during the interview and at the point of analysis. (335, 396, 398) To illustrate, during one interview the researcher became aware that the participant had repeated the phrase ‘they have to pay’ a number of times and the researcher had been unconsciously assuming this referred to financial recompense. When asked (“*you have mentioned ‘they have to pay’ a number of times, what do you mean by that?*”), the participant replied “*they have to be accountable*”, which further exploration confirmed did not relate to money.

⁷¹ It appears some had been concerned they would not be familiar with medical and technical terms, which was not the focus of interview; others appeared to under-state their proficiency.

3.3.2 Informed consent

The Participant Information Sheet, introduction to the survey, Expression of Interest and Consent to Interview form and interview introduction script set out the terms and conditions of the study and participant engagement. Notwithstanding, the researcher frequently needed to explain to participants that they did not know who they were; did not have access to their medical or complaint records; were independent of the agencies; and while the agencies were partners in the study, they did not have access to individual responses. Important for the researcher in managing expectations was to clarify that the agencies were interested in the outcomes, and the focus and value of the study was its potential to inform future practise. However, the researcher had no direct control over how the agencies would respond to the findings, including any concrete actions that might result. Participants were advised that the study would result in publications and presentations as well as a thesis that would be publicly available through the university repository.

While not common, the researcher was contacted by some individuals about whether participation would directly affect their case – e.g. whether the researcher could review their case; or if the study would lead to a review and possible further action or a different outcome. The researcher explained the separation of the university from the agencies under study; that they had no access to the details of a case other than what participants provided; and had no role or influence in their case, which the agency had closed.

3.3.3 Privacy, confidentiality and anonymity

Confidentiality was a general condition of ethics approval, although organisational respondents to Survey 2 were asked whether any comments could be attributed, or whether all responses were to be treated anonymously.⁷² Overt anonymity was provided by establishment of a Unique Identifier for each potential survey respondent and separate identifier for interviews; separation of processes and administrative management of survey responses and offers of interview; and attention to security of communications (e.g. email content) and physical materials (locked cupboards, office and building).

More challenging to manage in this study, and well-recognised in the literature, is loss of anonymity due to the particulars of a case – the gender or age of study participants and/or professional involved; details, location and order of events; participant's written and spoken style and phrasing.(335, 398, 399) This particularly applied to free text responses in surveys as well as interviews.

Confidentiality (they would not be identified) was an expressed concern for some interview participants. Others explicitly questioned why direct attribution could not occur. Numerous

⁷² Due to variability in responses to this question, the category of respondent only is reported.

surveys were returned with the name, address and/or telephone number of the participant on the return envelope or survey proper.

As noted, selected interview extracts are illustrative of recurring themes and were reported in more than one interview. In places, gender or other details in interview extracts have been adjusted to maintain anonymity. Some details are generalised, indicated through the use of brackets [e.g. name of drug].⁷³

3.3.4 Harms

Potential harms to participants and researcher were assessed. The researcher and regulatory agencies gave careful consideration to the number and timing of follow-up notices that would be ethically appropriate to send to non-respondents; the potential distress contact or additional contact might cause; and whether or not to include cases where a death had occurred. The sensitive nature of the subject matter and distress arising from a range of reported circumstances⁷⁴ was regularly discussed by the researcher and their supervisor and strategies put in place to manage any adverse impacts on the researcher. (394)

It was agreed a single reminder would prompt and afford a further opportunity to respond for those interested. There was concern that more than one might cause distress to those who did not want to be reminded of events; or be potentially perceived as intrusive or harassing by those who had made a conscious decision to not respond when they received the initial notice.

Previous studies have highlighted the range of negative emotions experienced by complainants about events giving rise to the complaint, including anger, shock, betrayal and humiliation. (192, 306, 400) The sensitivity of issues and potential of the study process to reopen or exacerbate such feelings was the subject of detailed discussion at the point of study design and reflected on throughout the process. One agency specifically questioned the appropriateness of including cases involving a death for this reason.

Considering potential participant interests, it was thought the risk of causing pain as a result of making contact and the study process was outweighed by the opportunity to contribute to individual practise and system improvements; consistent with outcomes sought by complainants in previous studies. (83, 301, 310, 311, 317, 401) From the researcher's perspective, there was awareness that the potential risks of harm demanded heightened sensitivity about the importance of careful preparation to ensure clear and respectful engagement and communication at all times; and a preparedness to be flexible and

⁷³ On occasion interviews traversed subject matter so specific that the participant would undoubtedly be identified. Where this became apparent in the course of the interview, this was discussed with the participant and after with the researcher's supervisor.

⁷⁴ This included death, catastrophic injuries, assault, significant financial burdens etc.

responsive during interactions with participants. Further, exclusion of cases involving a death would mean data and the perspectives of an important cohort would be missing, diminishing the power of the study. Importantly, it was also thought exclusion might be regarded as disrespectful or even disempowering by not affording the individuals involved an opportunity to make the decision to participate or not.

In survey responses and at the time of interview, some respondents did express anger or distress about the original events, the response from the practitioner or their employer when approached about the issue and/or the agency that managed their complaint. However, the opportunity to explain their views and the reasons for these views and potential benefits to others appear to outweigh these feelings for most, including events involving death or catastrophic outcomes.⁷⁵ Some interviewees explained that the process of the interview was seen as a watershed – an opportunity to communicate their experience and then “*close the book*” or “*put it behind them*”.

Events involving a death were not separately identified in the survey, although 109 cases indicated a death was involved. Notable in relation to AHPRA were interviewees whose matter involved a death who were particularly upset about not being contacted at all. This was raised directly with the agency by my primary supervisor in quarter two of the study.

Where an interviewee sounded as if they were becoming distressed when recounting events painful to them (as opposed to reporting feelings of distress), they were asked if they would like to pause or ‘take a moment’. On occasions I specifically stated that I could hear that they sounded upset and, depending on what appeared most appropriate, ask if they would like to stop or have a short break. No-one wanted to discontinue the interview. On these occasions, I would wait quietly, providing a space for the interviewee to collect themselves and continued when it appeared appropriate. I deliberately concluded these interviews on more generic (less immediately personal) questions and when it appeared appropriate to finish.⁷⁶

⁷⁵ One parent whose child died emailed, expressing concern about the insensitivity of the process. A letter from the researcher’s supervisor explaining the process, including blinding of the researcher to names and circumstances; acknowledging the unintentional distress caused; and offering an apology and condolences was immediately sent in response. The apology was accepted.

⁷⁶ Two study respondents who contacted the researcher by phone asking to be interviewed were not. This was because the individuals sounded very agitated and upset during the conversation and the researcher was of the view that an interview would not be appropriate. Two survey respondents who had made more than one complaint and were interviewed after the closure of the first matter subsequently asked for no further contact. One made the request to help them disengage from the issues that gave rise to their original complaint. One was so angry and dis-satisfied with the response to their second complaint they saw no purpose in further participation.

3.4 Perspective 1: individuals and organisations who made a complaint or notification

Survey 1 is an anonymous self-completed survey of all complaints made by individuals and organisations concerning any of the following professions- medicine, nursing and midwifery, dentistry, psychology, and pharmacy. Complaints must have been managed by any of the three agencies (AHPRA, HPCA or HCCC) and closed during the survey period (1 July 2013 to 30 June 2014 inclusive).⁷⁷

The 12-month sample period was selected following assessment of return rates in other surveys and to achieve sufficient returns to provide a representative dataset of complainants, issues and profession types; as well as agency processes and outcomes. The survey start date was adjusted to align with agency data management and annual (financial year) reporting processes. As computer access could not be assumed; the survey was distributed in hard copy form with a link for online completion using SurveyMonkey®. A reply-paid envelope was included for hard copy returns and a dedicated postal address and secure post-box established. All materials were designed and prepared by the researcher, which were packaged and couriered to the agencies for distribution in accordance with the Study Protocol.⁷⁸ A notice about the study was placed on the website of the three agencies.

The agencies assigned a Unique Identifier Number ('UID') to each complaint (within scope) at the point of closure to ensure anonymity and only one survey per closed matter. The package included an invitation to participate from the research supervisor, the survey form, Participant Information Sheet and a covering letter from the agency prepared by the researcher in consultation with the agencies. This letter was designed to ensure recipients understood the basis of the contact and that the researcher did not have their name or contact details. The letter explained why the agency supported the study and that the agency would not know the detail of individual responses. Except for the letterhead of the agency concerned these letters were identical.

Consideration was given to distributing surveys on a continuous basis and being included with the agency letter of closure. Ultimately, we agreed that distribution would occur monthly by each agency for all matters closed in the previous month.⁷⁹ After each distribution, the

⁷⁷ Due to timing of distribution and reminders, the survey closed in January 2016.

⁷⁸ An issue log was established and additional processes were subsequently established as needed e.g. to advise the agencies of matters returned unopened; identification of surveys returned without the relevant UID.

⁷⁹ A large-scale survey previously undertaken with the HCCC had enclosed the survey with the HCCC closure letter (Daniel AE, Burn RJ, Horarik S.(1999) *Patients' complaints about medical practice* MJA 170(12):598-602.) However, the HCCC now routinely included a one page survey with its closure letters to obtain feedback on its processes and there was concern that including the study survey would confuse potential participants. This proved relevant, as even with the separation of processes, a small number of individuals forwarded the HCCC survey to the university researcher in error. It was also thought the scale and logistics associated with a national study would be more easily and consistently managed through a monthly distribution. Although involving a small delay, events

agencies provided the researcher with a list of UIDs for surveys distributed. Four to six weeks after the initial distribution, the researcher, relying on the UID provided the agencies with a return list for non-responders to the survey and the agencies distributed one follow-up package for each.⁸⁰

3.4.1 Survey 1 development

The content and structure of Survey 1 were informed by a literature review of reasons for complaints about health practitioners and surveys previously undertaken (301, 307, 308, 310-312, 328, 400, 402-405); literature on current best practice in complaint management (32-35, 39, 45-48, 127, 406, 407); and information about complaint trends, classifications, legislative requirements and processes used by the agencies. Large scale patient surveys used in Australia and Europe (e.g. Picker Institute) were reviewed as was literature on general survey design and validation.(335, 389, 390, 408) The final form was influenced by practicalities of length; survey design and printing conventions and visual appeal (colours; spacing).

Following initial development, the draft survey was piloted with individuals identified by the researcher, or individuals recommended through 'snowballing' from this cohort.(335) A 10-question template response for people piloting the survey was distributed with the draft. Targets included people known to be in good and poor health; who had expressed concerns about health care or lodged formal complaints; and people with no knowledge of health complaint processes. A deliberate demographic mix was sought to reflect members of the general population that might receive the survey. Thirty-two responses were received.⁸¹

Following this initial feedback, the survey was revised and re-tested.⁸² In addition to individuals, feedback was obtained from members of the ARC linkage grant study team; local and inter-state experts with experience in general or health-complaint survey design and administration; and the agencies.

and views were anticipated to be still fresh in respondents' minds. In NSW, to avoid duplication, the HCCC sent a list of all matters it distributed to the HPCA before the HPCA distributed its surveys.

⁸⁰ It was initially intended that a full repeat package would be sent. However, given the volume and cost of follow up packages, it was decided after the first month of distribution to send only the reminder letters from the researcher and agency together with the Participant Information Sheet. Recipients were invited to complete the survey on-line or by using the survey previously sent; and advised they could contact the agency or researcher directly if they preferred to receive another hard copy.

⁸¹ Responses achieved the desired demographic mix and included ranges in age (16-80 years); education (high school to post-graduate); employment (students; retirees; working); profession (administrative; trade; professions), sector (public, private, academic and non-Government); responsibility (junior, middle CEOs, self-employed); language (English first or second language); geography (city, town and regional areas); and disability experience.

⁸² As part of these revisions, a trial design was tested that separated surveys directed to individuals and those for organisations. This was tested for three reasons - the demographic questions for each were different; as a strategy to minimise the survey length; and to minimise any confusion about which demographic sub-section should be completed. However, this approach was subsequently discarded on the grounds of adding complexity as well as difficulties for one of the agencies in identifying organisations.

3.4.2 The Survey 1 instrument

Survey 1 consists of six Parts and 35 core questions plus demographic questions. (Table 3)

To ensure consistency, responses were not compulsory in the on-line version.⁸³

Parts 1 and 5 provide baseline data on why the complaint was made; what people wanted or expected from the process; and their satisfaction rating and comments on process and outcome, including whether they would recommend the process to others. Comment on possible improvements was invited. Parts 2-4 provide context including the type of practitioner and issues involved; where events occurred; actions taken by the agency and the outcome.

Table 3: Survey 1: instrument summary

Part	Focus	Response method
Intro	Rationale and instructions for completing survey - If more than one practitioner & (if yes) number and type - Provide Unique Identifier	Yes, no and text
1	Reasons - why made - What wanted for practitioner - What wanted from process for self/organisation - Supplementary question on compensation - If would use practitioner again	- Rank in order any relevant responses - Rank in order plus 'other-describe' option - Rank in order plus 'other-describe' option - List choice (tick)
2	Context: about the complaint/notification - Practitioner type and sex - Issues - When and where occurred - If first tried to resolve through other means and how	List choice (tick); 'other-describe' option included; mix of question types: some select one response only; others option to select more than one (where relevant)
3	How handled by agency - Actions: what first told, if referred elsewhere, if withdrawn & why, if went through conciliation and if so, the outcome - If investigated; if disciplinary action taken - Length of time to deal with matter & any delay	List choice (tick); 'other-describe' option included; if yes/no question: 'yes', 'no' & 'don't know' options included
4	What happened - Outcome (result) - If further action planned and if so, type - If aware of any improvements and if so, type	List choice (tick); 'other-describe' option included; if yes/no question: 'yes', 'no' & 'don't know' options included
5	Experience & Satisfaction - Extent to which issues resolved at point of closure - Process: role and powers, assessment criteria, kept informed, decisions explained, treated respectfully, fairness, affect health - Satisfaction with process and results - If would recommend process to others - Other comment, suggested improvements	5 point Likert scale and free text comment
6	Demographics Definition of 'individuals', '3rd party professionals and 'organisations' provided with 3 sub-sections - Part 6A: details about individuals completing the survey (person that made the complaint) - Part 6B: details about third party professionals and organisations completing the survey - Part 6C: details about the 'patient' where different to the person completing the survey (complaint lodged on another person's behalf)	List choice (tick) and 'other-describe' option included
Close	Provide Unique Identifier Thank for completing	Hard copy: ID to confirm initial entry correct; and to capture if not entered at start On-line: asked to enter ID twice at start

Respondents were asked about any additional steps they planned or had taken and their awareness of any changes in education, service or practice that were implemented as a result of their complaint. Demographics are not collected, or if collected are not recorded by the

⁸³ The one exception was a request to enter the Unique ID twice at the beginning of the online survey, a device to encourage participants to include the number and avoid incorrect entries. In the hard copy version, participants were asked to insert their Unique ID at the beginning and the end of the survey.

agencies. To provide insights as to who is (or is not) using the systems, Part 6 sought demographic information about the complainant, and further details if made on behalf others.

In the design phase a difference emerged about how complaints involving more than one practitioner were recorded by the agencies.⁸⁴ To manage this, respondents were asked at the start of the Survey if their matter involved more than one practitioner, and if so, the number and type. A double sided additional response form was included with nine questions. In cases where more than one practitioner was involved and had been dealt with and closed as a single complaint, respondents were asked to complete Survey 1 in relation to the main practitioner and to use the additional form for other practitioners (as relevant).

3.4.3 Survey 1 interviews

People completing Survey 1 were invited to participate in a follow up interview by lodging an Expression of Interest and Consent Form (EOI) enclosed with the survey package. The EOI was used as a mechanism to manage uncertainty about the potential number of offers that might be received and to facilitate selection of a range of participants according to established criteria; the Patient Information Sheet advising it would not be possible to interview all people who offered. To separate responses from EOI forms, those taking the survey on-line were redirected to another web-site (WuFoo™) to complete the EOI. All interviews were conducted by myself; providing consistency of approach.⁸⁵

A selection matrix was established to obtain a range of respondent and subject practitioner⁸⁶ types, agency and outcome categories. (Table 4) A numerical target for interviews was not set as I used purposive sampling until theoretical saturation was achieved in relation to the initial interview schedule [A3.1]⁸⁷ or issues arising during the course of the study.

Interviews were arranged in accordance with the selection matrix; as was possible from EOIs made. Potential interviewees were contacted by telephone or email (depending on their nomination) and an interview schedule established. Interviews ranged from 15-60 minutes (in a few cases longer). Individuals not interviewed were contacted by telephone or email to thank them for their offer.

⁸⁴ The HCCC typically will join and manage these as a single complaint, where-as these would be classified separately by AHPRA. This could result in an asymmetry of returns. If additional and related complaints are lodged these may also be joined. Conversely, matters will be separated if one proceeds to further action while other components are closed.

⁸⁵ The EOI form asked for contact details, potential interview times and consent to audio-taping. While preferred as a means to fully and accurately capture responses, those declining the latter were not excluded from consideration, and (if selected) contemporaneous and detailed notes were taken and transcribed. The Ethics approval stipulated that if anyone under 18 years of age offered to be interviewed, my primary supervisor would undertake the interview. However, this did not occur.

⁸⁶ 'Subject practitioner' refers to the practitioner the complaint was about

⁸⁷ Additional tables contained in the appendices appear in brackets e.g. [A3.1] is Appendix 3, Table 1.

Table 4: Interviews: selection matrix

Respondent (source)	Individual (consumer or practitioner) for self Individual (consumer or practitioner) for other Organisation, 3rd party professional (employer; non-employer)
Subject practitioner (subject of complaint)	Dental practitioner Medical practitioner Nurse/midwifery practitioner Pharmacy practitioner Psychology practitioner
Agency	AHPRA (different jurisdictions) HPCA HCCC
Outcome as advised by complainant	Don't know, No action Explanation, Information, Apology Conciliation (or resolution) Conditions (subthemes: caution/reprimand; health/education program; counselled; undertakings) Registration surrendered, suspended or cancelled

The initial interview schedule focused on questions relating to views about the role or purpose of the complaint process, including comparisons with taking legal action; and perceptions about the occurrence of error. This included, for example, whether errors were perceived to be rare or common, with prompts including comparisons with other professions. [A3.1]

Questions were adjusted to accommodate the particulars of the case and respondent. For example, reference to 'error' was not appropriate to all cases and was excluded from the question list. After the first quarter of the survey period, a 'short form' interview method was adopted. This was in part due to saturation on the range of responses to key questions from the initial schedule being achieved⁸⁸; and to better understand issues emerging from survey returns.

'Short form' interviews focused on specific issues or questions after observing trends in survey responses, or to better understand respondent's reasons and motivations. For example, after reviewing survey rankings and comments, a sample of interviewees were asked about their reasons for selecting '*wanted practitioner disciplined or punished*' in their survey and what action they were thinking about when they selected this choice (discussed further in Section 4.4.1.2). A small number of respondents were specifically asked for further information about their experience and reasons for ranking when they had sought an apology or had made a complaint involving a communication issue. This was again prompted by observing negative survey rankings and comments combined with reflections on the literature reported in Chapters 1 and 2. For similar reasons, some respondents were interviewed to better understand why they were dissatisfied with an outcome notwithstanding action being taken by

⁸⁸ No dominant or consistent response to the initial scheduled questions was established; however common themes emerged and began recurring in Quarter 1. A sample of interviews using the original schedule was maintained over the course of the study, which reinforced these initial themes.

the regulator; others still who were very positive when the dominant response theme was negative. A sample of responses to these questions appears in Chapters 4-6.

3.5 Perspective 2: peak organisations

Organisations representing community and professional stakeholders known to work at national or jurisdictional level were purposefully selected for Survey 2. Target groups were organisations that might expect to be engaged in consultations on access, systems for or information about complaint processes as a conduit to the community or community of interests they represent and included:

- (1) **Consumer organisations:** consumer health organisations whose primary role is to represent health consumer views and interests and consumer organisations that have a broader policy remit that have taken a leading role in consumer health issues.
- (2) **Population organisations:** non-Government organisations representing the needs and interests of population (demographic or cultural) groups, including those identified in the literature as typically under-represented in the use of health complaint processes. These include Aboriginal and Torres Strait Islander peoples; people whose first language is other than English⁸⁹; older people, particularly those in group and institutional care; people with disability; people with mental illness; and people living in rural and remote areas.⁽⁴⁰⁹⁻⁴¹²⁾ Also included were organisations that have a policy role that includes comment on reviews and directions relating to public policies, institutions and services.
- (3) **Professional organisations:** health professional associations and organisations whose primary role is to represent member or profession views and interests either at a policy level or through providing advice, support or defense on individual matters.

Participants were invited through an email letter to the organisational chief executive explaining the purpose of the study, why they were being approached and inviting their participation through an on-line or hard copy survey.

I identified target organisations using the following processes: an internet search of key terms relating to the organisations; a search of websites and annual reports; information provided by the study agencies, including organisations represented on advisory processes and lists of professional and defence organisations; and a review of submissions made to major reviews at national and jurisdictional levels.⁹⁰(179, 202, 250, 413, 414) Duplicate listings were deleted

⁸⁹ In Australia these are referred to as culturally and linguistically diverse (CALD) communities.

⁹⁰ Submissions to reviews were categorised by source; excluding individuals; those not referencing complaints; organisations represented via other agencies. Except for agency advisory bodies, disease-specific organisations were excluded on the basis of representation through consumer health peaks (confirmed by cross-tabulating peak membership listings against national health priority areas and major burden of disease categories). The

and exclusion criteria established. To capture organisational views, surveys were directed to the CEO (or nearest equivalent) and recruitment information specifically explained this.

3.5.1 Survey 2 development and instrument

Survey 2 consists of four Parts and 41 core questions plus organisational profile questions. (Table 5) It is identical for the three target groups except for the first page explaining why the organisation has been selected.

The survey accommodated expected variation in role and knowledge of the agencies. It was designed to obtain at least a preliminary response from those with low levels of knowledge or engagement, achieved by keeping sections relevant to them short and 'skipping' them after the first section to the last two pages of the form.

The survey was piloted with a community organisation that was within scope for the survey; members of the ARC study team and the agencies.

Table 5: Survey 2: instrument summary

Part	Focus	Response method
Intro	Rationale and instructions for completing survey Position of person completing Whether consent to being named in reports About the organisation - Name, location - Who organisation represents or works with - Type of services provided - If data collected, and if so type	List choice (tick); 'other-describe' option included
1	Knowledge of and experience with complaint bodies - Level of engagement with complaint bodies - Factors affecting member/service users willingness to make complaints - Role in making or assisting individual complaints - If first tried to resolve through other means & how	List choice (tick); 'other-describe' option included
2	Individual complaints - If made or assisted with a complaint in last 2 years to AHPRA, HCCC or HPCA. If no role- directed to Part 3 - Understanding of complaint body role - Process/satisfaction with experience - Adequacy of complaint body powers - Experience with mandatory notifications - Concerns or complaints made about complaint bodies	List choice (tick); 'other-describe' option included; some free text comment
3	Complaints leading to improvements - Experience of individual complaints leading to improvements - Experience of policy work leading to improvements - Use of complaints to identify broader risks in health practice	List choice (tick); 'other-describe' option included
4	Innovation and change - Emerging trends in complaint type or how handled - How effectiveness of complaint system should be judged - Other comment, suggested improvements	Free text comment

professional defence organisation list was assessed to ensure that at least one organisation offering coverage for each profession was included.

3.6 Response rates and limitations

A total of 7,972 Survey 1 packages were distributed, with 2,226 full and supplementary surveys returned, representing a 31 percent return rate following exclusions.⁹¹ (Fig.4)

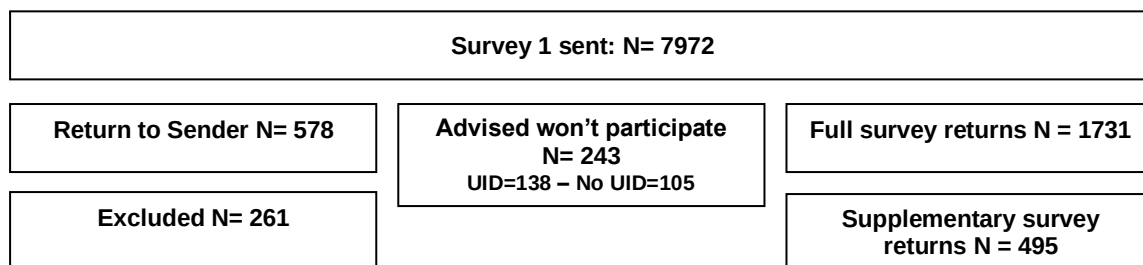


Figure 4: Survey 1: distribution and return rates

Supplementary survey returns include returns where attached as addition to one survey (where case involved more than one practitioner and cases where additional response form only lodged (in lieu of full survey)

Return to sender: returned due to: unclaimed or refused post; insufficient address and unstated

Exclusions: incomplete on-line surveys; matters where researcher notified complainant died; duplicate surveys sent in error

Over 240 individuals telephoned, emailed or wrote to the researcher to advise that they would not participate in the study. Where given, reasons for not participating included that there was no point (e.g. no change or improvement would result; agencies are biased); they were too unwell, angry or upset; or they had made their point and regarded the matter as closed.

A significant 1,010 respondents from Survey 1 offered to be interviewed. Of these 163 (16%) did not fully complete the EOI form and were not able to be contacted. It became clear from subsequent contact initiated by respondents that notwithstanding advice in the Patient Information Sheet and covering letter, many believed the researcher had their details or access to a data base to contact them.

There were 747 (74%) available volunteers who were not interviewed, either because interviews were not able to be arranged or because they could not be accommodated in the schedule. A total of 32 full and 68 short-form (single focus) interviews were undertaken for the purposes of analysis. (Table 6)

Table 6: Interviews: completed and analysed

SOURCE			SUBJECT PRACTITIONER					AGENCY		
Self	Individual for other	Organisation 3 rd party professional	DENT	MD	NMW	PHARM	PSY	HCCC	HPCA	AHPRA
47	39	15	7	67	14	4	8	27	18	54

Table 8 continued

OUTCOME				
Not known	No action Apology Information	Conciliation Attempted Offered Completed	Conditions Actions excluding suspend, cancel	Registration surrendered suspended cancelled
9	59	4	30	8

⁹¹ Exclusions were defined as: 'Return to Sender' plus 'Excluded' but not including: 'Advised would not participate'.

There were 295 Survey 2 packages distributed by email, with 80 returns, providing a 29 percent return rate following exclusions (N=18).

3.6.1 Survey 1 response rate limitations

The return rate for Survey 1 (31%) is lower than comparable surveys, which report returns of 49 to 75 percent (83, 301, 308, 310) although Jones et al (314), which was of a comparable scale to this study, reported a 16 percent return rate. Data for a complete analysis of distribution and returns by source were not available. However, the return rate for this study was influenced by the low rate of returns from organisations, not included in comparable studies. Inclusion of more targeted approaches in comparable studies involving clinicians may also be relevant.(139)

Notwithstanding the low return rate, the overall size of the Survey 1 dataset enabled credible extrapolations from the data to be made. Further, returns are proportionate to distribution by agency and profession. (Table 7)

Table 7: Survey 1: returns

	DR N	NMW N	PHARM N	DENT N	PSY N	TOTAL N	Distribution %	Return %
AHPRA	2445	1004	224	415	277	4365	55	60
HPCA	1083	319	138	206	77	1823	23	17
HCCC	1274	161	25	261	63	1784	22	23
	4802	1484	387	882	417	7972		1731 full
<i>Distribution (%)</i>	60	19	5	11	5			495 supplementary
<i>Return (%)</i>	60	19	5	9	7			2226 Total

3.6.2 Presenting data from different sources in Survey 1

Due to the dominance of consumer responses (66%), these data are reported frequently as additions to tables appearing in the body of the thesis where significant variation appears from the 'all response' data. Fewer numbers frequently limit meaningful inclusion about practitioner and organisational responses to the same extent, although data from all sources are routinely included in fuller tables contained in the appendices.

However, given asymmetries in the proportion of complaints made about different professions, in places data are reported for complaints about medical or nursing practitioners only; or reported as 'medical' and 'all other' practitioners.

Administratively, the process for lodging a complaint or notification are the same, regardless of whether a matter is raised by a patient, their friend or relative, a health provider or other person. However, it might be expected that given differences in relationship and power, these data would be presented separately. However, given the similarity of issues and substantive content of responses made irrespective of source type, they are presented as a whole, with comment made on differences of note as relevant.

3.6.3 Organisational respondents Survey 1

Responses from organisations are low, particularly from NSW. It was recognised at the outset that this would likely be experienced due to larger health providers handling numerous complaints and the study design (one survey per each complaint closed) de-incentivising responses from this cohort.⁹² This proved to be the case for large NSW public hospitals. It was agreed by the researcher and agencies that these facilities would be managed by a short supplementary survey after closure of Survey 1 to gain overall views on the management of complaints in the Study period.

In the first quarter of Survey 1 the researcher was contacted by other organisations that had both a high volume of cases and specific statutory responsibility in the complaint process due to referral arrangements and their obligations.⁹³ These groups were identified as suitable for the supplementary survey process and were excluded from further rounds of Survey 1 distribution. Resources, including a supplementary survey, a Participant Information Sheet and protocol were therefore prepared and ethics approval obtained on 11 September 2014. However, due to other limitations, the sample pool was very small and primarily related to NSW agencies. As the response rate was so small, these data are not reported.

3.6.4 Survey 2 response rate limitations

The return rate for Survey 2 (29%) was also low. However, while returns from population and consumer organisations were lower than professional organisations, the overall return rate was proportionate relative to surveys distributed. (Table 8)

It was anticipated that the return rate for population peaks would be low due to the federated structure of many organisations.⁹⁴ There was also some uncertainty about the return rate from professional organisations as it was distributed in a period when significant changes to funding for health services were announced.

While associated with quantitative studies, given the expected variability in the sample, from the outset it was intended Survey 2 responses would be treated primarily as qualitative data relative to Survey 1 responses, and are reported as such.

⁹² Feedback from large facilities to the researcher during the study period confirmed this was an impediment.

⁹³ These were Drugs and Poisons Units in jurisdictional Health Departments and Occupational Health and Safety agencies. As the study progressed, the researcher was also contacted from time to time by others with high volume issues, including hospitals; aged care facilities and aged care complaint managers. However, these groups were not excluded from Survey 1 distribution for two reasons. Firstly, it could not be consistently pursued as one of the agencies indicated it could not readily or consistently identify organisations at that point as respondents were recorded by individual name. Secondly, some responses were being received from these sources.

⁹⁴ The number of relevant representative groups for inclusion was found to vary across population groups; some having a well-established national and jurisdictional based representative structure; others with variable coverage. A growth in smaller specific-interest organisations was also identified; some of which cross population categories. All potentially relevant organisations were included, both to test the level of knowledge of and engagement with health complaint processes and to ascertain if there were new or particular issues relevant to specific populations.

Table 8: Survey 2: returns

Target group	Distribution		Exclude ¹	Not participate ²	Subtotal	Return		
	N	%				N	%	%
Population peaks	143	48	4	3	136	34	43	25
Consumer & consumer health	46	16	0	3	43	10	13	23
Professional & defence	106	36	2	6	98	36	36	37
Total	295		6	12	277	80		29

[1] Exclude: unable to contact

[2] Not participate: unable to participate; advised not suitable to participate

Incomplete returns defined as not completing first section treated as nil return N=2 [not presented in table]

3.6.5 Study limitations

The study is based on voluntary self-completed surveys about perceptions and experiences. It is possible that the responses may not reflect the experiences of others who lodge complaints. In particular, it is possible that respondents represent those less satisfied with the process or outcome; although feedback from those who decided not to participate suggests that respondents may also be more motivated than others.

The study includes one 'co-regulatory' jurisdiction (NSW). Because of the study timing, it was not possible to incorporate a second model that emerged (in Queensland) over the course of the study; which may have provided additional or different insights. The study may be limited by not including in the study some or all of the jurisdictional commissions that retain a role in complaint management.

There has been a range of developments and reforms to complaint processes over the course of this study. It is possible that some issues that featured significantly in responses have been addressed either in part or more substantially. Comment on developments as relevant is made in recognition of this.

Some variation was observed on key indicators when comparing jurisdictions, for example, in relation to reported delays and outcomes. [A3.1] However, given the limited scale of the data, no substantive observations can be made and so these data are not reported in this thesis.

A range of source-specific, issue-specific, population and policy issues were raised in the surveys and interviews. These included people making a complaint that related to an examination for medico-legal purposes; people whose relatives had died; issues relating to regulatory requirements (e.g. mandatory notifications) and particular practices or standards. It is beyond the scope of this thesis to report these in full, and many are only touched upon. They will be the subject of future publications.

3.7 Data analysis

An Excel (2010) spreadsheet was established to record Survey 1 responses and data from hard copy returns were entered manually. A similar spreadsheet was prepared for Survey 2

responses. Online surveys were downloaded and copied into the appropriate spreadsheet. Coding rules were established for managing missing, ambiguous or inconsistent responses. As the two surveys contained numerical and text responses, these rules were tested with one quantitative and one qualitative research expert. After all responses were entered, each original survey was re-checked in full against the Excel spreadsheet for entry errors and to ensure consistency in applying coding rules. The final Excel spreadsheets (minus text responses) for each survey were transferred to SPSS 22 for analysis.

Frequencies and cross-tabulations of Survey 1 responses were undertaken. As supplementary surveys followed the pattern of full responses, full survey responses were analysed for reporting purposes.

Initial cross-tabulations were undertaken to assess ranked responses by source type; subject practitioner profession and agency. Subsequent cross-tabulations were undertaken to identify relationships as issues emerged; through frequencies and analysis of survey comments and interviews. This included, for example, understanding factors associated with reported 'delays' and 'compensation'.

Following this initial analysis and qualitative analysis of text responses, a logistic regression model was established to investigate the most negative and most positive responses to experience measures as survey response trends towards negative rankings emerged. The most positive responses were also tested to identify whether the same factors were influential. For survey 2, frequencies were tabulated, but due to more limited numbers, regression analysis was not attempted.

Comments accompanying rankings for each individual experience and satisfaction measure in Survey 1 were initially entered into an Excel spreadsheet and stratified according to rank with filters for subject profession; source type and agency. As possible comments were categorised according to whether they related to the agencies, original events or other bodies. Comments provided by respondents were initially quantified, with tables created for frequencies categorised by response ranking, agency; subject practitioner and source type.

For each experience and satisfaction question, an initial word by word and line by line reading of responses was undertaken to highlight key words and phrases. Word by word analysis was particularly useful in capturing key emotions. Repetitions and common concepts were then grouped into broad categories; comprising some 20-25 categories per question. Coding for each question was reviewed to check for consistency of approach (for quantitative purposes) and for interpretive potential.

The initial categories established were substantially revised as additional survey responses were added, analysis resulting in a gradual discarding, merging and refinement of categories,

establishment of sub-categories and identification of key explanatory concepts. Notes on possible cross-category relationships, contextual points and questions arising from the data were made continuously; and a diary kept through the process.

Although comments were initially analysed and coded on a 'question by question' basis; common categories across measures emerged and matrices established to explore and synthesise dimensions between and within categories. NVivo (version 10) was used selectively as a tool to explore relationships between categories and to pursue emergent concepts such as 'value' and 'right'. Questions and issues arising from the data were pursued by further quantitative analysis or the interview process.

Line by line coding and analysis of comments in Survey 2 was undertaken for their explanatory value relative to key issues and emergent concepts arising in Survey 1. This included, for example, barriers in access to complaints processes or making complaints.

Interviews were transcribed by the researcher, some using Dragon® NaturallySpeaking Professional (Version 12) speech recognition software; and content analysis of the transcribed surveys was undertaken using Excel and NVivo software. Interview extracts are designed to illustrate and expand on issues raised in surveys; those included reflecting views expressed in multiple interviews on the same subject. A line by line analysis of extracts from interviews was undertaken for specific purposes, such as understanding what survey respondents meant by 'disciplinary action'. Analysis of select interviews was also undertaken to explore the temporal dimensions of respondents' reports.

Chapter 4. Results: about the survey respondents

This chapter addresses study Objectives 2 and 3 by describing the profile and motivations of those making a complaint; and any significant variation in responses between complaint systems or professions.

Sections 4.1 - 4.5 relate to Survey 1. Section 4.1 describes respondents to Survey 1 and Section 4.2 the professions the complaints were about. Section 4.3 reports on when and where events occurred and issues that led to the complaint being made, including major issues relating to specific professions. Section 4.4 reports on the reasons given for making the complaint; what they wanted for the practitioner; what they wanted for themselves or their organisation and whether they would use the practitioner again. Section 4.5 reports on respondents' views about error. Section 4.6 describes the organisations responding to Survey 2, the extent of their contact with the agencies and their involvement in complaint processes.

4.1 Survey 1: who made the complaint or notification

The majority of the 1,731 completed full surveys related to complaints lodged by consumers (66%), followed by health practitioners ('practitioners') (21%) and third party professionals or organisations ('organisations') (14%). [A4.1]⁹⁵ Individuals account for the majority of complainants for all professions except nurses and midwives ('nurses'), where organisational complainants account for nearly half of the responses; with nurses representing the largest proportion of surveys completed by organisations.^{96,97} (Table 9)

Table 9: Survey 1: returns by source (respondent) type and profession of subject practitioner

	Individuals [1]		Organisations [2]		Total	
	N	%	N	%	N	%
All responses	1490	86	241	14	1731	
AHPRA	873	84	169	16	1042	60
NSW	617	90	72	10	689	40
Medical (DR)	988	95	58	6	1046	60
<i>All excluding medical practitioners</i>	502	73	183	27	685	40
Nursing/midwifery (NMW)	175	54	152	47	327	19
Pharmacy (PHARM)	72	86	12	14	84	5
Dental (DENT)	155	98	4	3	159	9
Psychology (PSY)	100	87	15	13	115	7

Totals may not equal 100% due to rounding

Subject practitioner is the practitioner the complaint is about

[1] Individuals include consumers and practitioners

[2] Organisations include organisations and third party professionals (3PP) where a 3PP is not a registered health practitioner e.g. a lawyer

⁹⁵ Additional tables contained in the appendices appear in brackets e.g. [A4.1] is Appendix 4, Table 1

⁹⁶ 'Individuals' throughout this thesis refers to both consumers and practitioners

⁹⁷ As indicated in Chapter 3, the low level of organisational responses for pharmacists (3%) reflects the high volume of matters handled by pharmaceutical service units (PSUs) within jurisdictions; the study design (one survey per closed complaint); and exclusion of PSUs in survey distribution from month 3 onwards.

4.1.1 Demographic profile of individuals completing the survey

Sixty-three percent of all individual respondents completing the survey were female, this figure being slightly lower in matters handled by the HPCA. [A4.2] In comparison, just over half of all Australians are female.(415) The median age of respondents was 50 years, compared with an Australian median of 37 years.⁹⁸(415) Two percent were Aboriginal or Torres Strait Islander peoples compared with three percent identified in the Australian census.(416) Ninety percent had English as their first language, compared with 81 percent of the Australian population who speak only English at home.(417) Some 40 languages were spoken by people whose first language was not English. Twenty-one percent reported having a disability, consistent with the population generally (18.5%).(418, 419) While not specifically asked, a small number (N=10) indicated they had a mental illness; compared to an estimated one in five Australians who experience mental illness each year.(420)

Three-quarters of respondents lived in a city or regional centre, consistent with the overall population distribution.(421, 422) Ninety percent of individual respondents from outside NSW indicated where they lived, with nearly 60% either from Victoria (31%) or Queensland (28%), followed by Western (17%) and South (16%) Australia. Tasmania and the ACT accounted for four percent each and the Northern Territory one percent. This is broadly consistent with the population distribution across Australia.⁹⁹

4.1.2.1 Practitioner complainant/notifiers

The demographic profile of individual respondents can be divided into two groups- consumers and practitioners. When compared there was little difference except for level of education, disability status and to a lesser extent where they lived. Only small variations were noted when comparing agencies. [A4.2] Educational profile differs significantly – 89 percent of practitioners had a university education compared with 38 percent of consumers. Thirty-five percent of consumers had a diploma or trade certificate and 28 percent had primary or high school credentials as their highest level of education.

The gender and age of practitioner complainants who were doctors were compared with all other practitioners. A higher proportion in the ‘non-medical’ cohort were female (77% compared with 61%), reflecting the dominance of complaints about nurses, where practitioner complainants are predominantly female (88%), reflecting the profession profile. [A4.3]

⁹⁸ 53 percent of Australians are working age (25-64 years) and 15 percent are 65 and over (Australian Institute of Health and Welfare (2015) *Australia's Welfare 2015*). While the decadal age groupings of the survey do not correlate directly, just under two-thirds of survey respondents were working age and therefore over-represented; and under 10 percent were aged 65 and over and therefore under-represented relative to the general population.

⁹⁹ In order of population size (proportion of Australian total), these are the states of NSW (~32%), Victoria (~25%), Queensland (~20%), Western Australia (~11%), South Australia (~7%) and Tasmania (~2%); the Australian Capital Territory (~2%) and the Northern Territory (~1%).

Practitioners lodging concerns about non-medical practitioners were also younger – with a higher proportion aged 30-49 years (47% compared with 30%).

Ninety-eight percent of health practitioners who made a complaint and completed the survey described their relationship to the practitioner complained about. Sixty-one percent (N=214) were in the same profession [A4.4], medical and nursing practitioners accounting for 82 percent of these. For all professions except nurses, approximately half of the practitioners were in the same profession. Of those in the same profession that provided further details (N=177), just under half (47%) were a peer, 41 percent were senior and only 12 percent junior to the practitioner subject of complaint. The juniors consisted almost entirely of medical or nursing practitioners. Comment is limited due to the small numbers involved; however, nurses represent the lowest level of complaints from peers of all professions under study.

4.1.2 Type of organisation completing the survey

Nearly three-quarters of organisational respondents were from a public or private hospital or other health provider. (Table 10) The AHPRA and 'all NSW' proportions are similar across organisation types.

Table 10: Survey 1: organisational respondents: type of organisation and agency managing

	AHPRA		NSW		HPCA		HCCC		Total	
	N	%	N	%	N	%	N	%	N	%
All responses	169		72		58		14		241	
Public hospital	80	47	35	49	32	55	3	21	115	48
Private hospital	16	10	4	6	3	5	1	7	20	8
Other health provider	30	18	11	15	7	12	4	29	41	17
Education provider	6	4	3	4	2	3	1	7	9	4
Government organisation	16	10	9	13	5	9	4	29	25	10
Aged or community care	11	7	2	3	2	3	0	0	13	5
Other	10	6	8	11	7	12	1	7	18	8

Sixty-three percent of organisational complaints were about nurses and midwives; medical practitioners accounted for nearly one-quarter. (Table 11) Sixty-eight percent of all organisational complaints were lodged by employers (86% in the case of nurses).

Table 11: Survey 1: organisational respondents: subject practitioner and agency managing

		AHPRA		NSW		HPCA		HCCC		Total	
		N	%	N	%	N	%	N	%	N	%
	All practitioners	169		72		58		14		241	
Subject practitioner	DR	41	24	17	24	13	22	4	29	58	24
	NMW	108	64	44	61	36	62	8	57	152	63
	PHARM	6	4	6	8	6	10	0	0	12	5
	DENT	2	1	2	3	2	3	0	0	4	2
	PSY	12	7	3	4	1	2	2	14	15	6
Employer	All practitioners	121	74	43	26	36	22	7	4	164	68
	NMW	98	75	32	25	27	21	5	4	130	86

Totals may not equal 100% due to rounding

4.1.3 Complaints and notifications that were made for someone else

Twenty-seven percent of all individuals complained on behalf of someone else, the proportion higher among practitioner complainants (38%) compared to consumers (24%). [A4.5] A smaller proportion (16%) of organisations said they took action for others, nearly 80% of these complaining about a medical or nursing practitioner, in equal proportions.

One-quarter of all complainants acted for a child; one-third for either a parent or partner. (Table 12) Another quarter acted for their client/patient or the broader community and nine percent for the practitioner, a colleague or staff. In complaints about a medical practitioner, most respondents acted for immediate family (i.e. children, partner and parents) compared with clients, patients and the broader community for all other practitioner types.

Table 12: Survey 1: relationship to respondent where respondent acted for another person

	Total		DR only		All other [1]			Total		DR only		All other	
	N	%	N	%	N	%		N	%	N	%	N	%
Child	120	24	84	27	7	8	Other relative, friend	43	9	29	9	7	8
Partner	84	17	62	20	11	12	Client, patient [2]	117	24	53	17	36	40
Parent	85	17	67	21	11	12	Colleague [3]	43	9	21	7	17	19

[1] All other = all other professions, excluding medical practitioners

[2] Client, patient, future patients, residents, broader community

[3] The practitioner, colleague, staff, practitioner's employer

4.2 Survey 1: which profession the complaint or notification was about

Medical practitioners were the subject of 60 percent of the 1,731 completed (full) surveys, followed by nurses and midwives (19%), dental (9%), psychology (7%) and pharmacy (5%) practitioners. Individuals accounted for over three-quarters of complaints about medical practitioners, but less than half of all other professions. (Table 13)

Table 13: Survey 1: returns by source (respondent) type and subject profession

	Total %	Medical practitioners %	All other practitioners %
Consumer	66	77	47
Practitioner	21	17	26
Organisation	14	6	27

Totals may not equal 100% due to rounding

The proportion of survey returns is consistent with the proportion of complaints received by the agencies for the five professions in the survey period (2103-14). (Table 14) Survey returns relating to AHPRA (60%) are under-represented relative to matters received (68%) or closed (67%).

Table 14: Survey 1: returns compared with 2013-14 complaint/notification figures

	Complaints/notifications received						Complaints/notifications closed						Survey Returns
	AHPRA		NSW		Total		AHPRA		NSW		Total		
	N	%	N	%	N	%	N		N		N	%	
DR	3812	59	1773	57	5585	59	3680		1835		5515	59	60
NMW	1414	22	596	19	2010	21	1321		556		1774	19	19
PHARM	322	5	192	6	514	5	286		178		464	5	5
DENT	582	9	369	12	951	10	636		379		1015	10	9
PSY	319	5	168	5	487	5	322		162		484	5	7
Total 5 professions	6449		3098		9547		6245		3110		9355		
% of all professions		68		32		95		67		33		95	

Source: Australian Health Practitioner Regulation Agency (2014) *Annual Report 2013/14*¹⁰⁰

4.2.1 Gender of practitioner the complaint or notification was about

Sixty-five percent of subject practitioners were male, although this varied across professions, being higher among medical and dental practitioners (81% and 71% respectively) and lowest among nurses and midwives (17%) the latter reflecting the profession profile. [A4.6]

Males are over-represented in complaints in all professions except psychology. [A4.6] Any variations between agencies and practitioner types are associated with low numbers, and consequently no conclusions are drawn.

4.3 Survey 1: when and where events occurred that led to the complaint or notification and the issues involved

The most common places associated with complaints were sole or group private practice (44%) and hospitals (31%). (Table 15) The former is highest for dentists (91%) and pharmacists (90%).¹⁰¹ Hospitals accounted for over half of nursing matters and one-third of medical practitioners. Twenty percent of nursing matters occurred in residential or aged care facilities. [A4.7] The location of events is broadly consistent across the agencies. Individual respondents identified sole and group practice in just under half of complaints; public hospitals accounting for a similar proportion for organisational respondents.

Table 15: Survey 1: main location of events that gave rise to the complaint/notification by subject profession, source (respondent) type and agency managing

	Total		Subject profession											
			DR		All excl. DR [1]		NMW		PHARM		DENT		PSY	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Hospital all [2]	526	31	336	33	190	28	172	53	3	4	6	4	9	8
Sole/grp practice	760	44	532	52	228	34	12	4	1	90	143	91	72	64

Table 15 continued

	AHPRA		Agency HPCA		HCCC		Individuals		Source (respondent) type					
									CONS		PRACT		ORG	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Hospital all	328	32	83	29	115	29	409	28	289	26	120	34	117	49
Sole/grp practice	439	43	122	43	199	50	714	48	597	53	117	33	46	19

[1] All excl. DR= all professions excluding medical practitioners

[2] Hospital all = public hospitals (inpatient and outpatient) and private hospitals

¹⁰⁰ There is some variation with final figures due to subsequent data reviews by the HPCA (AHPRA *Annual Report 2013/14* p. 46) and as published by the NSW HCCC (2014) *Annual Report 2013/14* (Complaints received: DR: N=1664 Proportion of complaints for 5 professions=59%; NMW: N=476 17%; PHARM N=167 6%; DENT N= 361 13%; PSY N= 148 5%)

¹⁰¹ A pharmacy outside a hospital setting is included as private practice.

One-fifth of respondents said the events leading to their complaint occurred less than six months prior to completing the survey; over half less than 12 months and three-quarters less than 2 years. (Table 16) The proportion of complaints over two years old was lowest for dental and nursing practitioners; if made by an organisation or handled by a NSW agency. [A4.8]

Table 16: Survey 1: when events leading to the complaint/notification occurred (time prior to completing survey) by subject profession

	Total		DR		NMW		PHARM		DENT		PSY	
	N	%	N	%	N	%	N	%	N	%	N	%
Less than 6 months	360	21	209	20	69	22	24	29	39	25	19	17
Less than 12 months		54		52		61		70		55		48
Less than 2 years		79		77		87		94		82		72
2 or more years		19		22		13		5		18		28
Total	1699		1027		321		82		155		114	

Totals may not equal 100% due to rounding

4.3.1 Issues giving rise to the complaint or notification

Respondents were asked to describe the event that led to their complaint by selecting all answers that applied to them from a menu of fifteen categories¹⁰²; and to indicate the main issues within these categories. 'Care or treatment' was most commonly raised (57%), followed by 'conduct' (47%), 'communication' (40%) and 'competence' (31%). (Table 17)

'Communication', 'care or treatment', 'access arrangements', 'fees' and 'reports' were issues most frequently raised by consumers; while organisations (followed by practitioners) accounted for the highest proportion of 'health' (impairment) related matters. [A4.9] A similar proportion of matters relating to 'consent', 'privacy' and 'complaint' management were raised by both consumers and practitioners. Issues raised by all concerned 'conduct', 'competence' and 'medication'.

Table 17: Survey 1: main issue that the complaint/notification was about

	Care, treatment		Conduct		Communication		Competence		Medication, pharmacy		Complaint response		Records	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
All	984	57	806	47	692	40	538	31	404	23	393	23	320	19
AHPRA	585	56	497	48	410	39	347	33	259	25	245	24	202	19
NSW	399	58	309	45	282	41	191	28	145	21	148	22	118	17
HPCA	141	49	126	44	100	35	77	27	58	20	58	20	43	15
HCCC	258	64	183	45	182	45	114	28	87	22	90	22	75	19

Table 17 continued

	Access, care arrangements		Consent		Reports		Health		Bill, Fees		Privacy, confidentiality		Discharge, transfer	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
All	292	17	256	15	200	12	196	11	187	11	171	10	105	6
AHPRA	179	17	153	15	119	11	135	13	95	9	118	11	67	6
NSW	113	16	103	15	81	12	61	9	92	13	53	8	38	6
HPCA	34	12	38	13	28	10	40	14	23	8	24	8	8	3
HCCC	79	20	65	16	53	13	21	5	69	17	29	7	30	7

¹⁰² These categories were: Bills or fees; Access or care arrangements; Discharge or transfer arrangements; Records; Reports or certificates; Communication; Consent; Medication or pharmacy; Care or treatment; Practitioner conduct or behaviour; Practitioner health; Practitioner competence; Privacy or confidentiality; Complaints; 'Other'

There was a high degree of consistency between the national scheme and NSW; variations mainly reflecting roles, e.g. AHPRA and HPCA show a higher proportion of ‘*health*’ related matters than the HCCC; which the latter would not normally handle unless conditions were breached and the matter referred for investigation. The most notable variation relates to a higher proportion of ‘*care or treatment*’ complaints handled by the HCCC.

‘*Conduct*’ features in the top three issues across all professions; and ‘*communication*’, ‘*care or treatment*’ and ‘*competence*’ feature in the top four issues for four of the five professions. (Table 18)

Notable variations between the professions include nurses, who accounted for a higher proportion of ‘*health*’-related matters; psychologists had higher proportion of ‘*privacy and confidentiality*’ issues and dentists ‘*bills or fees*’ matters (although the latter was only the fifth highest category of issue for that profession). Practitioner differences are discussed in more detail in the following sections.

Table 18: Survey 1: main issues in order of frequency by subject profession

	Highest	%	Second	%	Third	%	Fourth	%	Fifth	%
DR	Care, treatment	66	Conduct	46	Communication	46	Competence	32	Cplt response	25
NMW	Conduct	53	Care, treatment	41	Medication	31	Competence	29	Health	28
Pharm	Medication	77	Conduct	29	Communication	27	Cplt. response	25	Bills, fees	16
Dent	Care, treatment	74	Competence	39	Conduct	37	Communication	34	Bills, fees	29
PSY	Conduct	57	Communication	48	Competence	37	Care, treatment	28	Reports	28

Forty-one percent of people interviewed had included communication as an issue in their complaint. Cases 1 and 2 were selected for inclusion of practitioner communication as a primary focus of complaint. These are different to other complaints about communication which focus on the disclosure, non-disclosure or veracity of information provided. Both respondents had sought an apology.

Case 1 highlights the cumulative impact of interactions from original events through to the complaint process that can add to feelings of distress and perceptions of unfairness. The case highlights several dimensions of value that emerged over the course of the study. These include value of self as a respected and respectable person; notions of comparable value and superiority (‘esteem’); historical value of the practitioner-patient relationship; value (importance) of issues raised; and the value (cost) in raising concerns.

Also raised are notions of patient ‘rights’ and what is ‘right’, in terms of practitioner behaviour and agency assumptions and behaviours. The latter includes deferring to practitioners and communicating ‘thresholds’, which appears in other complaints, including Case 9. This case also illustrates a narrative relating to a long-standing condition and ‘lack of solutions’; in

contrast with other narratives about a series of interactions relating to events giving rise to the complaint and their management. Unlike others who sought a mediated process, they would have valued a direct response from the practitioner.

Case 2 focuses on the potential of poor communication to impact on health outcomes; and comments on a missed opportunity by the agency to obtain feedback to improve the process. Consistent with other responses, the interviewee stresses they are not a 'common complainer'; reporting they reflected carefully before raising their concerns. The closure interaction communicated to them they are unnecessary, superfluous to the full process.

Box 2: Interview extract: complaints involving communication

'Cathy' (Case 1) describes feeling belittled by the doctor she complained about. This appears reinforced by the time and expense involved in a specialist consultation and the lack of 'solutions' offered to address her condition. She feels further humiliated by being encouraged to lodge a complaint, but then being told her issue did not warrant action beyond seeking a response from the doctor; and being told no 'wrong' was identified. This is reinforced by lack of an apology and 'justifying' by the doctor. Cathy suggests it would help if the 'burden of proof' on which complaints were assessed was made clearer to help people decide whether they want to make a complaint. This is linked to the humiliation she expresses which may have been avoided. The interaction with the (complaint) agency is unusual in the explicit exchange about the standing ('high esteem') in which doctors are held, but consistent with perceptions of bias and unfairness of other respondents. The reported exchange between Cathy and the agency highlights how sensitive complainants are to the nuance of what is communicated, whether intended or not.

Case 1

Respondent: When we spoke to people, everybody said, "Go ahead with this. The doctor really shouldn't have been able to do that". And then, once you lodge then they say, "No", that's not enough, it doesn't meet their burden of proof, but we didn't know what their burden of proof was we had to meet. When we verbally spoke to anybody, they said "yes, you have got a good complaint, go ahead, go ahead". So you think, ok, something might come of this, and it didn't.

Interviewer: Did you find it difficult to make the complaint?

Respondent: Only that I had never done it before. And I don't normally like to complain about people, but it was actually my husband that pushed it and the state that I was in after my last visit with this doctor. He [my husband] said 'no, it's not right'. I came out of there so distressed and just couldn't believe all the time and money that we had spent [describes financial circumstances], and then his response. And then I thought, maybe my husband is right. Maybe he shouldn't be able to do that.

Interviewer: Had anyone contacted you in the period from when you lodged the complaint and received a response?

Respondent: I think there were two phone calls at the end. One saying "this is his response- I've sent you an email- we can talk about it after you have read the email". So I read the email, his response to my complaint; and we talked again, and I said "well, I don't see any apology there; I don't see any explanation there." And that's when she said 'under the criteria of what we do, he really hasn't done anything wrong. Doctors are held in high esteem and all of that.' And I said "and what about patients?"

Interviewer: She said "doctors are held in high esteem"?

Respondent: Yes

Interviewer: And you said "and what about patients"?

Respondent: Yes, because are we not held in high esteem? He's a doctor, he's better than I am?

Interviewer: What was the context for those remarks - can you remember?

Respondent: Oh, just that she was saying that my complaint didn't meet any burden of proof. As far as they could see, he really hadn't done anything wrong within their boundaries.

Interviewer: Can I ask, you lodged your complaint, they contacted you and said 'let's discuss this'; even though you weren't happy with the content of that conversation- if I can put it that way- did you think that it was a helpful process?

Respondent: It should have been. If I had known more about it before I went into it. If I had known what the criteria was they were looking at. Before you put yourself through all of that, and then get told 'nope, as far as we can see'.

Interviewer: Understanding more about how things are looked at, how issues are assessed?

Respondent: If you have that information, maybe you can make a more informed decision about whether you would like to go ahead with it. But when you're not sure and nobody explains anything to you, and all they say in the beginning is, it goes to this commission and it will be looked at – they don't tell you that there is a heavy burden of, I guess, proof. And I guess because doctors are held in such high esteem within our community, their standards at which they accept is not good practise or not a good service that they are providing – but you don't know what those standards are. ... I wasn't so much saying that I was accusing him of malpractice or anything like that. I just was unhappy with things that he said to me and the treatment that I received. And the treatment I didn't receive.

Interviewer: Do you mean your medical treatment or his behaviour or language towards you?

Respondent: Both, both. I mean it's not necessarily malpractice or negligence, but morally, some of the things he said to me he shouldn't have said. But again, what she [from the HCCC] was saying to me was that doctors are held in high esteem and that my complaint doesn't meet the burden of proof that there was any wrongdoing on his part. And I said, "well why am I not held in high esteem – you don't know me and you don't know him". Because he is a doctor, why does that necessarily make him better than me? I have worked in the community, I have paid my taxes, I contribute to my community by doing volunteer work, why am I not good enough because I don't have 'doctor' in front of my name? The message I was getting was that I

wasn't good enough and that he was better than me, so we are just going to throw this out.

Interviewer: *So you feel there were different levels of regard, or respect there?*

Respondent: Yes

Interviewer: *Was there any dispute about what you raised?*

Respondent: He acknowledged that what was said and everything was correct. He wasn't saying that I was making it up or that it didn't happen; but he was justifying it; [and] that made it ok- it didn't fall within the realms of bad behaviour on his part.

Interviewer: *You saw his response?*

Respondent: Yes

Interviewer: *Did you think that was helpful?*

Respondent: In a way, but it would have been more helpful if he had actually addressed it to me; and made some sort of apology or explanation to me. Rather than, he has done it to them. And still, at this point, has made no contact with me at all. I mean that would be something. If he made contact with me, and apologised if he caused any; he knew I was distressed on the day I walked out and I haven't been back to see him.

Interviewer: *This is someone you had seen for quite some time?*

Respondent: I had seen him several times- he is a specialist. And I had seen him a number of times and had to pay for the visits. And it would have been nice. I mean, you are paying big money for a specialist visit; and he knew I was extremely distressed; and I asked - what was the solution to fix my problem and all he said was [quotes]. I mean, that's not an answer; that a specialist should be saying and that will fix the problem. I felt that I was being belittled in a way.

Interviewer: *You indicated in your survey that you withdrew at one point – is that correct?*

Respondent: It was at the end, when she said, given his response, you can take it further, or you can withdraw now. This was when she was saying that there was nothing in what he did or said that makes it, any wrongdoing on his part. She said "you can pursue it if you want to, but the outcome will be the same; in that nothing will happen". And so that's when I said, "Well, I mean really is there any point then? You are telling me now that my complaint isn't valid; so why then would I try and take it further and have everybody else tell me it's not valid?"

Interviewer: *Can I ask, did she say that it wasn't valid or the fact that she didn't think it was going to be pursued suggested to you that they thought it wasn't valid?*

Respondent: More that she suggested that it wasn't valid. But again, when I said that that's how I felt; that you have just virtually said that my complaint isn't valid, she didn't correct me. She didn't say "Oh no, that's not what I am saying". I mean she didn't say it in those words that 'your complaint is not valid'; more that you can take it further but that there isn't enough evidence to say there was any wrongdoing. And that's when I said [what I did] and she didn't correct me.

Case 2

Respondent: An apology was to have appeared through the complaint process. It didn't make a huge difference to me - I found the solution in my own way, but I wanted a response that showed he saw what he done and understood what he done and that he wouldn't do it again and that's the real priority. I left the process unsure that - if that - had been achieved.

Interviewer: *Had you raised this directly with the doctor?*

Respondent: I had raised it with the practitioner first. I phoned that afternoon and spoke to the practice. He phoned back and said yes, you need that dose, but he didn't explain the results or the implications of the findings. I got a little more information from the doctor. I had been experiencing [name] problems and my mother died of [type] cancer. I had had a [name of test] and was shown a picture or a scan that I didn't really understand and the doctor said "you're fine". He then launched into a tirade about my weight and was very rude. He mentioned [name of very thin people] as "an ideal state". My mother had eating disorders and was very overweight and blamed her medical problems on weight. So it was very pertinent to my situation. I had gone to a dietician for weight loss and could lose [number] kg but was really struggling. I therefore felt really undermined by the doctor; shattered. It was like a verbal assault; so bad that the nurse said "he was pretty hard on you", so it wasn't just my perception that he was behaving inappropriately. He had recommended a double dose of medication when I saw him in the morning and on the phone when I called. I questioned it in the afternoon as I had already doubled the dose and he didn't explain why it should be increased again. Also neither my GP nor my dietician wanted me to do this. Therefore, it was very important to be clear about the dose and the reason it was being increased so much.

Interviewer: *What happened after that?*

Respondent: I waited 7 to 10 days before I went to the HCCC. I wanted to be clear about what I thought the issues were and what I wanted out of the process. For example, I wanted the dosage explained. I wanted a clear statement about [name] cancer. I wanted the verbal assault on me about my weight addressed. And I wanted his outdated advice about diet addressed. His manner, his medical advice and his diet advice is what I wanted addressed. I got a letter of apology - I would call it a 'reasonable attempt'. I was surprised I didn't get this letter directly through the process. I feel it was a result of my going to the HCCC and not genuine contrition on his part.

Interviewer: *Did you have the opportunity of commenting on or discussing the doctor's response?*

Respondent: When I got an email from them (the HCCC) I thought they wanted to know my response to this letter. But they just said "we don't need your decision, we've decided to close the case." This is a really critical step. It would have been nice to give feedback on what I thought about his response. For example how he made excuses for his behaviour, how the dietician had pointed out that my losing [number] kg under the circumstances was good. I feel that it was a qualified apology, and didn't get a chance to respond to that (his feedback). My concern is that he's still doing it - he is still behaving that way.

Interviewer: *What do you think the consequences of that are?*

Respondent: I think it could easily end up with a lot of women with eating disorders, that's why it matters. He attacked me. Attacking the self-image of women is significant for women and I don't think he understood that and I don't think they [HCCC] understood that it has serious consequences.

Interviewer: *Do you have any other comments about the process?*

Respondent: I think it is really good that there is a complaint process; I think the work is important. But I also think it can be refined and improved

4.3.1.1 Main issues involving medical practitioners

Comparing medical practitioners with all other professions, the most notable differences are a higher proportion of '*care and treatment*' and '*communication*' issues for medical practitioners. (Table 19)

Twenty percent of '*communication*' issues were directly associated with inappropriate or poor care or an adverse outcome. '*Complaint response*' is also proportionally higher for this practitioner group, although not insignificant for all professions. The proportion of the three most commonly reported issues are similar for AHPRA and NSW.

Table 19: Survey 1: main issues involving medical practitioners

	Care, treatment		Conduct		Communication		Competence		Cplt response	
	N	%	N	%	N	%	N	%	N	%
All practitioners	984	57	806	47	692	40	538	31	393	23
All excluding DR [1]	291	43	322	47	210	31	208	30	132	19
DR	693	66	484	46	482	46	330	32	261	25
DR AHPRA	391	66	271	46	270	46	200	34	159	27
DR NSW	302	66	213	47	212	46	130	28	102	22
DR HPCA	95	60	82	52	65	41	47	30	37	23
DR HCCC	207	70	131	44	147	49	83	28	65	22
Consumer [2]	576	71	356	44	395	49	259	32	214	27

[1] All excluding DR = all professions excluding medical practitioners

[2] Consumer = consumer complaint about a medical practitioner

Common issues relating to '*care or treatment*' were inadequate consultation, examination or treatment; incorrect diagnosis or failure to diagnose and adverse outcomes (or failure to report or respond to an adverse event); followed by wrong or unnecessary treatment. (Table 20) '*Other*' treatment comments related to a lack of infection control or lack of communication or honesty about treatment.

Over one-quarter of '*conduct*' issues related to aggressive, bullying or harassing behaviour; followed by unprofessional or unethical behaviours and skill or supervision issues associated with poor care or adverse outcomes. Fraud or other unlawful conduct, and inappropriate physical or sexual comments or contact accounted for approximately one-third of issues (in equal proportions).

Over half of '*competence*' issues related to poor technique associated with inappropriate or poor care or outcomes; and just less than one-quarter to a lack of skill or qualifications including out-of-date practices. The remainder concern inadequate assessment or diagnosis; and issues relating to safety (associated with either skill or impairment); and poor communication or care.

In similar proportions, '*complaint response*' issues included a failure to respond to a complaint; a lack of response or refusal to meet, and hostile, angry or threatening responses. These were followed in turn by lack of a complaint process, being punished or experiencing retaliatory behaviour for raising a complaint or reports of obstructive responses and behaviour.

Some respondents commented about the agencies, including their difficulties in having their issues taken seriously; frustration that a pattern (i.e. more than one complaint) is required for a problem to be recognised or acted on; challenges facing people with mental illness in having their complaints recognised; and concern that complaint data are not shared.

Table 20: Survey 1: issue sub-categories (where specified) involving medical practitioners

Table 20: Survey 1: Issue sub-categories (where specified), involving medical practitioners												
Care, treatment ¹	Inadequate		Diagnosis		Adverse		Wrong, unnecessary		Other treatment		Other	
	N	%	N	%	N	%	N	%	N	%	N	%
	303	21	289	20	262	18	224	16	256	18	90	6
Conduct ²	Aggressive		Unprofessional		Skill, conduct		Inappropriate physical		Fraud, other unlawful		Inappropriate sexual	
	N	%	N	%	N	%	N	%	N	%	N	%
	141	27	120	23	85	17	57	11	56	11	50	10
Communication ³	Wouldn't listen, answer		Rude, disrespect		Didn't speak, explain		Inappropriate		Not truthful			
	N	%	N	%	N	%	N	%	N	%		
	81	28	78	27	73	25	36	16	18	6		
Competence ⁴	Technique		Currency, skill		Assessment, diagnosis		Other					
	N	%	N	%	N	%	N	%				
	154	54	66	23	32	11	31	11				
Complaint response ⁵	Not respond at all		Didn't act, refused		Hostile		Lack process		Punished		Obstructive	
	N	%	N	%	N	%	N	%	N	%	N	%
	52	20	50	20	49	19	42	16	36	14	19	7

Percent is the proportion of responses with identified sub-category issues (excludes responses where the main was category selected but the sub-category was not specified). Participants could select more than one issue sub-category.

[1] Care, treatment: Inadequate= inadequate consultation, examination, testing or treatment; lack of skill, competence; supervision; oversight; Diagnosis= failed to assess, diagnose; wrong diagnosis; Adverse= adverse outcome (unexpected complications, harm or death); failed to respond or disclose adverse outcome; Wrong, unnecessary= wrong, unnecessary, excessive treatment or procedure; Other treatment= failed or refusal to treat; failed to monitor, follow up or review; Other= includes lack of hygiene or infection control; lack communication or honesty about treatment.

[2] Conduct: Aggressive= Aggressive, threatening, bullying or harassing; Unprofessional= unprofessional, unethical or dishonest communication or behaviour; Skill, conduct= skill, supervision or conduct associated with inappropriate, incomplete, poor or adverse care, management or outcome or rough or painful handling, examination or treatment; Inappropriate physical= inappropriate physical contact or assault; Fraud, other unlawful= fraud; over-servicing; other criminal or unlawful conduct; Inappropriate sexual= Inappropriate sexual comments, contact or relationship.

[3] Communication: Wouldn't listen, answer= wouldn't listen, answer questions or used jargon; Rude, disrespect= rudeness; disrespect; disinterest; abusive; Didn't speak, explain= didn't speak to me; explain or respond; inadequate consultation, referral, handover or communication of reasons for treatment or results; Inappropriate= Inappropriate comments; communication.

[4] Competence: Technique= poor technique; inappropriate, poor or adverse care/outcome; and/or requiring further treatment to rectify; Currency, skill= out of date treatment or practice; not qualified, skilled or competent to do work; Assessment, diagnosis= incomplete, lack of adequate assessment; failure to diagnose; misdiagnosis; Other = other- unprofessional, unethical conduct; fraud; other- safety related [relating to practices; impairment; other- aggressive, bullying, not listening, poor/failure to communicate, treat or refer [other subcategories in similar proportion).

[5] Complaint response: Didn't act, refused= listened but didn't do anything; refused to meet; Hostile= practitioner or their representative hostile or angry; threatening response; Lack process= lack of a complaints process; Punished= punished for making complaint; Obstructive= cover up; false response; obstructive; brushed off; dismissed; treated 'light weight'; supported practitioner; issue not addressed.

4.3.1.2 Main issues involving nursing and midwifery ('nurse') practitioners

The most common complaints about nurses related to 'conduct' (53%) and 'care or treatment' (41%). (Table 21) Issues were broadly consistent when comparing AHPRA and NSW responses. A higher proportion of 'conduct' and 'medication' matters managed by the HCCC and 'health' matters by the HPCA reflect the division of responsibilities in NSW. 'Care or treatment' is proportionally higher from consumers; 'conduct' from consumers and practitioners and 'health' concerns were almost exclusively from organisations or practitioners.

Table 21: Survey 1: main issues involving nursing/midwifery practitioners

	Conduct		Care, treatment		Medication, pharmacy		Competence		Health	
	N	%	N	%	N	%	N	%	N	%
All practitioners	806	47	984	57	404	23	538	31	196	11
NMW all	174	53	135	41	102	31	94	29	92	28
NMW AHPRA	126	55	100	44	71	31	68	30	65	28
NMW NSW	48	50	35	36	31	33	26	27	27	27
NMW HPCA	19	36	17	32	11	21	12	23	22	42
NMW HCCC	29	64	18	40	20	44	14	31	5	11
Consumer [1]	42	62	38	56	17	25	18	27	1	2
Practitioner [2]	65	61	42	39	40	37	36	34	33	31
Organisation [3]	67	44	55	36	45	30	40	26	58	38

[1] - [3] Consumer/practitioner/organisation = source of complaint about a nurse/midwifery practitioner

Complaints about nurses were proportionately higher for ‘*medication*’ matters (the largest sub-category relating to unlawful prescribing or dispensing) and significantly higher for ‘*health*’ issues (predominantly substance misuse and mental health impairment). (Table 22) Safety features significantly in ‘other’ sub-category comments made e.g. 30 percent in ‘*conduct*’; 71 percent in ‘*care or treatment*’ and 80 percent in ‘*competence*’ related complaints.

Table 22: Survey 1: issue sub-categories (where specified) involving nursing/midwifery practitioners

Table 22: Survey 17 issue sub-categories (where specified) involving harm by midwifery practitioners												
Conduct ¹	Aggressive		Fraud		Other criminal conduct		Other					
	N	%	N	%	N	%	N	%				
	51	25	26	13	26	13	63	30				
Care, treatment ²	Inadequate		Failed to monitor, follow up		Adverse outcome		Wrong treatment		Delayed treatment		Other	
	N	%	N	%	N	%	N	%	N	%	N	%
	50	21	35	15	25	10	22	9	22	9	21	9
Medication, pharmacy ³	Wrong, unlawful prescribe, dispense		Given wrong drug or dose		Inadequate records, storage, security		Other					
	N	%	N	%	N	%	N	%				
	35	21	30	18	22	13	43	26				
Competence ⁴	Poor technique		Outdated treatment, practice		Other							
	N	%	N	%	N	%						
	29	35	15	18	40	48						
Health	Alcohol, substance misuse		Mental health impairment		Physical health impairment							
	N	%	N	%	N	%						
	44	49	35	39	9	10						

Percent is the proportion of responses with identified sub-category issues (excludes responses where the main was category selected but the sub-category was not specified). Participants could select more than one issue sub-category.

[1] Aggressive= aggressive, threatening, bullying or harassing. Analysis of ‘conduct’ comments indicates 30% of ‘other’ related to standards, safety; 30% to unprofessional conduct and 29% to rudeness and other inappropriate behaviour.

[2] Inadequate= Inadequate consultation, examination, testing, treatment; Adverse outcome= unexpected complication, harm, death. Analysis of ‘care/treatment’ comments indicates 71% of ‘other’ related to issues of safety or competence.

[3] Analysis of ‘medication/pharmacy’ comments found 56% of ‘other’ related to administration of medication including safety issues; 26% related to records including falsification of records and 23% to theft or misuse.

[4] Analysis of ‘competence’ comments indicates 80% of ‘other’ related to skills, knowledge, professional standards and safety.

4.3.1.3 Main issues involving pharmacy practitioners

Unsurprisingly, 77 percent of issues relating to pharmacists related to ‘*medication or pharmacy*’. Of these, nearly one-third concerned dispensing the wrong drug, dose or delivery method; and 27 percent unlawful or wrong dispensing, the latter including inadequate or mislabelling of products. (Table 23) These two sub-categories were also linked to ‘*competence*’ issues that were subject of complaint. Twelve percent of dispensing issues reported actual or potentially serious side-effects including life-threatening consequences and/or requiring hospitalisation.

‘*Conduct*’ represented 29 percent of identified issues. One-third related to ‘dispensing’ matters discussed above. ‘*Conduct*’ included threatening, harassing or discriminatory behaviour; fraud or theft; overcharging; and advertising practices.

Together with medical practitioners, pharmacists had the highest proportion of complaints (25%) relating to the practitioners complaint process or response to issues when raised. This included lack of a process; a hostile or indifferent response; blaming others and perceptions of ‘cover up’.

Table 23: Survey 1: issue sub-categories (where specified) involving pharmacy practitioners

Medication, pharmacy	Dispensed wrong drug, dose, delivery method		Wrong, unlawful dispensing		Side effects ¹		Inadequate records, storage, security		Not explain how to take or side effects		Other	
	N	%	N	%	N	%	N	%	N	%	N	%
	30	31	26	27	12	12	7	7	6	6	11	11
Conduct	Aggressive, harassing ²		Fraud		Other							
	N	%	N	%	N	%						
	5	26	5	26	9	47						
Communication	Rudeness, disrespect		Not listen, answer questions ³		Inappropriate comments		Other					
	N	%	N	%	N	%	N	%				
	12	33	12	33	8	22	4	11				
Complaints	Lack complaint process		Didn't act or respond		Hostile response, punished ⁴		Other					
	N	%	N	%	N	%	N	%				
	4	19	6	29	7	33	4	19				

Percent is the proportion of responses with identified sub-category issues (excludes responses where the main category selected but the sub-category was not specified). Participants could select more than one issue sub-category.

[1] **Side effects**= experienced side effects or actions had potentially serious side effects.

[2] **Aggressive, harassing**= aggressive, threatening, bullying or harassing behaviour or inappropriate physical contact or assault.

[3] **Not listen, answer questions**= wouldn't listen, answer questions or speak with me, used jargon.

[4] **Hostile response, punished**: practitioner hostile or angry; punished for complaining

4.3.1.4 Main issues involving dental practitioners

The most common dental issues were ‘*care or treatment*’ (74%), ‘*competence*’ (39%) and ‘*conduct*’ (37%). (Table 24) Similar issues were identified in AHPRA and NSW responses.

Table 24: Survey 1: main issues involving dental practitioners

	Care, treatment		Competence		Conduct		Communication		Bills, fees	
	N	%	N	%	N	%	N	%	N	%
All practitioners	984	57	538	31	806	47	692	40	187	11
DENT all	118	74	62	39	58	37	54	34	46	29
DENT AHPRA	66	76	38	44	41	47	31	36	23	26
DENT NSW	52	72	24	33	17	24	23	32	23	32
Consumer [1]	104	76	51	37	47	34	46	34	40	29

[1] Consumer = consumer complaint about a dental practitioner

Wrong or unnecessary treatment accounted for half of reported issues in '*care or treatment*' and inadequate treatment for one-third; followed by adverse outcomes; lack of hygiene or infection control; and either incorrect diagnosis or a failure to diagnose. (Table 25)

Nearly two-thirds of '*competence*' issues related to poor technique, with nine percent concerning refusal to refund for poor work or the patient having to pay for additional corrective work. Nearly half of '*bills or fees*' issues were about overcharging, including misuse of government funded or subsidised programs; and substitution of inferior products. Eleven percent of '*communication*' issues included comment about inappropriate, poor or adverse care or outcomes; and/or charges.

Table 25: Survey 1: issue sub-categories (where specified) involving dental practitioners

Care, treatment ¹	Wrong, unnecessary		Inadequate ²		Adverse outcome		Hygiene		Diagnosis	
	N	%	N	%	N	%	N	%	N	%
	107	48	59	34	40	23	13	6	11	5
Competence ²	Poor technique		Out of date		Cost, fee		Other safety			
	N	%	N	%	N	%	N	%		
	40	63	13	20	6	9	5	8		
Conduct ³	Care, outcome		Aggressive		Rough, painful		Fraud		Other	
	N	%	N	%	N	%	N	%	N	%
	24	33	16	22	14	19	11	15	8	11
Communication ⁴	Not listen, speak		Rude, disrespect		Other					
	N	%	N	%	N	%				
	41	54	32	42	3	4				
Bills, fees ⁵	Overcharge		Cost, not deliver		Lack agreement					
	N	%	N	%	N	%				
	25	47	19	36	8	15				

Percent is the proportion of responses with identified sub-category issues (excludes responses where the main was category selected but the sub-category was not specified). Participants could select more than one issue sub-category.

[1] Care, treatment: Wrong, unnecessary= inadequate, wrong or unnecessary consultation, examination, testing or treatment; Inadequate= inadequate consultation, examination, testing, treatment or follow up; Hygiene= lack of hygiene or infection control; Diagnosis= incorrect or fail to diagnose.

[2] Competence: Poor technique= poor technique; inappropriate, poor or adverse care/outcome; needed to have additional/repair work as a result; Out of date= out of date treatment or practice; not qualified to do work; not follow specialist advice; Cost, fee= refused refund for poor work; had to pay extra to get repaired etc.

[3] Conduct: care, outcome= conduct associated with inappropriate, incomplete, poor or adverse care/outcome and/or charges; Aggressive: aggressive, threatening, bullying or harassing; including pressure for additional work to be done; Rough, painful= rough or painful handling, examination or treatment; Other= inappropriate physical contact or assault or other unprofessional or unethical conduct.

[4] Communication: Not listen, speak= wouldn't listen; didn't speak to me or explain or answer questions; Rude, disrespect= Rudeness or disrespect; inappropriate comments.

[5] Bills, fees: Overcharge= overcharging including misuse of government funding programs or substitution of inferior product; demanding payment when inappropriate; refused refund; charge for unnecessary work; Cost, not deliver= cost or cost and non-delivery or poor/unusable result or harm (e.g. don't fit; cause pain; loss tooth); had to pay or pay again to have original problem or problem created by treatment fixed; Lack agreement= lack of agreement to or disclosure of costs or work involved.

4.3.1.5 Main issues involving psychology practitioners

Complaints about psychologists were proportionately higher in four of the five most commonly cited issues for this profession, being ‘conduct’ (57%), ‘communication’ (48%), ‘competence’ (37%) and ‘reports’ (28%). (Table 26)

Over three-quarters of complaints about a report were made by a consumer, who also accounted for nearly two-thirds of communication issues. Small numbers make observations about agencies difficult.

Table 26: Survey 1: main issues involving psychology practitioners

	Conduct		Communication		Competence		Care, treatment		Reports	
	N	%	N	%	N	%	N	%	N	%
All practitioners	806	47	692	40	538	31	984	57	200	12
PSY all	66	57	55	48	42	37	33	29	32	28
PSY AHPRA	46	55	37	44	32	38	24	29	26	31
PSY NSW	20	65	18	58	10	32	9	29	6	19
Consumer [1]	38	54	35	49	25	35	19	27	25	35

[1] Consumer = consumer complaint about a psychology practitioner

Nearly one-quarter of ‘conduct’ issues involved aggressive, threatening or bullying behaviour (two relating to impairment) and 17 percent to fraud, including falsification of reports. (Table 27)

‘Other’ conduct responses included unethical, unprofessional or misleading statements or conduct (47%); and discriminatory or offensive statements, attitude or behaviour (15%). One-third related to a report or other advice or evidence and three percent to unsafe practices. Most ‘report’ issues (79%) related to lack of objectivity, inclusion of false statements; and unprofessional behaviour in commissioning or undertaking the work such as failure to meet or interview the subject.

‘Communication’ issues included inappropriate comments or requests, rude and disrespectful behaviour or failure to listen to or speak to the subject of a report.¹⁰³

¹⁰³ Respondents indicated these reports were being prepared for medico-legal; workers compensation or Family Court purposes.

Table 27: Survey 1: issue sub-categories (where specified) involving psychology practitioners

Conduct ¹	Aggressive, harassing		Fraud		Inappropriate sexual		Other	
	N	%	N	%	N	%	N	%
	19	23	14	17	8		33	40
Communication ²	Inappropriate		Wouldn't listen, speak		Rude, disrespect		Other	
	N	%	N	%	N	%	N	%
	27	33	27	33	21	26	6	
Competence ³	Skill		Out of date		Other			
	N	%	N	%	N	%		
	23	64	8		5			
Care, treatment ⁴	Inadequate		Diagnosis		Adverse outcome		Refuse, delay	
	N	%	N	%	N	%	N	%
	30	48	11	18	11	18	9	
Reports ⁵	Inaccurate		Refuse, delay in providing					
	N	%	N	%				
	26	79	7					

Percent is the proportion of responses with identified sub-category issues (excludes responses where the main was category selected but the sub-category was not specified). Participants could select more than one issue sub-category.

[1] Conduct Aggressive, harassing= aggressive, threatening, bullying or harassing; Fraud includes falsification of reports or writing reports without interviewing the person; Inappropriate sexual= comments, contact or relationship.

[2] Communication Inappropriate= offensive questions, comment, requests.

[3] Competence Out of date treatment or practice; poor technique

[4] Care treatment Inadequate= inadequate, wrong or unnecessary consultation, examination, testing or treatment; Diagnosis= incorrect diagnosis or failure to diagnose; Refuse, delay= refuse, fail to treat or delayed treatment.

[5] Reports Inaccurate= inaccurate statements including false statements; failure to meet or interview subject; lacking objectivity; unprofessional; unusable report.

4.4 Survey 1: reasons for making the complaint or notification

Respondents were asked to give reasons for their complaint; ranking in order of importance any that applied to them from an eight-item menu. Separate questions were then asked about what they wanted to happen to or for the practitioner and what they wanted for themselves.

The main reason given was so it would not happen to the complainant or someone else again (80% of responses). This was followed by a belief that what occurred was wrong, unfair or unjust (75%); that what happened was unsafe for themselves or others (65%) and that the practitioner should not be in practice (46%). The top three reasons accounted for 61 percent of all responses and the top four 74 percent. (Table 28)

Reasons were proportionally similar for AHPRA and the NSW agencies, with some differences in the reasons '*shouldn't be in practice*' and '*mandatory notification*', particularly when comparing AHPRA and the HCCC. The mandatory notification difference reflects the low representation of organisational responses handled by the HCCC and that mandatory notification featured in 69 percent of organisational responses. The reasons '*not happen again*' and '*wrong, unfair, unjust*', were significantly higher for individuals, these two responses accounting for two-thirds of first ranked responses from this respondent category.

Table 28: Survey 1: reasons for making the complaint/notification by agency managing and source (respondent) type

	Not again ¹		Wrong, unfair ²		Unsafe ³		Not practice ⁴		Against law ⁵		Mandatory ⁶		Told should ⁷		Other law ⁸	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
ALL	1379	80	1303	75	1126	65	791	46	641	37	476	28	281	16	244	14
AHPRA	829	80	789	76	699	67	514	49	387	38	313	30	169	16	154	15
NSW	550	80	514	75	427	62	277	40	254	37	163	24	112	16	90	13
HPCA	211	74	183	64	168	59	123	43	105	37	97	34	40	14	42	15
HCCC	339	84	331	82	259	64	154	38	149	37	66	16	72	18	48	12
CONS⁹	1016	90	966	85	750	66	524	46	394	35	153	14	188	17	126	11
PRACT¹⁰	242	68	228	64	234	66	142	40	151	42	157	44	62	17	61	17
ORG¹¹	121	49	109	45	142	59	125	52	96	40	166	69	31	13	57	24
Ranked first – select categories																
CONS	368	33	371	33	128	12	92	8			5	<1				
PRACT	80	23	67	19	59	17	20	6			73	21				
ORG	24	11	22	10	31	14	19	8			102	45				

Includes ranked and selected but non- or equal-ranked (equal first or second) responses.

[1] Not again= didn't want it to happen to me or anyone else again. [2] Wrong, unfair= what happened is wrong, unfair or unjust.

[3] Unsafe= what happened is unsafe for myself or others. [4] Not practice= practitioner should not be in practice.

[5] Against law= what happened is against the law. [6] Mandatory= mandatory notification under National law for health practitioners. [7] Told should= didn't want to but was told I should. [8] Other law= required under other law.

[9] - [11] Source of complaint = consumer, practitioner, organisation

The most significant variation in the pattern of reasons given for practitioners is the higher rate of mandatory notifications for nurses. (Fig.5)

In 58 percent of cases the notification was associated with 'conduct', followed by practitioner 'health' (40%) and 'care or treatment' (38%). Avoiding recurrence and justice were also notable for nursing, being lower relative to other professions.

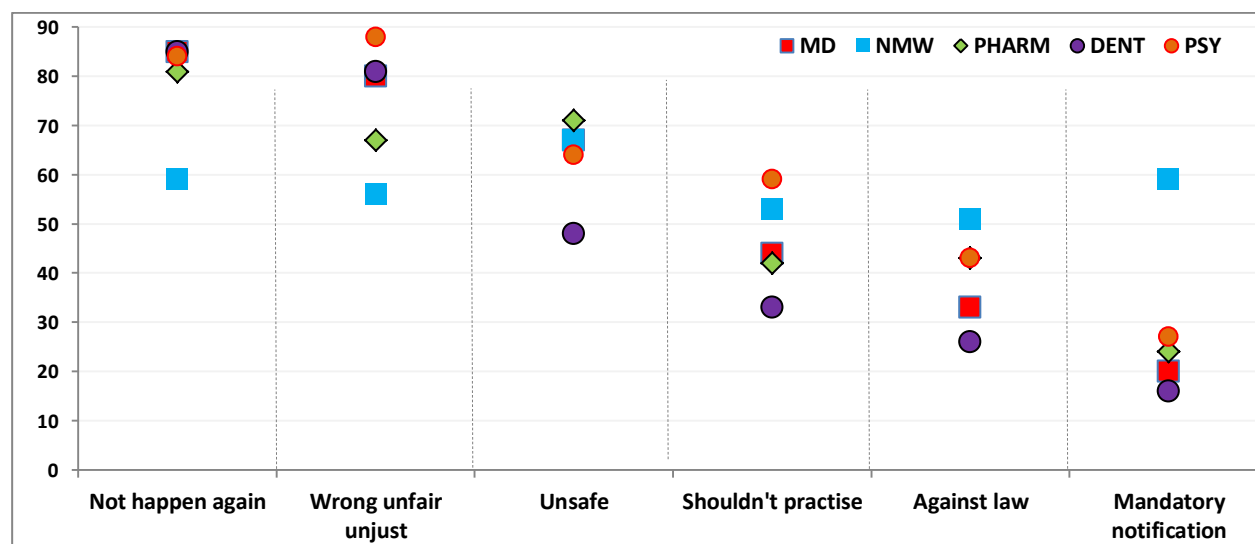


Figure 5: Survey 1: main reasons for making complaint/notification about the practitioner by subject profession (%)

Includes all selected responses, ranked and non-ranked, for each response category for each profession – respondents' could nominate more than one category of reasons

4.4.1 What respondents wanted to happen to or for the practitioner

Selecting from a four-item menu (plus *‘other’*) respondents ranked in order of importance what they wanted to happen to or for the practitioner.

The most frequent responses were *‘wanted practitioner to improve their standard of treatment or care’* (75%); followed by *‘wanted practitioner disciplined or punished’* (63%); *‘wanted practitioner assessed’* (have health check or treatment) (40%) and *‘wanted practitioner stopped from practising’* (35%). (Table 29) Including *‘other’* the top three categories accounted for 78 percent of all first ranked responses and a similar proportion (75%) of all responses.

The proportion of responses was similar across the agencies; with a slightly higher response for *‘wanted practitioner assessed’* for matters handled by AHPRA (42%) compared with NSW, particularly the HCCC. As with *‘reasons’* discussed above, this appears due to the lower representation of organisational responses from NSW and that *‘wanted practitioner assessed’* was the highest among organisational respondents (55%). Less expected is the lower rate of *‘improve standards’* among organisations as compared to both other respondent categories. Interviews suggest this may relate to a high proportion of matters from organisations relating to nurses about whom action had previously been taken.

Table 29: Survey 1: what the respondent wanted for the practitioner subject of the complaint/notification

	Improve standards ¹		Disciplined or punished ²		Assessed ³		Stopped ⁴		Other	
	N	%	N	%	N	%	N	%	N	%
All responses	1297	75	1092	63	686	40	612	35	416	24
AHPRA	793	76	660	63	443	43	389	37	256	25
NSW	504	73	432	63	243	35	223	32	160	23
HPCA	203	71	172	60	110	39	94	33	61	21
HCCC	301	75	260	64	133	33	129	32	99	25
CONS [5]	884	78	788	70	417	37	385	34	281	25
PRACT [6]	270	76	191	54	136	38	125	35	81	23
ORG [7]	143	59	113	47	133	55	102	42	54	22

Includes ranked and selected but non- or equal-ranked (equal first or second) responses.

[1] Improve standards= wanted practitioner's standard of treatment or care improved. [2] Wanted practitioner disciplined or punished. [3] Assessed = wanted practitioner assessed (have health check or treatment). [4] Stopped= wanted practitioner stopped from practising. [5] - [7] Source of complaint – consumer, practitioner, organisation

Comparing professions, *‘improve standards’* was ranked highest for all practitioners except psychologists, where *‘disciplinary action’* ranked higher. (Fig.6) Also notable is the higher *‘have practitioner assessed’* response for nurses, which was most frequently associated with issues of *‘conduct’* (51%), *‘health’* (46%) or standard of *‘treatment or care’* (43%).

Nurses and psychologists also had the highest *‘stopped from practising’* response, most frequently associated with *‘conduct’* (54%) and *‘care’* (46%) for nurses and *‘conduct’* (64%), *‘communication’* (61%) and *‘competence’* (54%) in the case of psychologists.

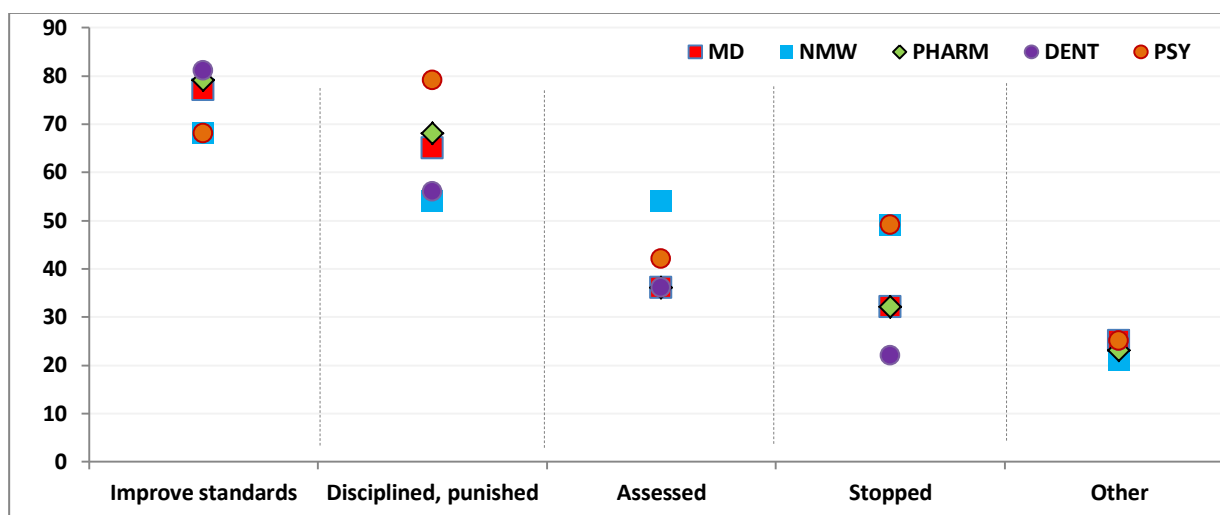


Figure 6: Survey 1: what respondent wanted for the subject practitioner by profession (%)
Includes all selected responses, ranked and non-ranked, for each response category for each profession – respondents could nominate more than one category of what was sought

4.4.1.2 What ‘disciplinary’ action and ‘other’ action meant for respondents

The response ‘*wanted practitioner disciplined or punished*’ was highest among consumers (70%), although it also featured in approximately half of responses from the other two sources. (Table 29) Over one-third (39%) of respondents selecting both ‘*discipline, punish*’ and ‘*improve standards*’ ranked the two either first or second; and three-quarters (77%) that selected ‘*discipline, punish*’ also selected ‘*improve standards*’. Comments (N=375) were analysed, and found to be proportionate to responses for all professions.

Fifty percent (N=88) of ‘*discipline, punish*’ comments related to actions the respondent wanted the subject practitioner to take; and 47 percent nominated actions by agencies. A small proportion (3%) mentioned systems improvement. Of practitioner-related actions, 86 percent related to accountability, acknowledgement, rectification or treatment, information, explanation or apology. The remaining 14 percent were financially focused, with a mix of refunding the complainant or their insurer, covering costs or providing compensation.

Of those nominating actions from the agencies or other regulatory institutions, 35 percent related to monitoring, education and standards. Most of these related to the specific practitioner e.g. investigate or review their practices; assess and provide support for impairment; require education be undertaken; monitor and supervise the practitioner.

Two-thirds (65%) of actions sought were more specifically ‘sanctions’ in nature and included reference to the practitioner being directed, counselled or disciplined; or to have their registration subject to restrictions or revoked entirely. A small number believed criminal charges should be made.

Analysis of the one-quarter of respondents who nominated ‘*other*’ actions shows a similar pattern. These also included comments on ensuring public safety and standards or seeking clarification of what the standard in the circumstances was. Thirty-nine percent (N=74) nominated actions they wanted the practitioner to take; 47 percent (N=89) identified actions by agencies; with the remainder relating to system improvements (7%). Six percent did not specify what they wanted.

The pattern of actions sought from the practitioner by those that nominated ‘*other*’ was nearly identical to that of those nominating ‘*discipline, punish*’. Actions sought from agencies were also similar. However, the proportion of ‘*monitoring, education and supervision*’ actions represented over half of comments (52%) in this case.

The factors and intentions behind ‘*discipline, punish*’ responses were tested further with a sample of respondents at interview. (Box 3) The breadth of actions sought was similar to survey responses - ranging from keeping a record of issues raised; undertaking further education; making amends; to ‘stern action’ or ceasing practice. Findings for broader practice improvements also featured.

Common themes include patient powerlessness relative to practitioners and assumed credibility of the latter by agencies; and a ‘*call to account*’ for these practitioners through a higher authority. Regulatory intervention (giving direction or imposing requirements) is sought as the practitioners themselves or the organisations they work for are not accountable; responsive or behaving appropriately.

Reference is made to the difficulty in making and proving complaints and the risks posed by potential or actual harms caused, especially ‘*repeat offenders*’. The perceived inadequacy of actual regulatory responses is palpable. Potential conflicts of interest between regulator and those regulated are raised.

Box 3: Select responses to interview questions: disciplinary action

Question: “In the survey you selected ‘discipline/punish’ - what might that involve?”

Prompt: “What did it mean for you; what actions or steps did you have in mind?”

Respondent: Ideally, that they **wouldn't be allowed to practice**. There were several reports locally that they had misdiagnosed and made very **serious errors**. They shouldn't be in practice. I **almost died** as a result. I told her I had a [cardiac condition] – this was never checked. I got a test when I was in hospital [elsewhere] – why couldn't she have done this. I had told her I couldn't breathe, I went to her twice. I would like to think of someone else was in a **similar situation**, they would get a different assessment and treatment.

Interviewer: Why did you rate the process so low?

Respondent: Well, it definitely **is linked to the outcome**. And frustration that I didn't know **what had to be done to prove** a misdiagnosis. And I was so **upset that they lied**. One of the people said “it's **your word against hers**”. The only way around it is to take a tape recorder. I worked previously in complaints- so I know the system; I know how difficult it is to get complaints through.

SURVEY: **Agency:** AHPRA. **Subject:** DR. **Respondent:** individual. **Other suggested complain:** relative (a health professional). **Why made:** 1. Unsafe 2. Shouldn't practice. 3. Not happen again. 4. Wrong, unfair, unjust. **For practitioner:** 1. Discipline, punish 2. Stopped 3. Improve standards 4. Assessed. **For self:** 1. Compensation (for: 1. Costs 2. Pain, suffering 3. Lost wage). 2. Apology 3. Explanation 4. Reimbursement, fees waived, bill adjusted. **Issues:** Care treatment (including wrong diagnosis; inadequate treatment, adverse event). **Outcome:** No action. **Satisfaction process:** Very dissatisfied. **Satisfaction outcome:** Very dissatisfied. **Recommend process:** Probably wouldn't. **Suggestion:** “Less deference be paid to medical professionals”

Respondent: I'm not sure as I don't know how the medical system works, but maybe something like it goes into or onto a record. For example, something like a 'points' system. It's like when you get a speeding ticket, we get demerits on license and there is a record of what happens. So, if ten people complain about the same doctor, there is a history that can be seen. SURVEY: Agency: HCCC. Subject: DR. Respondent: individual. Other suggest complain: No. Why made: 1. Wrong, unfair, unjust 2. Unsafe 3. Not happen again. For practitioner: 1. Improve standards 2. Discipline, punish. For self: 1. Reimburse, waive fees, bill adjusted 2. Treatment, service 3. Apology 4. Compensation for: costs. Issues: Competence, inadequate treatment, adverse event. Outcome: No action; explanation; fees/costs waived/reduced Satisfaction process: dissatisfied "Not giving the case due consideration". Satisfaction outcome: dissatisfied. Recommend process: Probably would "No other choices available, so better this than nothing at all". Suggestion: "A face-to-face meeting with doctor and someone from commission, so there is a dialogue and commission has stronger basis for a final outcome/decision"
Respondent: I knew he was a repeat offender; that he had many, many complaints about him. He had gone in too far, [did] more surgery when the margin was clear. He needed to be brought back into line and to be made responsible for what he did. He used scare tactics, said I needed surgery there and then. But I wasn't comfortable that he had the expertise, as he wasn't fully trained in this area. He said "you don't know what you're talking about". I felt he used bullying tactics, to frighten me into having surgery. I was so upset and told my GP so I was sent to a specialist for a second opinion. And [the specialist] said it was fine to try the cream and only have surgery if that didn't work. [The specialist] knew that this other doctor had been reprimanded; and had gotten other complaints about him. [The specialist] put in a complaint to the Board about him [also]. I feel the board [Medical Council] needs to stand up to these people. They said [Council] that the doctor had been counselled and spoken to. Interviewer: had you raised the issue of unnecessary surgery as well? Respondent: Yes I did. His response was that what he did was within the law. I feel the board [Council] didn't have the guts to stand up to him. Being spoken to was not enough – he was a repeat offender. I understand that at least 25 complaints had been put to the board [Medical Council] previously. SURVEY: Agency: HPCA. Subject: DR. Respondent: individual. Other suggest complain: Health professional. Why made: 1. Not happen again. 2. Shouldn't be in practice. 3. Wrong, unfair, unjust. For practitioner: 1. Discipline, punish 2. Stopped 3. Improve standards 4. Assessed 5. Other: "Didn't want him to continue performing these procedures unnecessarily and continue to be claiming Medicare". For self: 1. Reimbursement, fees waived, bill adjusted 2. Apology 3. Explanation 4. Other: "Wanted the Board to stand up to someone who performs multiple services unnecessarily". Compensation [not originally selected in 'what wanted', answered in supplementary question]: 1. Costs 2. Pain, suffering. Issues: Bills (Charging Medicare for multiple unnecessary services); care treatment; conduct; competence. Outcome: Counselling "He had been spoken to, and obviously talked his way out of it." Satisfaction process: dissatisfied. Satisfaction outcome: dissatisfied. Recommend process: Definitely would "Would recommend complaint being lodged rather than do nothing. People need to be accountable." Suggestion: "Always felt I was behind with medical knowledge (in the process). Take notice of complaints laid by other respected professionals in regard to this same practitioner. Question his qualifications – should be looked into"
Respondent: I'm a professional person in a different profession. But I know if I had done something like this, not something heinous, our board would expect us to do extra training. What I wanted was for them to recognise what they had done - made an error - and have training so it doesn't happen again. There was also an issue in this matter that I found out through the Coroner, not through AHPRA, was that the monitors were not connected and weren't read. I also found out there isn't a universal carbon dioxide monitor in a hospital system and that the doctor wasn't familiar with the equipment being used and that the monitor was also linked do something else. It's very unfortunate that the [complaints] process isn't taken a step further. They look at the individual but there isn't then the extra step of having a focus on how to prevent it happening to anyone else. That is, it's an individual focus, not systemic. SURVEY: Agency: AHPRA. Subject: DR. Respondent: individual. Other suggest complain: Lawyer. Why made: 1. Not happen again. 2. Wrong unfair unjust. 3. Unsafe. 4. Shouldn't practice. For practitioner: 1. Discipline, punish 2. Improve standards. 3. Stopped 4. Assessed. For self: 1. Explanation. 2. Apology 3. Reimbursement, fees waived, bill adjusted. 4. Compensation for: 1. pain, suffering Issues: Care (Inadequate, delayed treatment; fail to diagnose; adverse event, failed to respond/disclose AE; competence. Impact on health: Significant ("The matter was ongoing and seemed to stall for a great period of time"). Outcome: Apology; caution or reprimand issued. Satisfaction process: Dissatisfied "The matter took a long time to process and the outcome was not desirable." Satisfaction outcome: Dissatisfied. Recommend process: Probably would. Suggestion: "The speed of processing the complaint. I was told the delay in my matter was an inability to obtain an independent expert. I would have thought a regulation agency would have experts readily available"
Respondent: They need to make amends in some way for the very, she caused me physical harm; basically it was a physical assault. It was done in anger, while her assistant was there. I don't know how you fix behaviour like that. I was so terrified to go back to treatment after that. I felt so powerless as a patient in front of her. And yet she's not accountable. I went to my general practitioner and asked her about it so she is aware of it too. Interviewer: how did her assistant react? Respondent: Not at all. She deferred to the specialist and in the end the doctor began talking to her over me (the patient) about another patient. I said to her, please don't do that. But she went ahead, caused resultant damage and exacerbated an already existing condition. I have had excellent medical care in the past and I have worked in hospitals and I know that she is an exception to the rule, but I'm concerned that she just got away with it as I was the only person that had made a complaint about her. AHPRA said that unless five other people also complained about her, they would not take action. And they were the only [specialty] in town at the time. SURVEY: Agency: AHPRA. Subject: DR. Respondent: individual. Other suggest complain: No. Why made: 1. Against law. 2. Unsafe 3. Didn't want to but told should 4. Not happen again. 5. Wrong unfair unjust. 6. Shouldn't practice. For practitioner: 1. Discipline, punish 2. Assessed 3. Improve standards 4 Stopped. 5. Other: "I wanted her to admit that what she did was wrong instead of denying it and fabricating an alternative explanation." For self: 1. Compensation. 2. Other: "I don't want her to be allowed to treat other patients so callously and dangerously. She used excessive force and at no time did she have my permission to do this." Issues: Care treatment; consent; conduct; competence; breach privacy; complaint (hostile, punished for complaining); treatment report inaccurate. Outcome: No action "Doctor lied about events and her version was accepted. Apology of sorts given. Incorrect explanation given. Told there would need to be at least six complaints before disciplinary action would be taken." Satisfaction process: Very dissatisfied "I feel that I was passed over by hospital [name], Dr [name] and AHPRA." Satisfaction outcome: Very dissatisfied. Recommend process: Definitely wouldn't "Not at this stage as no action was taken against the doctor. I would recommend they seek immediate legal action against the Dr and hospital by a reputable firm such as [name] who "fight for fair". Suggestion: "Dr [name] does not have the bedside manner to deal with patients directly... she betrayed the most basic

<i>principle of training i.e. "do no harm." She needs anger management training and should practice confidentiality with regard to discussing one patient's issues in the presence of another patient. I could go on indefinitely, but this unprofessional conduct has hugely impacted my health, cosmetic appearance and stress level."</i>
Respondent: I wanted the organisation to take ownership of her behaviour, as she wasn't. There had been a number of complaints about care, staffing and behaviour. These were repeatedly being pushed aside and going nowhere. I wanted the organisation to be responsible for following its own procedures, as it wasn't doing this. I wanted it to be accountable. I raised my concerns through the organisation first. I didn't go to the Aged Care Complaints Commission as I knew it would have been treated as a human resources matter. I didn't have any confidence that the organisation would take action. Families repeatedly complained and nothing happened. SURVEY: Agency: AHPRA. Subject: NMW. Respondent: health practitioner. Other suggest complain: No. Why made: 1. Against law. 2. Unsafe. 3. Mandatory. 4. Not happen again. 5. Wrong unfair unjust. 6. Shouldn't practice. For practitioner: 1. Discipline, punish 2. Stopped 3. Dismissed. For self: 1. Apology 2. Other: staff changes. Issues: Care, treatment; competence. Impact on health: Very significant (<i>"I had to leave my employment on the advice of my GP"</i>). Outcome: No action (<i>"unable to access evidence"</i>). Satisfaction process: Neutral. Satisfaction outcome: Very dissatisfied. Recommend process: Probably wouldn't. Suggestion: <i>"Have the authority/powers to gain the internal documents from the organisation which contains the evidence (none were accessed)."</i>
Respondent: They need to be supervised because breaching privacy is very serious (I'm studying law) and you can't do this. For me it has to be a proportionate response. There are different levels of what "punishment" means. For example it may run from supervision to reprimand or retraining to improve practice, or a fine, or it may mean mediation, taking legal action because of what happened as a result. I know already in this case that the person has to be supervised – I found out through my solicitor. I think about it differently – from when I first made the complaint to now. Interviewer: <i>what has changed to make you think differently?</i> Respondent: Well I'm older and I'm studying, so I understand the system a little bit more. At the time I only understood a little bit. SURVEY: Agency: AHPRA. Subject: PSY. Respondent: individual. Other suggest complain: Relative; lawyer. Why made: 1. Wrong unfair unjust. 2. Not happen again. 3. Shouldn't be in practice. For practitioner: 1. Discipline, punish 2. Stopped. 3. Improve standards. For self: 1. Apology 2. Explanation. 3. Compensation for: 1. Pain, suffering. 2. Costs. 3. Lost wages. Issues: Report; consent; competence; privacy. Impact on health: Some impact (<i>"The fact that the family broke because of her"</i>). Outcome: Don't know (<i>"Haven't heard a thing"</i>). Satisfaction process: Very dissatisfied (<i>"Haven't heard anything"</i>). Satisfaction outcome: Very dissatisfied (<i>"Don't know what happened"</i>). Recommend process: Probably wouldn't <i>"Maybe if they were informed"</i>. Suggestion: <i>"Don't leave the complainant out of the loop."</i>
Respondent: I was interviewed for a report for [legal proceedings]. The way they went about doing the report was unethical, how she got the information. I feel they use the term "common practice" too liberally- the psychologist said the how they did the report was "common practice" but two other psychologists said it wasn't and one of them had 30 years [of] experience. This psychologist had interviewed certain people for the purposes of the report who were biased and didn't use or interview people who weren't biased. And therefore you don't get a balanced report. It shouldn't be allowed. They [AHPRA] didn't follow up the complaint at all. For example when I called they said they understood that I was going through court and I indicated my concerns about bias and they said it if any other information was needed I would be contacted about this. But they didn't and just wiped it without further enquiry. SURVEY: Agency: AHPRA. Subject: PSY. Respondent: individual. Other suggest complain: Health professional. Why made: 1. Wrong unfair unjust. 2. Not happen again. 3. Unsafe. For practitioner: 1. Improve standards. 2. Discipline, punish 3. Other (<i>"Practitioner to reassess actions and the damage caused"</i>). For self: 1. Explanation. 2. Apology. 3. Other (<i>"Wanted psychologist to reassess report written"</i>) Issues: Report (Inaccurate, inappropriate comments; conflict of interest). Outcome: No action. Satisfaction process: Very dissatisfied (<i>"No follow up requests for information"</i>). Satisfaction outcome: Very dissatisfied. Recommend process: Definitely wouldn't. Suggestion: <i>"Follow up with the complainant before closing to ensure all information is given. The question at the beginning [of the notification form] implies to give a minimal amount of information so they can assess whether investigation is required and because of this complainants assume they will be contacted for extra information if required."</i>
Respondent: What happened, is we - my niece and I - went to the doctor. We'd changed doctors- we'd gone to different doctors there many times, but had always been bulk billed. But when we went to the receptionist, we weren't bulk billed. Why didn't someone tell us beforehand? This led to an argument with the receptionist and they said [we] were advised. The doctor then rang up and abused my niece and cancelled the pathology test that had [been] done and which was bulk billed. After that, I got the Medicare cheque and took it back to them - to Medicare - as we had already paid. But I found out they get paid anyway. And what annoys me, is he gets away with it because he's a doctor. Interviewer: <i>What do you think would have been more appropriate under the circumstances?</i> Respondent: They should have been given a stiff letter from the Medical Association. He should have been put in his place about what he can and cannot do. He should have paid back the money. My niece is on a pension, she can't throw money away like that. The problem is its one government department investigating another. It's so annoying, it shouldn't be allowed. SURVEY: Agency: HCCC. Subject: DR. Respondent: individual. Other suggest complain: No. Why made: 1. Wrong unfair unjust. 2. Against law. Not happen again. 3. Unsafe. For practitioner: 1. Discipline, punish. For self: 1. Reimbursement, fees waived, bill adjusted. 2. Apology. Compensation [not originally selected in 'what wanted', answered in supplementary question] for: 1. Costs. Outcome: No action (No power to deal with it) Impact on health: Significant (<i>"Through stress"</i>). Satisfaction process: Neutral. Satisfaction outcome: Very dissatisfied. Recommend process: Definitely wouldn't (<i>"It needs to be handled by someone else and not a government department."</i>)

4.4.2 What respondents wanted for themselves or their organisation

Respondents identified and ranked in order of importance what they wanted for themselves or their organisation, selecting from a five-item (plus 'other') menu. The most frequent responses were *'wanted an explanation or information'* (54%), followed closely by *'wanted an apology'* (52%); and wanted *'other'* (41%). (Table 30)

Excluding 'other' responses, 'apology' and 'explanation' accounted for 78 percent of all first-ranked responses. 'Reimbursement, bills adjusted or fees waived' and 'compensation' attracted a similar proportion of responses (26-27%). Comparing agencies there were no variations of note. While proportionately higher for consumers, 'explanation' was significant for all respondents. Unsurprisingly, 'apology', 'reimbursement' or 'compensation' was significantly higher for consumers. An additional question about compensation is discussed below.

Table 30: Survey 1: what the respondent wanted for themselves or their organisation

	Explanation ¹		Apology ²		Compensation ³		Reimbursed Fees waived ⁴		Treatment service ⁵		Other	
	N	%	N	%	N	%	N	%	N	%	N	%
ALL	936	54	894	52	473	27	442	26	320	19	708	41
AHPRA	549	53	544	52	296	28	260	25	188	18	454	44
NSW	387	56	350	51	177	26	182	26	132	19	254	37
HPCA	154	54	136	48	64	22	60	21	51	18	111	39
HCCC	233	58	214	53	113	28	122	30	81	20	143	36
CONS [6]	671	59	723	64	405	36	369	33	248	22	343	30
PRACT [7]	164	46	129	36	56	16	55	15	43	12	210	59
ORG [8]	101	42	42	17	12	5	18	8	29	12	155	64
Ranked first												
CONS	268	24	332	29	104	9	115	10	58	5	207	18
PRACT	95	27	67	19	11	3	5	1	14	4	158	44
ORG	72	30	14	6	-	-	6	3	12	5	136	56

Includes ranked and selected but non- or equal-ranked (equal first or second) responses.

[1] Explanation= wanted an explanation or information. [2] Apology= wanted an apology. [3] Compensation= wanted compensation. [4] Reimbursed, fees waived= wanted reimbursement; bills adjusted or fees waived. [5] Treatment, service= wanted treatment or service. [6] – [8] = Source of complaint – consumer, practitioner, organisation.

Comparing professions, notable variations can be seen with dental practitioners, which attracted the highest response for 'reimbursement/bill adjusted/fee waived' (57%) although medical practitioners accounted for 60 percent of this category (dentists 21%). Dental practitioners also attracted a comparatively low 'explanation' or 'other' response. (Fig.7) Proportionately, nurses attracted a lower 'apology' and a higher 'other' response (62%), although medical practitioners accounted for 55 percent of these comments overall, followed by nurses (29%).

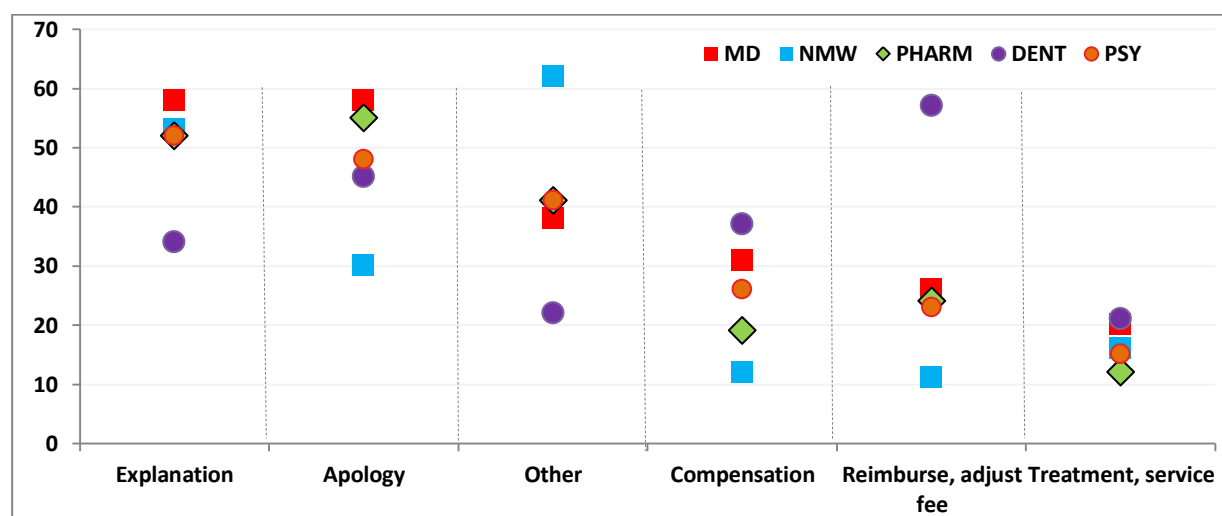


Figure 7: Survey 1: what respondent wanted for themselves or their organisation by subject profession (%)
Includes all selected responses, ranked and non-ranked, for each response category for each profession – respondents could nominate more than one category of action sought

Given the high proportion of 'other' responses (41%, N=527), thematic content analysis was undertaken. The major foci of these remarks included wanting an assurance of change; public protection; and explaining why the issues they raised were important. The majority of comments (80%) either reinforced or made more nuanced comment on why the complaint was made; action sought by, for or to the practitioner; and what the respondent was seeking for themselves or their organisation. (Table 31)

Table 31: Survey 1: what the respondent wanted: content analysis and exemplars of 'other' comments made

Focus	Exemplars
Q: Why made complaint Q: What wanted for self or organisation N= 277 [41%] Main response categories • Address issue, avoid recurrence, maintain safety, standards • Bring to regulators attention; to have independent investigation undertaken • Make broader profession aware of issue	To prevent it happening again; To protect the public; I wanted people to be aware of what happened so hopefully it wouldn't happen again and services can be improved; Wanted broader awareness of a problem which was being adequately managed in-house; Hoped for alert placed on AHPRA registration details to alert other potential employers; An assurance that the practitioner's professional conduct would improve- that current and future patients would not be subjected to the same substandard treatment; A thorough investigation; I wanted a change in practice ...I tried to deal with it with the doctor and the practice and was unsuccessful. So I took it further; No rebound punishment for making complaint; I would have liked to have known what steps the offending doctor was required to undertake to prevent this again; Information must be given to all other potential [name] surgery candidates to tell them what could happen to them as per my experience; I wanted the doctor to be told by a relevant "authority" that his behaviour was not acceptable or professional; The relevant authorities made aware of poor medical practice; Wanted a proper investigation to be carried out to ascertain whether or not this was an isolated case; Relevant health standards body need to know individual complaints- ours may be a small piece of a large jigsaw; Wanted Commission to be aware of practice of overcharging in case other people also complaining; Wanted an independent ruling to supplement our own investigation; To inform doctors and health staff of serious failings in treatment; Some genuine review of what happened;
Q: Wanted action by practitioner or regulator N= 369 [55%] Main response categories [practitioner action] • Accountability, acknowledgement, address issues or conduct • Improve standards and practice [individual practitioner] Main response categories [regulator action] • Assess, monitor, investigate • Practitioner stopped (dismiss, deregister, limit)	Want issue not to be ignored. Doctor to take responsibility for his actions and consequential harm to patient wellbeing; I wanted the practitioner to acknowledge his negligence but, most importantly, I wanted him to check the medical records of his other patients to make sure that what he had neglected to address with me had not happened to any of his other patients; Wanted evidence that the practitioner had undertaking further study surrounding best medical practice and wanted proof of a competency to practice assessment; proper professional accountability; apology to the patient; For awareness for the individual and for the profession regarding standards; I want the specialist to charge a more responsible fee- 300% above the schedule fee is extortionate; Simply wanted an improvement in patient care and improvement in communication with other providers; I wanted the doctor to realise his conduct was rude, arrogant, unpleasant and unacceptable; Admittance, in writing, of wrongdoing and heartfelt apology; Wanted the Dr to recognise his shortcomings Adequate oversight of practices, and cessation of some - unsafe assessment, diagnostic and in particular prescribing practices over a long period of time; Wanted to ensure that the practitioner was fit for practice as...behaviour...indicated otherwise; Wanted improvement of practice and avoidance of future complications of procedures; We wanted to know the doctor had been adequately assessed such that if found "innocent" we would know [their] actions had been screened and genuinely wasn't a public risk; Wanted independent assessment of practitioner and measures taken to improve standards of practice; Wanted the registration revoked- nurse was a danger to the profession; Fraud is an ongoing and real threat to the integrity of paper based assessments of a practitioners' competence. An outcome that would discipline the practitioner as well as serve as a deterrent to others would have been more appropriate. Objective opinion of standard current practice; Inspection of practice - an unannounced visit; This doctor is ripping off Medicare and shouldn't be allowed to practice; I wanted the practitioner to be cautioned as a minimum and his licence reviewed
Other: investigation process or outcome N= 30 [4%]	A better explanation other than 'sorry, but we will have to wait and see if there are any other complaints' before... act; notification of the outcome and decision; [Numerous] allegations related to unsafe or improper practice... no investigation undertaken... not reviewed for action for 18 months following lodgement. After this time the clinician had resigned from the service and was working [through an] agency throughout other hospitals.

4.4.2.2 Respondents seeking compensation

Forty-five percent of respondents who selected '*compensation*' also selected '*reimbursement, bills adjusted, fees waived*'. As previously noted, a supplementary question about the reasons for seeking compensation was included. Following a screening question ("*question not applicable or did not want compensation*") respondents were asked to rank (number in order) any of three reasons that applied to them – compensation for '*lost wages*'; '*pain and suffering*' or '*costs incurred as a result*'. Of 568 responses, reasons given were '*pain and suffering*' (30%, N=514), followed by '*costs*' (25%, N=435) and '*lost wages*' (15%, N=251).

There was some inconsistency in how this supplementary question was answered (e.g. some indicated '*not applicable*' but then also ranked reasons) and a disparity between respondents indicating they wanted compensation in the initial question about what they wanted for themselves (27%) and the supplementary question about compensation (33%). This disparity appears related to reimbursement being initially selected and then treated as compensation in the supplementary question (Table 30); as reflected in comments e.g.

"The issue was that a [separate] medical doctor's insurance company would not compensate for expenses I would have to pay out for [additional] treatment." (Ref 1534)

Only a small minority (N=23) selected '*compensation*' as the only thing they wanted for themselves; three-quarters (N=18) of these relating to medical practitioners. Of the 23 cases, 19 sought compensation for '*pain, suffering*'; six for '*costs*' and four for '*wages*'. Eleven cases related to adverse events or outcomes (e.g. loss of limb or function post-surgery; significant period of hospitalisation due to medication); eight related to other treatment issues (e.g. failure to diagnose; delayed treatment); and four to other issues (inadequate report; billing practice; loss of employment following notification).

The majority sought other outcomes that were consistent with (and in cases ranked more highly) to those of all respondents on key measures, including avoiding a recurrence; improving standards and seeking an explanation or apology. (Table 32) Unsurprisingly, '*discipline, punish*' responses were also higher.

This overall response pattern is also seen in cases where a death occurred. Of 109 identified cases, 31 indicated they were seeking compensation. Of these cases, only five ranked '*seeking compensation*' first, one commenting:

"I initially did not want compensation, but after 2 years of hell I do." (Ref 521)

In contrast, '*apology*' and '*explanation*' accounted for 65 percent of first-ranked responses. '*Not happen again*' was selected in all but one case and was the highest-ranked reason for making a complaint in half of responses. '*Disciplinary*' action was sought in all but one case;

and ‘*improve standards*’ featured in all but two, as well as accounting for nearly half of first-ranked responses in what was sought for the practitioner.

Table 32: Survey 1: respondents seeking compensation or reimbursement

	Wanted compensation and reimbursement [N=289] DR=66% Dent=16%		Wanted compensation but not reimbursement [N=193] DR=75%		Wanted reimbursement but not compensation [N=162] DR=52% Dent=28%		All responses	
	Total %	Rank 1 %	Total %	Rank 1 %	Total %	Rank 1 %	Total %	Rank 1 %
Reasons for making complaint or notification [1]								
Not happen again	95	23	92	30	89	36	80	27
Wrong, unfair unjust	95	36	90	31	88	36	75	27
Unsafe	83	13	69	10	56	11	65	13
Should not practice	72	13	55	10	33	4	46	8
What wanted for practitioner [1]								
Improve standards	88	33	74	33	81	57	75	41
Discipline punish	88	28	76	32	65	22	63	23
Be assessed	63	8	34	5	36	6	40	12
Stopped	61	19	45	16	19	5	35	11
What wanted for self								
Explanation	76	17	50	16	57	19	54	25
Apology	84	25	72	33	70	27	52	24
Treatment	53	7	15	4	17	5	19	5
Other	25	9	15	4	18	3	41	29
Compensation		17		28		-	27	7
Reimbursement		19		-		24	26	7
Why compensation was sought (supplementary question)								
Pain suffering	N=226 81	48	N=171 89	66	N=47 29	17		
Costs	N=225 80	26	N=101 52	14	N=64 40	22		
Wages	N=132 47	10	N=69 36	10	N=14 9	3		

[1] Main reasons given – all categories not included

At interview people spoke of the practicalities of additional costs or lost income following an adverse event and the negative impact on daily life. Often dominating discussion are perceptions of injustice. Weaving in and out of reference to financial considerations is the aggravation, effort and injustice of having to pursue ‘rightful’ or even modest recompense for harms caused or additional expenses incurred. This appears prompted or compounded when the practitioner in question offered no apology or acknowledgement; is experienced as uncaring or ‘patient blaming’; or is seen to continue their life without any effect. (Box 4)

In Case 4, comparison is also made with incidents where the respondent did not make a complaint in other incidents when the error was acknowledged. Regulatory agencies as well as health services are criticised for delays which preclude compensation through civil action.

Other respondents took legal action either concurrently with lodging a complaint, or after completing legal action. Those who did so concurrently typically related to cost; those who did so after indicated their primary concern was to protect others; an end that would not be achieved through the legal process. (Cases 5, 6)

Box 4: Select responses to interview questions: legal action for compensation

Case 3

Respondent: They probably are a good doctor, but in this case they did the wrong thing. **They didn't have the decency to come and see me.** Someone from the hospital came to see me and asked me questions for an hour, asking about how it would affect me, so did one of his team, but not him.

Interviewer: Do you think from those questions they were thinking that you would take legal action?

Respondent: Definitely, they were worried. I didn't take any action for the money although I lost my job and my [limb]. At the end of the day, **I didn't get any answers. I felt they were trying to cover things up.** They wanted to know how much money I was earning, how it would affect my daily life at home, how it affected my mental health. They sure were worried about legal action.

Interviewer: Did you consider taking legal action?

Respondent: I saw a solicitor. They told us that we would win but ...[describes obstacles]

Interviewer: Did you take it further, with someone else?

Respondent: No, I decided that **it was too much money; that it was too hard**, that it was far too hard and mentally not worth it. **The reason that I had gone to a solicitor is that I lost income;** I lost my life. I had a great job but I just couldn't work, it affected me mentally and my whole life, because I lost it all. But at the end of the day, it doesn't matter. **I didn't want millions, but I should have got loss of wages.** I think they dragged it out for years so nothing could be done. **It was handled very badly. It was disgusting, how I was treated.** He could have come and seen me in hospital - I was there for [number] weeks, he should've come and seen me on a regular basis.

SURVEY: Agency: AHPRA. **Subject:** DR. **Respondent:** individual. **Why made:** 1. Wrong unfair unjust. **For practitioner:** Improve standards. **For self:** 1. Apology 2. Compensation for costs. **Issues:** AE. **Outcome:** Don't know "Two line letter saying case resolved; nothing to answer for." **Satisfaction process:** Very dissatisfied. **Satisfaction outcome:** Very dissatisfied. **Recommend process:** Definitely wouldn't.

Case 4

Respondent: I wanted compensation – **I was off work for a month. It wasn't that important, more acknowledging that he** [the surgeon] **had made a mistake.** The surgeon tried to say it was my fault that is, I vomited and [caused the problem].

Interviewer: How was this raised?

Respondent: I had gone to a lawyer to find out what could be done. My friends and family had pushed me about this because of the surgeon's attitude. He had refused to see me, and given me only Panadol for pain. 24 hours later I did a [name] test and the problem was identified. Even then, the surgeon wouldn't believe the radiologist and insisted on a CT scan and even then when he said I needed to go to theatre again it was like I had disrupted his weekend and interrupted his life. **It was his attitude and I wanted an apology.** For example I know things go wrong, I'm a healthcare professional myself and if I make an error, then I'm the first person to own up, I don't blame my patient. It's a small town and therefore I contacted a lawyer interstate. The lawyer suggested I start with a letter of complaint to the local healthcare complaint commission and gave me their number. I spoke to them and they sent me the forms and they advised me by letter that it would go to the medical board for assessment. It took three years. The board had it investigated. They dismissed the pain relief side of things but felt there was a case in relation to the care. They said they couldn't tell me all the details of what they had done, but would keep me updated. After three years, at the three-year mark, they found he was negligent and required him to go to training. I went back to my lawyer and they said it was now too late to take action.

Interviewer: Can you tell me why you went back to the lawyer at that point?

Respondent: I was so angry that **I wanted to hurt him in some way, and financially was the best way** – for him to have to pay something. I was so **angry at not being acknowledged.** I had had a lot of surgery and had a small mishap - for example I was given a drug I was allergic to, and **the doctor in that case came and apologised and I didn't take that any further. Accidents happen and they had said they were sorry. This doctor, the one that I made the complaint over, didn't care.** After I had the second surgery, I got [name of condition] and went to the public hospital accident and emergency [A&E]. The doctor came to the hospital and was so arrogant, he was annoyed that I had gone to the A&E and hadn't called him. I think it was more that he was embarrassed that other doctors found out what had happened. He just said "you have to come back in three months". Completely arrogant.

SURVEY: Agency: AHPRA. **Subject:** DR. **Respondent:** individual. **Why made:** 1. Not recur 2. Against law. **For practitioner:** 1. Assessed. 2. Improve standards. 3. Discipline/punish 4. Stopped. **For self:** =1. Apology; compensation for 1. Lost wages. 2. Pain, suffer. 3. Costs. **Issues:** adverse event; fail diagnose; discharge; records. **Outcome:** Conditions; supervision; education program. **Satisfaction process:** Very dissatisfied. **Satisfaction outcome:** Very dissatisfied. **Recommend process:** Neutral.

Case 5

Interviewer: Had you gone to AHPRA first, before you decided to take legal action?

Respondent: I did this concurrently- it was a dual process. I'm registered with AHPRA myself, I pay the fees every year, and I know that you have to abide by the law and abide by the guidelines for clinical reasoning. I knew that what he had done was not within the clinical guidelines.

Interviewer: What was the purpose for each process – what did you want from them?

Respondent: I knew that I would have to get follow up care as a result of what happened and I knew that I would have to pay for a lot of expenses. **It's why I took legal action- I knew that I would be facing these costs.** I went to AHPRA **so it would be on his record.** I know that if I did something wrong it would be on my record.

Interviewer: Did AHPRA communicate the outcome to you?

Respondent: "Yes, I got a pile of paperwork. It was **a slap on the wrist, but at least it's on his record.** I'm glad I went down the legal route. **I wouldn't have been satisfied with just the outcome** from AHPRA. **It wasn't severe enough. They just cautioned him.** I know from my lawyer, and that's just one lawyer, I don't know how many others there might be, that **there are other similar cases against the same doctor.** Also, I feel he **not only did irreversible damage, but he hadn't done the basics** and that really pissed me off. For example, he hadn't written proper notes, and I know how important they are from a legal point of view. I could tell from how they were written that they were written in one go."

Interviewer: Can I clarify- you're saying the notes were written post-event; that is, after you took action?

Respondent: "Yes, all in one go. The fact that they **only cautioned him;** everything that AHPRA is supposed to stand for and they just give him a **slap on the wrist.** And he's **still practising, still doing the same things.** So I wanted to ensure that **at least it was on his record.**"

SURVEY: Agency: AHPRA. **Subject:** DR. **Respondent:** individual. **Other suggest complain:** No. **Why made:** 1. Unsafe. 2. Shouldn't be in practice. 3. Not happen again. 4. Against law. 5. Wrong, unfair, unjust. **For practitioner:** 1. Discipline, punish. 2. Improve standards. **For self:** 1. Compensation for: 1. Pain, suffering. 2. Costs. 3. Lost wages. 2. Reimburse, bill adjusted, fees waived. **Issues:** Care treatment; Competence: *"had to undergo [number] revision surgeries; permanent scarring"*; Conduct *"malpractice"*; Medication *wrong prescribing*; Records. **Outcome:** Caution or reprimand. **Satisfaction process:** Dissatisfied. **Satisfaction outcome:** Very dissatisfied *"I feel Dr [name] was given a "slap on the wrist" and didn't receive a harsh enough punishment"*. **Recommend process:** Definitely would *"Definitely need to lodge complaint, but don't expect a satisfying result"*. **Suggestion:** *"Harsher punishment for malpractice, enforce restrictions on practitioners and their surgeries. Public awareness and knowledge of complaints made against each practitioner."*

Case 6

Respondent: Initially for us, we started the civil litigation because he wanted to know what had happened to him. How could he walk into a hospital for surgery and then be left [name of condition]. Obviously the surgeon wasn't talking. He was transferred to a specialist hospital later, so they weren't in a position to say *"this is what happened"* because none of them were involved in the initial surgery. As the situation developed, it became quite apparent that we would need money for his care. Unless powers such as the HCCC has or the Medical Board were changed to incorporate that, we were never going to get the money for his care by making a complaint. The only way we were ever going to achieve that was before a court of law.

Interviewer: *You completed legal action and then pursued a complaint after. What do you expect from that process?*

Respondent: I guess it's that public interest thing. How many other families is he going to hurt, maim or otherwise. And I think for us as a family, we need to know that we have done everything that we can to have made people aware. Of what he's done, and the implications. And that we're not on our own in this. We're not the first patient um you know. Ideally, we would like for him to just stop operating. From a realistic perspective, we know that may not happen. But there's always the chance that maybe it's our complaint is the one that makes the difference. And that someone says *"hang on a minute..."* And I know that maybe sounds a bit idealistic, a bit utopian, but for us, it's about knowing that we have attempted to get as much justice for our brother as we can because at no point did he offer an explanation to him about what happened. We had no idea exactly how badly the surgery went wrong. He refused to speak to me even, and I'm his next of kin.

Interviewer: *You had asked to speak with the doctor?*

Respondent: Yes. Like to me, he knew almost immediately that something was very wrong. And his automatic reaction was to shut down.

SURVEY: Agency: HCCC. **Subject:** DR. **Respondent:** individual. **Other suggest complain:** No. **Why made:** 1. Not happen again. 2. Shouldn't practice. 3. Unsafe. 4. Wrong, unfair, unjust. **For practitioner:** 1. Stopped. 2. Discipline, punish. 3. Assessed. 4. Improve standards. **For self:** 1. Apology. 2. Explanation. 3. Reimburse, bill adjusted, fees waived. 4. Compensation for 1. Pain, suffering. 2. Costs. 3. Lost wages. **Issues:** Consent; Care/treatment; Competence; Complaint response. **Outcome:** No action. **Satisfaction process:** Neutral. **Satisfaction outcome:** Dissatisfied. **Recommend process:** Neutral.

4.4.3 Steps taken before making a complaint or notification to the agencies

Two-thirds of all participants (N=1,126) said they took steps to resolve the complaint before approaching the agency (Table 33); 98 percent providing information about their actions. The proportion taking steps was similar across respondent categories and agencies; some HCCC variation associated with smaller organisational respondents.

The most commonly reported steps were to raise the matter directly with the practitioner (42%) or their employer (16%); followed by internal inquiries (13%); with similar proportions approaching a professional association or another organisation (11%). Five percent approached a lawyer and three percent a Member of Parliament. Some respondents reported taking a number of steps before approaching the regulator. (Box 5) Case 7 reflects reports by many respondents about their determination to pursue 'wrongs'; frustration with agencies not recognising or responding to issues or discrepancies; but being worn down by the time, effort and exhaustion entailed *"I left it In the end, it just consumes you"*.

Organisations approached the subject directly in a higher proportion of cases than either consumers or practitioners and were more likely to pursue internal inquiries, which is unsurprising given the high proportion of organisational respondents that were health services and employers.

Table 33: Survey 1: respondents that had first taken other steps before approaching agencies

	Whether first took other steps										Major types of actions taken [1]					
	AHPRA		NSW		HPCA		HCCC		Total		With practitioner		With employer		Internal enquiries	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Total	705	69	421	62	175	62	246	63	1126	66	706	42	266	16	209	13
CONS	416	67	306	63	116	64	190	62	722	65	407	37	182	17	90	8
PRACT	159	67	70	61	22	51	48	68	229	65	157	45	61	18	45	13
ORG	130	77	45	63	37	64	8	57	175	73	142	60	23	10	74	31

Totals may not equal 100% due to rounding

[1] Major actions taken: raised directly with the practitioner; with their employer; internal inquiries or investigation undertaken

Box 5: Interview extract: taking other steps before approaching the regulator

Case 7

Respondent: I was so cross, the whole deal was terrible. I was devastated. If it wasn't for the fact that I work at a hospital I would take it further, but it's too hard. I don't want it to happen to someone else. I told others what had happened, and they said to "do something - let the hospital know, let patient liaison know". I thought I would get "sorry, a mistake was made", but they assessed it themselves and said "there's no issue". Therefore I went to the board within the hospital. I got a formal apology from the hospital and they acknowledged the treatment was wrong. But not from the doctor responsible. I was told the hospital would instigate a program so [more junior] doctors and new people would be monitored and reviewed. But informally I heard through a senior doctor who told me "it won't happen, they just say that." I wasn't satisfied with the response so I went to AHPRA. I got told "[I had] no grounds". I therefore requested information through FOI [Freedom of Information] and found out a lot more. If I hadn't, I would have still been bewildered. So I wrote to AHPRA pointing out all the holes in the argument and requested more information, but in the end, I left it. In the end, it just consumes you.

....

I believe they are just on the side of the doctors. I found things in the documentation that said things like "What did the person expect, after all they were a public patient". The answer is what you expect is a duty of care like "why is this person still [experiencing complications] ". I found out more information informally from people I had worked with.

4.4.3.1 Comparing professions involved when other steps were taken

Respondents were less likely to have taken other steps before making their complaint where the practitioner was a psychologist (55%) or medical practitioner (63%) compared with other professions (70-75%). (Table 34)

Table 34: Survey 1: respondents that had first taken other steps by subject profession

	DR		All excl. DR		Total		NMW		PHARM		DENT		PSY	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
All	649	63	477	71	1126	66	242	75	57	70	115	75	63	55
AHPRA	380	66	325	73	705	69	176	78	39	75	63	75	47	56
HPCA	95	61	80	64	175	62	36	68	14	58	23	72	7	41
HCCC	174	60	72	71	246	63	30	68	4	67	29	76	9	69
CON	498	63	224	71	722	64	52	78	33	70	102	77	37	53
PRACT	113	64	116	75	229	65	75	73	16	70	9	50	16	55
ORG	38	67	137	67	175	73	115	76	8	67	4	100	10	67

[1] All excl. DR= all professions excluding medical practitioners

Respondents who did take other steps were also less likely to raise their matter directly with a psychologist (36%) or medical practitioner (38%) compared with all other practitioner types (50-55%). (Table 35) Complaints about nurses were twice as likely to have had internal inquiries made first compared to all other practitioners, reflecting a dominant employment setting and higher proportion of organisational and employer sources for this group.

Medical practitioners accounted for approximately three-quarters of cases where a Member of Parliament or lawyer was initially approached; although the proportion of cases where a lawyer was initially approached is higher for psychologists. Care must be taken due to small numbers. However in the case of medical practitioners, 58 percent of cases where a lawyer was approached involved a report, the figure for psychologists being 33 percent.

Table 35: Survey 1: respondents that had first taken other steps by type of action taken

	With practitioner ¹		With employer ²		Lawyer ³		MP ⁴		Profession assoc'n ⁵		Other organis'n ⁶		Internal Inquiries ⁷		Other steps ⁸	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Total	706	42	266	16	84	5	54	3	188	11	181	11	209	13	177	11
DR	381	38	148	15	60	6	42	4	94	9	125	12	100	10	119	12
All other⁹	325	49	118	18	24	4	12	2	94	14	56	8	109	16	58	8
NMW	160	50	68	21	7	2	6	2	49	15	24	7	94	30	39	12
PHARM	41	51	13	16	2	3	0	0	10	12	5	6	1	1	4	5
DENT	84	55	20	13	4	3	2	1	21	14	19	12	5	3	7	5
PSY	40	36	17	15	11	10	4	4	14	13	8	7	9	8	8	7

[1] Raised directly with practitioner. [2] Raised with the practitioner's employer. [3] Consulted a lawyer.

[4] Raised with a local Member of Parliament. [5] Raised with a professional association. [6] Complained to another organisation.

[7] Internal enquiries or investigation undertaken. [8] All other action types not listed above. [9] All other= all professions excluding medical practitioners.

4.4.4 Would the practitioner be used again

Seventy-nine percent of respondents said they would not use the practitioner complained about again. [A4.10] This response was highest where the subject was a psychology, medical or dental practitioner (84-91%). Six percent indicated they may have to or that the practitioner was the only one available.

Interviews with employer respondents (particularly relating to medical and nursing practitioners) indicate that most take steps (and frequently significant steps) before raising their concerns with a regulatory body. Further, when this action is taken, the matter may have already been addressed (and was therefore made as a 'mandatory notification' under national law) or felt either they (or their organisation) have reached the limit of their interventions. Across all respondent categories, only three percent indicated they would use the practitioner again. These responses relate primarily to matters involving nurses made by a fellow practitioner or organisation.

4.5 Survey 1: errors, harms and accountability

The words '*mistake*' appeared 110 times and '*error*' 93 times in Survey 1; referring to all professions. Respondents commented on harms caused; and most commonly on the importance of acknowledging or raising awareness of errors to improve future practice. Others made reference to events involving error leading to the complaint, or adequacy of outcomes. Respondents who referred to '*awareness*' also referred to learning, practice improvements and/or avoidance of recurrence; and risk of more serious future harms. (Table 36)

Those commenting on acknowledgement of error in surveys did so in three main ways. The first was respondents' stating their experience of receiving or not receiving an expression of acknowledgement and their feelings about this; or the ongoing impact of an error or wrong.

Second, an expression of what the respondent was seeking from the complaint process, such as honesty; an admission of wrong or harm, sometimes in the form of an apology; or to have something rectified. Where provided, respondents were positive. Frequently however, while sought, these outcomes were not received and the tenor of comments typically negative. In places, lack of communication by regulatory authorities compounded the original error and lack of acknowledgement.

"The pharmacy admitted to me they had made an error that could have resulted in a terrible outcome. Why don't I then receive correspondence saying that they have identified ways that their practices will change to avoid a repeat of the error, and an apology? Instead, I am left wondering what has changed and why I bothered. Did anything change? I still don't know" (Ref 1480)

The third category covered similar ground but was expressed in terms of seeking intervention by a responsible authority for action. In cases, this was expressed as an action a practitioner should be *required* to take e.g. 'made' to admit an error; change their behaviour; take corrective action. In these cases, comment is about the need for accountability and its absence due to a lack of action; associated in places with the perception of letting practitioners "*get away with things*" or "*cover ups*". Sometimes, this relates not to the original practitioner, but others who become aware of a problem:

"Even though other dentists I have contacted were not in this complaint, their conduct needs serious consideration. Three dentists I have consulted regarding damaged front crown, even admitting it was tampered with, refused to give a written statement, or even verbal reassurance that I can rely on their expertise. It has to be made a mandatory reporting [requirement] for every practitioner when they witness a misconduct of other practitioners, or nurses." (Ref 501)

For others, it is more where the line of likelihood and acceptability should be drawn, particularly when harm has occurred:

"Doctors should have more accountability for correct diagnosis! We all make mistakes, but when they are glaring ones that shouldn't be missed, then why should the patient have to suffer and the Doctor gets off without even a reprimand?" (Ref 979)

"The final explanation seemed to find all the parties to the issue, but they all appeared to side-step the issue of responsibility so in the end no one individual was accountable, so it seems no one individual accepts responsibility for the problem. This sounds like human factors have led to a systems error occurring that could be fixed, but with there being a lack of ownership of the problem and without the recommendation of the watchdog (AHPRA) nothing is going to change, they will make the same mistake." (Ref 1522)

Table 36: Survey 1: sample of references to 'mistakes' and errors' in survey responses**Acknowledge, admit error; rectify**

Experience or impact

- I am very, very happy the way things went. It was a mistake. I accepted Doctor [name] apologies.
 - Not one of them will own up to the errors in my medical [care]. They all cover-up.
 - It took me a while to recover from the mistake that was made - now I double, triple check all my meds [medications] and suffer terrible anxiety - I feel like I have OCD when it comes to my meds.
 - I had to pay again for treatment because of his mistakes.
-

What respondent wanted

- Acknowledgement of mistakes and bad practices.
 - I want him to put in writing what he told me. *"He was wrong. He made a mistake."*
 - I want the practitioner to admit responsibility for the procedure going so wrong.
 - Acknowledgement from surgeon he made a huge mistake through arrogance.
 - I never received an apology, or acknowledgement of my physical pain. My witnesses were given [the] blame; we should not be blamed for someone else's mistake.
 - Wanted the error rectified. It was ignored and then covered up.
 - I simply asked for a full or partial refund of money because [the] court report was so full of mistakes it could not be used.
 - Reimbursement of out of pocket expenses to correct effect of mistake.
 - I requested and deserved to receive a written apology from the Pharmacist who put my life in danger and when pointed out his mistake, he didn't even verbally apologise.
 - Would have appreciated acknowledgement of errors from the offending pharmacy in writing and an apology.
 - Doctors have to be honest with patients. We all make mistakes, but we have to face up to them and that includes doctors, not put patients through hell like they have done to me.
-

Action by regulator

- [Practitioner] made to admit they made a mistake.
 - Wanted the practitioner at fault to be told not to lie to clients and not to attempt to blame [other practitioners] for his mistakes.
 - The doctor made many mistakes and also lied. I wanted him to have to adjust his report so it is accurate and truthful.
 - I am traumatised by the fact that this issue is being ignored by the commission. The health professionals have lied and refuse to admit they made a mistake.
 - I feel that misrepresentation is something the complaints board are not interested in. This practitioner is disreputable and I feel he can be bought. There were 19 mistakes in a medical report. There were untruths/lies in the same report and nothing was done about it. The whole thing was despicable and the practitioner was not held accountable.
 - The people should start to tell the truth and not just be a bureaucrat being paid for not doing their job. DOCTORS ARE NOT GOD and make mistakes for which they should be accountable.
 - Too many doctors are getting away with the errors they have made to a patient and they hide and cover-up. This has to stop. Any doctor that lies and covers up should be fined.
 - More notice needs to be taken when for example a medical person continually make the same mistakes which are totally unacceptable and no action is taken against them. Society has standard rules and the so-called professionals need to meet these standards.
-

Awareness and learning; improve future practice

- Wanted the person involved to be made aware of the mistake and [be] investigated to prevent future mistakes.
 - Wanted practitioner to understand her error.
 - Mistakes can easily be made; just wanted her to be aware a mistake was made.
 - Wanted the practitioner to learn from mistakes made, listen to family concerns as a "total picture" and not make inappropriate assumptions.
 - No [would not use practitioner again] - unless changed and learnt from their mistakes.
 - Important that people know when they have made a mistake and prevent more serious outcomes.
 - I decided to withdraw the matter. I felt that the doctor had made an error of judgement and I wanted to give him the benefit of the doubt.
-

Issues or events involving errors that led to complaint/notification

- I lodged a complaint on behalf of the patient after discovering the error that caused their hospital admission.
 - Dispensing error to patient – patient experienced life-threatening side-effects and ended up in hospital.
 - Patient under [his] care had had inadequate monitoring of [organ] function. Threatened me for correcting his mistake.
 - Wanted to add my voice to a number of well-publicised ongoing investigations against the same practitioner for the same and similar mistakes.
 - No reference to patient details on day of surgery (did not even refer to me by name) and no confirmation/consultation on procedure on day of surgery - this could have avoided error.
 - I witnessed RN facility manager forging hundreds of signatures on medication charts- facility was undergoing accreditation so she did this in an attempt to erase medication errors.
-

Comment on process or outcome

- Board decided Doctor in question "punished enough" for earlier mistakes.
 - 'No further action' as error made and no significant risk to public.
 - No, I certainly would not [recommend the process], as it appears that no one is prepared to stop [name] from mutilating people. His colleagues are obliged to repair his mistakes and his bungling procedures in operations.
 - If someone has been subject to an overt error or infringement of law via a health practitioner I would recommend civil legal action. If it pertains to a questionable practice or standard of care, I would tell them they have little recourse and are best served by moving on from what they might feel are very poor standards of healthcare.
-

Respondent interviewees were asked about their expectations of error. Some relayed the experience of communicating errors to professionals; Case 8 illustrating in more detail 'defensive' and 'avoidance' reactions. (Box 6)

In this case, the respondent was dispensed the incorrect dose of a medication that had life-threatening implications due to a pre-existing condition. 'Alison' was never contacted or given an apology or explanation. She is hopeful AHPRA will act; and in her survey indicates she would feel less satisfied if it didn't '*follow through*' but at interview emphasises the importance of an apology and acknowledgement; referring to long-lasting effects of events. She describes raising concerns with professionals: '*disgusted*' by a doctor who appears more concerned with the impact of reporting on the subject; her usual pharmacist who '*didn't want to get involved*'; the psychologist, who provided information about AHPRA to whom she is grateful. She would definitely recommend the process so '*action can be taken*'.

Box 6: Interview extract: experience of professional responses to reporting error

Case 8

Respondent: "My doctor [GP] said to me **"No one would have known"**. I have [name of condition] and my doctor said everyone would have just thought "oh, it was [name of fatal condition]". **No one has ever apologised to me. I have never received one phone call, or a letter, or an apology, or an explanation. I thought it was my due;** it was the least I was asking for. I was **extremely disappointed**; it was such a **huge error**. I feel I **deserved one** [an apology]. Maybe because they thought what did happen [after I took the medication] was over at the hospital."

Interviewer: *Do you know why you didn't receive an apology?*

Respondent: "I didn't get any help from anyone afterwards – **none of the health professionals would help me** – except for the psychologist that I was seeing. **My GP said to me "do you really want to ruin someone's career?" And I thought no, I don't want to do that, but I don't want it to happen to anyone else. That response, it really shocked me and I was really quite disgusted.** I have a serious life-threatening illness – so **it's not a minor matter**. I spoke to **my normal chemist [pharmacist] - they know how ill I am – and they had the same response. They were hyperventilating, and said they "didn't want to get involved"**. The **only one who helped me was the psychologist**. They wrote down the phone number and the details of where I had to go and said **"we are obliged to give you this information**. If you had complained about me, it would be the same". Before that I didn't know who to go to – fortunately I was seeing that psychologist, **otherwise I wouldn't have known**. I wouldn't have known they [AHPRA] even existed. **How many other people are out there that haven't complained because they don't know where to go to?"**

Interviewer: *you indicated in your survey that quite a few things would be done as a result of your report. Can I clarify - did the letter [from AHPRA] say they would do those things, or that they might do any or all of those things?*

Respondent: "Well, I took the letter to mean that AHPRA would do those things. I hope so. **I hope they do those things. But, the one thing I really wanted was an apology – and I never got it. I'm so stressed. I hyperventilate every time I go to take my tablets. That's how serious it is."**

Survey: Why made: 1. Not recur. 2. Unsafe. 3. Wrong, unfair, unjust. **For subject:** 1. Discipline, punish. 2. Improve standards. **For self:** 1. Explanation. 2. Apology. **Outcome:** Don't know. "*Possible action conditions or caution*". **Satisfaction process:** Satisfied. **Satisfaction outcome:** Satisfied: "*Knowing that action has been taken and that the person in question is now on probation (assuming they followed through on list of possible actions. I would feel very differently if not)*". **Recommend process:** Definitely would: "*People need to know there is somewhere you can complain to so action can be taken.*"

Perceptions varied in terms of expectations of errors occurring. (Box 7) Some referred to practitioners as 'professionals' and as experts that have attained a body of knowledge, were not expected to make mistakes. Others held the view that notwithstanding their 'professionalism' and expert knowledge, mistakes are inevitable, and what is important is how these are managed. One (health service) employer spoke at length about 'errors' and 'near misses' as generally involving failure to adhere to safety systems that had been established for well-identified sources of harms. In these situations, so-called 'errors' are less tolerable; in

contrast with more unexpected events that may occur and are associated with uncertainties of health care.

Some respondents who believed their issues did not involve error went on to speak about deliberate (knowing) actions which they believed should attract a different form of response.

Respondents that regarded mistakes as inevitable could not always resolve what falls within the category 'error'; what types should or should not attract sanctions or other action; and the form this should take. Linked closely to thinking about error is the importance of acknowledgement and recompense if harm is caused; with patients' expressing anger or frustration by the absence of either.

Box 7: Select responses to interview questions: error

Questions: Do you think errors are rare or common? What comes to mind when you hear 'error' or 'mistake'? Do you think the public expects errors to occur? Would the response be different if it were a pilot or a teacher?

Respondent: No, they are professionals and they shouldn't make mistakes. You wouldn't expect someone to make an incorrect decision

Interviewer: *Why is that?*

Respondent: Oh well they are professionals. That's the area that they have qualified in. Obviously they should be the best informed in the matter.

Interviewer: *What comes to mind when you hear 'error'?*

Respondent: Looking for a diagnosis that doesn't fit. Or dealing with basically, being flippant with a patient and dismissing their concerns and making them go somewhere else

Interviewer: *Do you think they are rare or common?*

Respondent: I think they're rare. But they can happen. Definitely.

Interviewer: *Do you think the question would be answered differently about a pilot or a teacher?*

Respondent: It would be the same response

Respondent: I'd like to think they are [rare] and in my experience generally they have been rare, but then you do hear about things like people losing limbs or surgical equipment being left in people's bodies. You do hear about it but I haven't directly experienced it. Shows [TV] sensationalise, but something like that is very serious and needs to be considered

Interviewer: *Do you think the public expects mistakes or perfect decisions all of the time?*

Respondent: I think the general public – medical practitioners have studied for a long time, are well qualified; they should have the time and the resource to do it. But at the same time people are human and mistakes are made and that is what happened here, a mistake was made. But the flip side is there is the person whose health is affected and you're there to improve their health not to harm [them] or deteriorate it further.

Respondent: I think you can have a bad outcome and it not be negligence. I think sometimes you can be unlucky that things panned out the way they did. But I think on the whole, medical professionals are professional. They have studied hard and you would like to believe that, that not everyone is bad. That everyone can have a bad day. And you can have a bad outcome, but it doesn't make it negligence.

Interviewer: *What comes to mind?*

Respondent: Put it this way. My father went in for an operation for [name]. We later found out that he didn't even have this. That is not a mistake. That is just plain bad diagnosis, poor management and complete negligence. Not only did he do a surgery on someone badly, they did it when they [the patient] didn't even have the condition. That's not a mistake. Multiple [tests] were done. That's not an error. How would I define mistake? [Sigh] to be honest, I'm not sure. You know if things were done correctly, say potentially getting an infection post-surgery. That can happen, even when you've done all of the right things in the world. Taken all of the precautions. You've done all of the right things, the surgery can be done perfectly, but it can happen. To me, that's like an incident. No one can necessarily be blamed for that. And then there the seriousness of the mistake. Is it bad, did they under-prescribe post-surgery or did they leave a sponge in you? Did they operate on the right limb? Did they not prescribe antibiotics when you had an infection? I suppose it's, to me it depends on what the actual issue is and what the potential implications were.

Interviewer: *Do you think the public expects mistakes or perfect decisions all of the time?*

Respondent: I think that we would like to hope that they would, but in the end, they're people. And people make mistakes. But there is a difference between making mistakes and negligence. And I think that is what people need to understand. They need the education. And in some ways the surgeons need to understand the difference as well. Doctors, they're medical people. They're not legal people. So there is a difference.

Interviewer: *Do you think the question would be answered differently about a pilot or a teacher?*

Respondent: For me, personally, no. They still have the lives of people in their hands. Would people feel differently? Quite possibly.

Respondent: Yes I think people do expect that nowadays. And it is how you manage that mistake. You can make quite big mistakes that will affect people greatly. But if you handle that properly and up front, very good open disclosure and so forth and supportive, then it doesn't seem to impact as much. I think with complaints it's the publicity and then the government being embarrassed that sometimes the action happens which I don't think is right - or shouldn't be political. Unfortunately, it is.

Box 7 continued

Respondent: I suppose if I were a patient I would not expect health practitioners to make mistakes. I think that the checks and balances for the most dangerous things we do to people are there, so if for example, if two nurses should be going to a patient's bedside to check the administration of medication, they should never waver from that. There should never be an occasion where one of them decided that they were too busy and went off and gave the wrong drug or gave it to the wrong patient. Or the wrong dose. Under those circumstances, because the systems and processes are in place to assist with preventing that. It's a classical situation, like you end up in the operating theatre and they operate on the wrong side. Well, there is a very comprehensive process in place to prevent that happening and different levels of checking in place; and if they still get it wrong after all these systems are in place, then it's bordering on negligence or "*I just can't be bothered doing it*". So, yes everybody is human, but the most dangerous things have been assessed as high risk so we have put in place things to try and prevent things from happening, so really, it shouldn't happen.... One can have adverse outcomes, but where risks are known and processes are in place and not followed, is different.

Interviewer: *Do you think systemically preventable errors are rare or common?*

Respondent: I think unfortunately, they do happen a fair bit because you review incidents, AEs or near misses, and a lot of the time it is about that the system not being complied with. For example, hand over care between physicians. We now have very specific procedures, you have a sort of checklist, same as nursing staff have on the ward, it's all there, there is no excuse for not doing that and in fact 50% of handover occurs at the bedside.

Respondent: I think they are human, and just because they are a doctor it doesn't mean they can't be morally bankrupt - it doesn't mean they can't act in self-serving, quite unconscionable ways, because they are all individuals. And being a doctor doesn't automatically elevate their moral compass. They have their own beliefs, their own reasons for doing things just like anyone else. Like I said, they're not gods, they are human beings and I do think you can anticipate that they will make mistakes. And if they make mistakes, you are injured, as a patient you should still be compensated for that. Like if you have a car accident... it's an insurance claim, whether intentional or unintentional. And you should be able to have recourse for that. But I think the insurance companies make it virtually impossible for the doctors to admit liability and say they are sorry. So doctors have to go to any lengths to not admit liability or accountability because otherwise they won't be insured or it affects their premiums quite significantly. So it's a huge impediment. I've read up on this and they can't say sorry, even if it was accidental. The medical insurers are playing a huge role in doing everything they can to ensure doctors avoid accountability. Even in my case... instead of the doctor saying, "*look I made a mistake and my patient was injured and quite significantly*", he has gone to the opposite extreme. So he angered me even more. If he just made a mistake like he said and didn't realise the risks when he prescribed it to me and put me at such risk, it would have made a difference. Like, I'm sorry and you have been seriously harmed and it's an insurance claim. No, it's gone way beyond that because he has tried to cover his tracks in every possible way.

So yes, we do expect doctors make a mistake but it's very confronting and extremely disappointing as a patient because you trust your doctor and you expect that they will protect you from harm and you trust that they inform you about procedures and medications. I was lucky, because of my background, I can read pathology reports and it saved my life. But the average patient would have no idea about any of this and entrust doctors implicitly and if they have been intentionally harmed, then that's a different ball game altogether; and I think we need processes in place and regulatory agencies in place that will investigate this and do something about this, because most people can't afford litigation either.

Respondent: Well, you would hope that they don't. But look, I suppose it's not something my friends and I talk about very much. And I suppose, well, you don't just talk about the mistakes. Everyone has a story but no, I think the expectation is that people should know what they're doing. I think people tend to think that once you get into the hands of a specialist they know more about what they're doing and I suppose I think that too.

Interviewer: *What do you think about when you hear 'error' or 'mistake'?*

Respondent: Look, I don't have a lot of interaction with them but I have to say most times they're not good. Any number of things comes to mind... like misdiagnosis [gives example].

Interviewer: *I'm interested in expectations – do you think that there is a general expectation that our health practitioners get it right all of the time?*

Respondent: Oh I think so. That is definitely; there is something in that. But I think to be fair to the public on that side, I think health care providers, particularly doctors hold themselves up for that too. They, in a way, expect to be treated like that as well as people do treat them that way, so that there is that expectation.

Interviewer: *From what you are saying, do you think that sets up an unhelpful dynamic?*

Respondent: Absolutely. In a way, because they can't get it right every time. But, they are dealing with the health of people so if they get it wrong it can be disastrous. So while they probably have a higher level of what we consider '*getting it right*' than everybody else, obviously mistakes are made. But what people need to do is be accountable for those mistakes. And that's what I think the HCCC has a role in doing.

4.6 Survey 2: respondent profile

Of the 80 responses, 50% (N=40) were from health professional; 36% (N=29) from population and 14% (N=11) from consumer organisations. (Fig.8) [A4.11]
All jurisdictions are represented in responses from each of these sources.

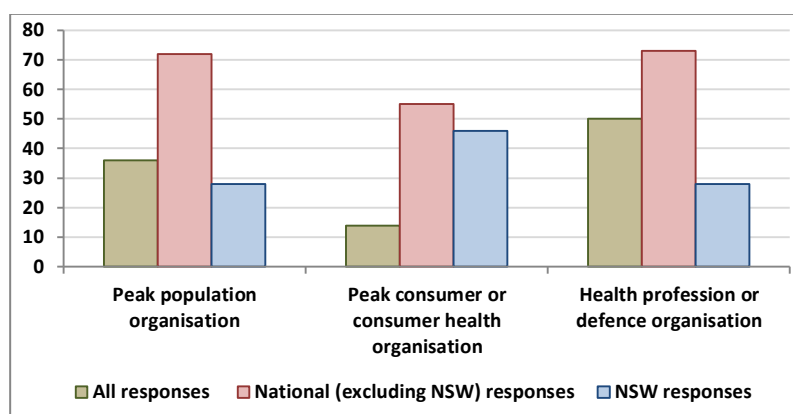


Figure 8: Survey 2: respondent profile

Seventy percent of responses were from organisations outside NSW with the exception of consumer responses; with a similar proportion of these received from national and NSW sources.¹⁰⁴ A diverse population is represented in membership and service users. (Fig.9) [A4.12] Services provided by respondent organisations included information and advice (74%); policy (69%) and legal and advocacy support (64%). [A4.13]

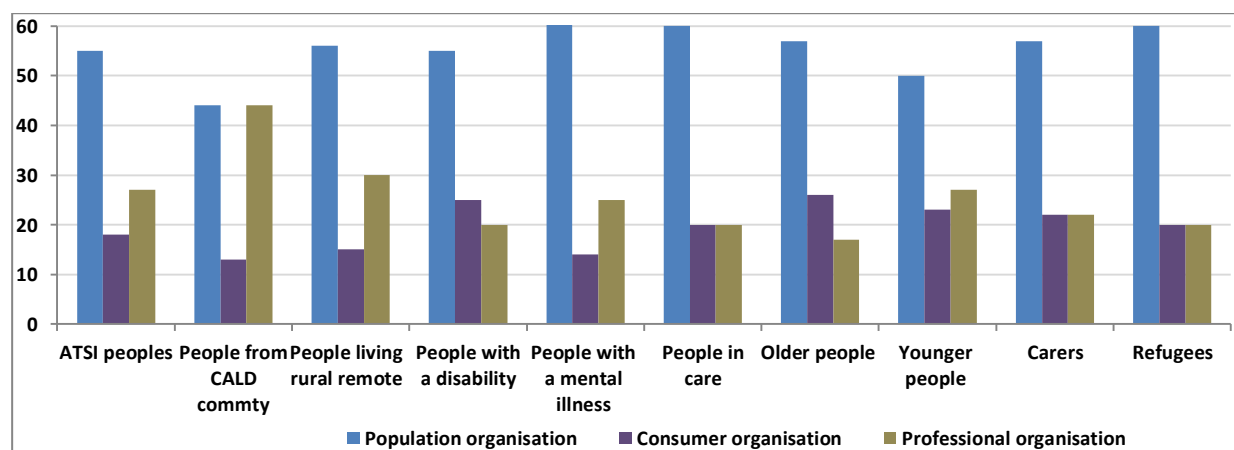


Figure 9: Survey 2: profile of the main target groups and service users of respondent organisations

ATSI= Aboriginal and Torres Strait Islander peoples; CALD= people from culturally and linguistically diverse backgrounds and communities; Rural, remote= people living in rural and remote areas.

4.6.1 Knowledge about or engagement with agencies

Respondents were asked whether they had contact from or engaged with any of the agencies or jurisdictional commissions; choosing from a six item menu.¹⁰⁵

¹⁰⁴ Of national responses (N=56), three-quarters were from the ACT, Queensland, South Australia and Victoria in nearly equal proportions; 22 percent from Western Australia; the remainder from the Northern Territory and Tasmania. Seventy-seven percent were single jurisdiction responses, 14 percent represented all jurisdictions and nine percent more than one jurisdiction. 'National' responses were taken to be those originating in or led by jurisdictions other than NSW (whether involving one or more jurisdictions), with the same approach applied to NSW responses.

¹⁰⁵ In this question AHPRA and Boards were separately identified; as were the HPCA and Councils. Menu items included: no contact; received information; commented on their fact sheets or policies; made submissions to reviews about them; member of their committee or working group; other type of contact.

Population organisations were more likely to have had no contact at all with the agencies; and were least likely to have received information or had another type of contact. [A4.14] The proportion of national respondents reporting having no contact with AHPRA (23%) or a Board (30%) was similar to NSW responses about the HCCC (25%). However, ‘no contact’ was higher for the HPCA (54%) and Councils (42%).¹⁰⁶

Only a small proportion reported being asked by the agencies about the needs or ability of their members or service users to make a complaint. (Fig.10) The proportion was highest for the HCCC, similar to responses for other jurisdiction commissions. [A4.15]

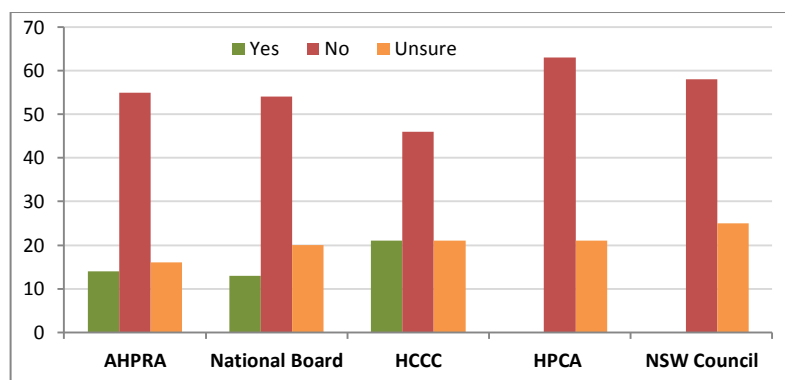


Figure 10: Survey 2: whether agencies asked about the needs or ability of respondent members/service users to make a complaint

At a national level, three-quarters of respondents who were approached for this feedback were professional organisations. In contrast, all organisation types reported this in relation to the HCCC; but none indicated being approached by the HPCA or a Council.

4.6.2 Experience with individual complaints and notifications

Fifty-seven percent [N=48] reported having experience with a complaint about a health practitioner; the most common action being to provide advice. [A4.16] Most of these complaints related to the (five) professions under study (95%). However, the majority (60%) of these related to matters managed by jurisdictional commissions outside of NSW or other types of regulatory bodies (e.g. Aged Care Complaints Commissioner); i.e. not to the agencies under study. [A4.17]

The scale of involvement with individual complaints varied from less than 50 to over 500 per year. [A4.18] Less than half (45%) of consumer organisations said they felt adequately equipped to assist a service user with a complaint about a health practitioner compared with population (65%) and professional (87%) organisations.

Community respondents with an individual advocacy role commented on the need for greater resources, skills and training for their staff or volunteers to adequately assist service users; and the need for specific support for people with mental illness. [A4.19] Agencies without a direct role in assisting with individual complaints suggested information setting out the roles

¹⁰⁶ Organisations outside NSW would not expect to be approached by NSW agencies. To exclude bias, particularly given the small numbers involved, figures were adjusted to include only AHPRA and National Board related responses in the ‘national’ respondent count; and only HCCC, HPCA and Council responses in the NSW respondent count.

and responsibilities of different agencies would be helpful, with web links if further details were needed.

Summary of Chapter 4

Chapter 4 addressed study Objectives 2 and 3 by describing the profile and motivations of those making a complaint; and any significant variation in responses between complaint systems or professions.

Differences between agencies in Survey 1 were not substantial; other than the HCCC attracting a lower rate of response from organisations. As discussed in Chapter 3, this was anticipated due to the study design.

Understanding who are and are not making complaints is an important barometer of accessibility. Most complainants were consumers; female; aged 40-60 and English speaking. Three-quarters lived in a city or regional centre. For one-quarter, high school is their highest level of education; approximately one-third have a trade certificate or diploma. Under-represented relative to their population profile are Aboriginal and Torres Strait Islander peoples; Australians from culturally and linguistically diverse communities; and people with mental illness. This is consistent with literature about under-representation of vulnerable and disadvantaged populations. The nature of barriers has also persisted - lack of knowledge and understanding of the right to complain and the process; the need to be identified and fear of reprisal (to service or employment); stress of the process and confidence in achieving desired outcomes.

Health professionals who made a complaint were mostly a peer of or senior to the practitioner subject of complaint. This reflects literature indicating that more junior staff are unlikely to report concerns; particularly about their seniors. The majority of organisations were health services and employers.

Issues raised are consistent with the location of employment and nature of work of the professional concerned; and most frequently relate to care, competence, conduct and communication. Analysis of comments shows a high correlation and 'compounding' of issues - e.g. poor care and competence; and those historically differentiated as technical or clinical and 'non-clinical', such as care and communication.

Notable is the significant proportion including 'complaint response' in identified issues (i.e. how the practitioner responded to the complaint), reflected in feedback about errors. The majority of respondents tried first to resolve their complaint before approaching regulatory authorities; thereby increasing the significance and expectation of the agency response. This is particularly notable in cases reporting 'recurring' practice and behaviours of concern. The role

of fellow professionals in bringing colleagues to account is also at issue, with 'avoidance' and discouraging responses featuring. This experience is not confined to consumers (Case 9).

Respondents reported a duty to raise concerns, the effort and risk involved and importance of issues raised. They felt strongly about events and frequently reflected carefully before making a complaint or were urged by others to do so. Consistent with available literature, they wanted an explanation and an apology – full and freely given; three-quarters seeking improvement in standards and action to ensure events would not recur. Disciplinary action was important but feedback mixed on what this entailed – 'stern action' and in cases stopped from practising; but frequently a 'higher authority' compelling action be taken by the practitioner; especially where they had not responded when raised directly with them or their employer.

In discussing what they sought, respondents raised concepts that emerged at scale as the study unfolded. This included the relative value and powerlessness complainants experience and lack of responsiveness from fellow professionals when support is sought. Narratives of events highlight the extended temporal and complex emotional dimensions involved in both the original events and complaint processes.

Survey 2 responses highlight the limited contact with or information community organisations had from agencies. Feedback indicates greater information and support about the complaint process and the role of different agencies is needed by community organisations. This is significant given the low level of knowledge and understanding of agency roles identified in this study.

The next Chapter reports on how complaints were managed.

Chapter 5. Results: how issues were dealt with

This chapter addresses study Objectives 2 and 3 by reporting how complaints were managed; and any significant variation in responses between complaint systems or professions.

Section 5.1 describes what respondents were first told about the complaint process; subsequent actions by agencies; and whether respondents withdrew their complaint or experienced delays. Section 5.2 covers the outcomes reported by respondents. Section 5.3 reports whether respondents' felt their issues were addressed; their awareness of changes that occurred as a result of their complaint and any plans for further action. Also presented in this section are Survey 2 responses about awareness of changes arising from complaints.

5.1 Survey 1: actions taken by agencies

The majority of respondents (71%) were initially told their complaint would be assessed for whether an investigation was required. [A5.1]¹⁰⁷ This was regardless of profession; the agency handling it; or category of survey respondent (i.e. whether the complaint was made by a consumer, practitioner or organisation). Twelve percent were told at the outset that no action would be taken; this proportion higher for dentists and doctors or when the complaint was made by a consumer. Less than 10 percent were asked for further information at the assessment stage. A few reported being told that urgent action would be taken (3%).

5.1.1 Referral of the complaint or notification

Forty percent of respondents (N=680) reported their complaint was referred, indicating a high rate of 'movement' before the regulatory agency received it. The most frequent referral involved another health complaint body (N=366); or other type of complaint body (N=121) such as the Aged Care Complaints Commissioner or an Ombudsman. [A5.2]

Eleven percent were referred to the practitioner complained about (N=115) or their employer (N=76); and a small proportion reported referrals to the police (N=41) or Coroner (N=22). Comments indicate some respondents answered this question in relation to their own actions.

In comparison, when asked about outcomes (at closure), only 2 percent of respondents (N=39) reported their matter was referred elsewhere.

¹⁰⁷ Additional tables contained in the appendices appear in brackets e.g. [A5.1] is Appendix 5, Table 1

5.1.2 Referral of the complaint or notification to conciliation or resolution

Eight percent (N=137) of Survey 1 respondents said their case was referred for conciliation.

(Table 37) Of these, 47 percent (N=65) were handled by the HCCC, 22 percent (N=30) by the HPCA and 31 percent (N= 42) by AHPRA.

As AHPRA does not have conciliation powers, these responses appear to relate to events prior to referral to AHPRA or after the agency decided not to take further action.¹⁰⁸ In NSW, 'conciliation' is a voluntary formal process that can be instigated by the HCCC; that agency also providing a complaint resolution service.¹⁰⁹ Some respondents answered in relation to the HCCC resolution service; and it appears some also answered in relation to other resolution processes.¹¹⁰

Of the 137 cases identified for 'conciliation', nearly two thirds (64%) involved a medical practitioner. Of the 120 respondents who provided further information a majority said conciliation did not proceed (44%) because they or the practitioner declined the process or that it was attempted, but failed to reach agreement (29%). (Table 37)

Table 37: Survey 1: whether conciliation was recommended and if recommended, the outcome

	All		DR		All excl. DRs [1]	
	N	%	N	%	N	%
Whether conciliation was recommended						
Yes [2]	137	8	88	8	49	7
No	992	58	596	57	396	58
Don't know	54	3	36	4	18	3
Not applicable (not HCCC matter)	534	31	318	31	216	32
Outcome [3]						
Didn't go ahead	53	44	46	49	7	27
Tried but no outcome	34	28	24	26	10	38
Complaint partly addressed	14	12	11	12	3	12
Complaint fully addressed	19	16	13	14	6	23

[1] All professions excluding medical practitioners

[1] Includes all cases where the respondent indicated conciliation was recommended, whether a HCCC matter or not

[2] 88% (N=120) of those that indicated conciliation was recommended answered this question; % = percent of outcomes reported

Reasons for complainants refusing conciliation varied, including feeling it was inappropriate on the basis that the complaint raised questions about clinical standards or that a death was involved, requiring greater accountability of the practitioner. (Table 38) Others saw no point in proceeding because the regulator had already decided no action would be taken by them; because of the practitioner's attitude; or which parties would be involved.

¹⁰⁸ In the survey question "Was conciliation recommended at any point" respondents were advised that the question "only applies to matters handled by the NSW Health Care Complaints Commission – answer 'question not applicable' if another body handled your matter". The additional responses appear to reflect efforts to conciliate or mediate before or after management by AHPRA or the HPCA. These responses are included for the information they provide. When asked in a later question about the outcome of their complaint (on closure) very few (N=15) reported their matter was referred for conciliation

¹⁰⁹ Matters received or managed by the HPCA that are identified for conciliation or resolution are referred from that agency to the HCCC.

¹¹⁰ Survey comments and interviews indicate some respondents answered in relation to jurisdictional complaint resolution processes as well as the HCCC resolution service; however, because some made no comment it is not possible to quantify the proportion that did this.

Table 38: Survey 1: sample of survey responses where conciliation or resolution was declined

Refused by complainant

- I refused to sit down with the two people I hold responsible for my wife's early and untimely death.
- I was asked to attend conciliation with a practitioner who failed to provide adequate pregnancy care. I lost my baby - how do you move past that in mediation?
- I advised that I did not want to proceed with conciliation.
- The complaint had been held by the HCCC for two years by then. The doctor (?) had responded (lied) and frankly I had no inclination to sit across from him in a system designed to protect him.
- Told 'no case to answer' therefore further action futile.
- I refused [conciliation] on principle as the doctors treated me like a leper.
- I refused to sit down with the two people in charge [held responsible for death].
- I didn't want to meet with him as he had shown himself to be uncaring and arrogant.
- I did not wish it to go to conciliation as there was nothing to conciliate - I requested that the outcome be reviewed instead, and then it was referred to the Medical Council - all of this for very little action of any kind.
- Conciliation with the hospital and VMO was recommended [by the HCCC]. The VMO declined and I formed the opinion that conciliation with the hospital would be a waste of time. After an appeal to the HCCC the matter was referred to the Medical Council.

Refused by practitioner or their representative

- Owner of surgery refused (doctor) conciliation.
- HCCC will communicate between health professional and client [but] no response received.
- Conciliation declined [by hospital].
- Doctor wouldn't participate in conciliation.
- The health commission recommended it, the hospital refused.
- [I] offered conciliation but it was not accepted.

The basis for deciding to refer a matter for conciliation rather than an investigation was also raised, as shown in the following:

Greater transparency in the method/criteria [used in] determining whether matters are investigated or conciliated is needed. "Investigated" should mean more than only criminal/corrupt behaviours – the elderly died from neglect and incompetence.” (Ref 266)

A refusal by practitioners to meet and speak with complainants was a source of great distress or anger; and a contributing factor in perceptions of unfairness or inadequacy of the complaint process. (Box 8, Cases 9-10)

Case 9 also illustrates that even where an employer acts (and is positively acknowledged for this) it may appear insufficient; and additional 'authoritative' intervention is sought. As in other cases, the respondent reports feeling powerless and a lack of understanding of how regulators make decisions. In both cases there is frustration with a process which is experienced as unhelpful and does not appear to recognise the complainant as the one 'wronged' by events and the associated long-term harms caused.

In Case 10 the respondent contrasts the management of the complaint and response of the practitioner with her own skills and experience as a manager. This is consistent with other cases, respondents frequently reflecting on their working lives; when they have acknowledged failings on their own part or that of their staff; and the prompt and sometimes 'stern' responses they have or would experience to errors or wrong-doing by their employer.

Case 10 also reflects frustration expressed by other respondents about assumptions made by agencies about what the complainant is seeking from the process.

Thirty-three of the 137 identified cases indicated their complaint was partly (N=14) or fully (N=19) addressed as a result of conciliation or resolution:

“Matter was resolved amicably and practitioner retracted diagnosis with full explanation... it was handled so well by the HCCC.” (Ref 928)

However, one of these 33 cases involved a practitioner who was “persuaded” to retire; with another six referred on for investigation and/or disciplinary action e.g.:

“Practitioner was terminated from [the] workplace. Conditions [were] applied.” (Ref 556)

Further, partial ranking results show some events are not within the agency’s control:

“At the time of mediation my patient informed me that she was happy with the outcome however since the meeting interventions [description provided] offered have been reduced/restricted by the hospital and my patient was considering informing the HCCC about this situation.” (Ref 1538)

Box 8: Interview extracts: practitioner refusal to meet

Case 9

This case highlights issues raised by many respondents: strong and long lasting feelings about events and a sense of injustice; in part due to the practitioner (lack of direct acknowledgement or apology) and in part the process (feeling powerless; lack of acknowledgment of the legitimacy of the complaint; that the practitioner can choose to not allow a copy of their response to be released and to not meet). ‘Martha’ believes the practitioner would have found a meeting difficult but important, as she believes they don’t comprehend the impact of their actions. She wanted ‘disciplinary action’ (the practitioner to not work in that field). She learns the hospital has acted but events were apparently not regarded as ‘serious’ by the Board; whose regulatory ‘thresh-holds’ are unclear. She comments positively on the hospital’s actions but indicates leaving it there is not sufficient. She feels dismissed and not only unacknowledged but disbelieved by investigative staff; and is concerned inaccuracies in her medical records may have influenced the expert reviewer – a view expressed by other respondents.

Interviewer: You indicated in your survey that conciliation was recommended, but it didn’t go ahead. Can you tell me what happened and why it didn’t proceed?

Respondent: After I put in my complaint, the HCCC did consult with an independent nurse and it was taken to and discussed with the Board – but they said it “didn’t meet the threshold”. I don’t know why, but it didn’t and I was then told it would go to conciliation. It was silly, really, because the nurse said “no” and that was it. And I thought it was so unfair – she got to see my complaint, which is fine, but I didn’t get to see her answer. And then she gets to say no to conciliation. And she never apologised.

Interviewer: If she had said yes to conciliation, would you have gone ahead with it?

Respondent: I don’t know. I think I would have - to ask why she did what she did, why she behaved the way she did and to explain to her so she understood the impact her behaviour had on us. I don’t think she really understands what impact she had. I’m getting upset now thinking about it- a year later. It’s still some time later and it’s still affecting me. It’s something I will never forget.

Interviewer: In the survey, you said that you wanted the practitioner disciplined. Can you tell me what you meant by that?

Respondent: She shouldn’t be working [in that area]. I’d made many, many phone calls and did find out [through the complaint process] she is working somewhere else.

Interviewer: Do you think that is appropriate?

Respondent: Yes, it’s very serious what she did. I think I was in shock. I spoke to the NUM [nursing unit manager] and she acknowledged what that nurse did was wrong.... She indicated the first time anything happens, it’s noted and the second time she would act and if it happened again after that, it would go the Director and she said my case was going to the Director. Everyone behaved beautifully. She called the patient liaison officer and they came and spoke to me. So the hospital was acknowledging that things weren’t right. I can’t remember why I decided to take it to the Commission after that. There were other things though. So I knew before I even left the hospital that I was going to make a complaint. The HCCC, it never it acknowledged that I was the victim or that what she did was wrong. It made me feel like I was lying; I was seen as a liar until the facts were proved that I was right. The process wasn’t emotionally helpful. And when I asked for information about what happened and why I got absolutely nowhere. I called and called but it was impossible to get any information on why some action wasn’t being taken.

Interviewer: You said they told you that the hospital was [action being taken] - do you think that may have been a factor?

Respondent: Maybe, it’s something I suppose, but I don’t really know. I felt powerless in it all. I know even though they say they are impartial, I felt they sided with her. I didn’t get to see her response. She got to decide that I didn’t get to see her response. She got to decide that she didn’t have to or didn’t want to meet with me. It would have been hard for her to meet, because she would have had to explain herself, she would have had to listen to me. And some of the information she provided, it was incorrect and I was really concerned about that because it meant that when the independent person read it, they would be reading lies. But they just made it a dead end, they wouldn’t respond. I have proof the records were incorrect. For example [describes issues, events]. I would like them fixed, it isn’t right. They said I could write an addendum to the records... I haven’t yet but I will because it is important. I would like them fixed, it’s important. I feel like it’s a cloud over my head. I haven’t yet but I will.

Case 10

Respondent: My husband came home and he said "Listen, you will have to do something. I'm not well and nobody's listening to me." That was his words- "no one's listening". All of them, after I complained kept on asking "What do you want out of this?" And I said to them "well, I don't want money". Because that's what they always think you want. I said I don't want this to happen to anyone else. Because no one will convince me that he wouldn't have lived longer if someone had listened to him. I wanted Dr [name] to say [to his employees] "Listen here, this is not good enough. You have got to listen to patients. You've got to sit and listen to them. And watch them. And take it in. And not just sit and look at a computer all of the time."

They asked me if I would I sit down and mediate, and I said 'yes'. She phoned back a month later. And she said we've been on to Dr [name] and he absolutely refuses to sit across from me and mediate, and I said "well I've never met such a gutless doctor in all of my life". Because all I wanted was for him to listen to my story. There was nothing vindictive. We didn't want money. I know how to deal with staff. I was in charge of a large office. Anyone can make a mistake. I've made mistakes. But I got pulled up and told about it. And that's what annoyed me about Dr [name]. I don't think he was faced and told "look you'll have to do something - there's a bad complaint here". It's about acknowledging and managing it.

Interviewer: Do you have any sense that that what you wanted has been understood?

Respondent: I don't think so. All I wanted was Dr [name] to know that his doctors are not up to standard. And if he had sat across the table from me, we could have talked. He could have said "Well, I'll do this or that." So that it would not happen to anyone else. And acknowledge that they did do slightly wrong things.

Interviewer: Do you know why he didn't want to meet with you? Did they ever give you any indication?

Respondent: No I don't think so. She just said he flatly refused. And the letter said if there was to be mediation, I couldn't speak about it in any way. It felt threatening.

Interviewer: What would you have like to have seen happen?

Respondent: I would have liked to have notification that if I didn't have mediation to say that Dr [name] had been instructed to speak to the doctors involved. To make sure that they are actually treating their patients in the best possible way.

Nineteen of the 34 cases who had 'conciliation' but with no outcome were in NSW; and all but two of the NSW cases involved a medical practitioner.¹¹¹ The most dissatisfied in this group were those offered informal resolution; who were critical of the voluntary nature of participation; the lack of mutual obligation and the inability to secure direct answers; and in some cases, reimbursement or compensation. (Box 9) Discussed in more detail in Chapter 6, Case 11 also illustrates respondents' perception of practitioners being able to manipulate the process and avoid accountability for harms caused.

Box 9: Interview extract: resolution attempted without outcome

Case 11

'Selma' made a complaint on behalf of her parent who had undergone surgery. Reported issues included a retained surgical instrument; post-operative infection and delayed wound healing (24 months); during which time her parent was unable to work and encountered additional costs (nursing, medication and supplies); which the doctor had initially committed to covering but subsequently has not. Selma says the doctor was unavailable post-operatively when complications were experienced; and has never accounted for events that occurred; or the adequacy of his treatment. After deciding not to undertake an investigation, the HCCC offered to assist with resolution. While anticipating the process would deliver answers to their questions, it did not; the respondent not understanding why the practitioner could pick and choose what information to provide.

Respondent: There was a reply from the initial paperwork (complaint) - they had a response from the doctor. However, we weren't allowed to see it. The Commission said 'Look, you are not going to find out exactly what they said word for word; but if you try and construct some questions; we will see if the doctor will answer them'. So we went through the mediation process, where quite literally we asked questions. Before this, [the HCCC person] said look, it is a very difficult situation this; what is the word I am looking for? Conciliation. It wasn't in person. Literally we put together a series of questions. They [the HCCC] said, look, we are not going to get direct answers. Essentially, the process is a little strange. I would have thought that I would put a question and get an answer, but we were warned that if we tried that way, it is completely optional for them to answer. And I thought well how can I enter into a two way discussion, if it is optional for them to answer? Like how do you mediate if it is optional answers?

....

Respondent: One of the questions that we asked was look, can we please get an understanding; because all we have got from you [the doctor] so far is "No, nothing went wrong, I did everything I could." And we said to him, look, other people were involved. Other doctors said something went wrong. Other doctors said there was this infection. Other doctors noted this; other nurses were there at the time. And the answers that we are getting [from you] include none of these.

¹¹¹ The remaining (national) cases included all professions, and appear to refer to actions taken to resolve the matter prior to it being referred to AHPRA (hospital or service level meetings; direct negotiation; attempted resolution through a consumer agency, professional association or legal representative).

....

Respondent: The thing that stuck in my mind was that what the doctor supplied to them [the HCCC] was optional. He picked and choosed [sic] what he wanted to answer. He picked and choosed [sic] what he wanted to supply. He picked and choosed [sic] what files to give to the HCCC. So of course everything would look glossy and fantastic and he did everything great. We were desperately trying to point out the questions that we wanted the answers for, and it was as if the questions were never asked, it was like *"Oh Mr doctor, what would you like to reply to this?"* Not *"Here is a question for you, please give me an answer."* It sounded like a game of politics. One side of the room is asking questions, and there is this long winded story and in the end the question is never answered.

Respondents who did not have access to or were refused mediation or a meeting with the practitioner said it should be made available as a way of resolving issues. Their responses were of two types. The first group comprised those frustrated by a complaint process they felt was long and distant and were seeking mediation:

"I have the same problems that I had at the start of this complaint. Nothing is resolved. I need a mediation service that will help me talk to the hospital [and doctor]." (Ref 437)

The second related to dissatisfaction with how the complaint process was conducted; with mediation sought as a means of circumventing perceived deficiencies; reported on in more detail in Chapter 6. Notably, features of the complaint process prompting interest in mediation mirrored those expressed by respondents dissatisfied with the resolution process they had experienced. Key point included a lack of transparency; lack of information provided to complainants; ability of practitioners to avoid answering questions; and perceived bias of the process, complainants recommending:

"[a] round table discussion with relevant assessors; and with [the] mediator and [the] practitioner present." (Ref 49 issue: inadequate treatment; refusal to treat; adverse event)

"The practitioner provided an inadequate response to the complaint. The investigators failed to pursue this. Conciliation should be a mandatory part of the process. There should be an opportunity for review where the complainant can question statements in the final response. (In my example there was no opportunity to challenge false statements in the final reports. I detailed these concerns in an e-mail; but received no reply." (Ref 1277 issue: consent; misdiagnosis; inadequate treatment)

"Mediation with doctors and [an] independent- not a medical- adjudicator. No solicitors. Make the doctors see how they have ruined lives and are not answerable." (Ref 349 issue: misdiagnosis; delayed treatment; loss of function)

5.1.3 Whether the complaint or notification was referred for investigation

Fifty-seven percent of respondents said their complaint was investigated. (Table 39) Fewer investigations were undertaken by NSW agencies; or if a dental practitioner was involved (49%). The highest rate of investigation involved pharmacists (70%).¹¹² Investigation of complaints made by consumers was lower compared with other respondent types. However, the *'don't know'* rate of response (18%) was similar regardless of the agency; subject practitioner or respondent.

¹¹² In Australia each jurisdiction has a Pharmaceutical Services unit or section in the Department of Health with regulatory responsibilities. It may be the high referral rate for pharmacists relates to referrals to these bodies to undertake inquiries or investigations

Table 39: Survey 1: complaints/notifications referred for investigation by agency, source (respondent) type and subject profession

Response by agency and source of complaint							Response by practitioner subject of complaint						
	Yes		No		Don't know			Yes		No		Don't know	
	N	%	N	%	N	%		N	%	N	%	N	%
All	964	57	426	25	302	18	DR	560	55	283	28	182	18
AHPRA	622	61	221	22	174	17	<i>All other¹</i>	<i>404</i>	<i>61</i>	<i>143</i>	<i>21</i>	<i>120</i>	<i>18</i>
NSW	342	51	205	30	128	19	NMW	207	65	60	19	52	16
HPCA	163	57	69	24	50	18	PHARM	57	70	10	12	14	17
HCCC	179	46	136	35	78	20	DENT	75	49	48	31	31	20
<i>Consumer</i>	<i>585</i>	<i>53</i>	<i>317</i>	<i>29</i>	<i>201</i>	<i>18</i>	PSY	65	58	25	22	23	20
<i>Practitioner</i>	<i>220</i>	<i>62</i>	<i>75</i>	<i>21</i>	<i>57</i>	<i>16</i>							
<i>Organisation</i>	<i>159</i>	<i>67</i>	<i>34</i>	<i>14</i>	<i>44</i>	<i>19</i>							

[1] All professions excluding medical practitioners

Excludes responses referring to investigation by other agencies (as identified by survey comments)

The following four categories of complaint accounted for 60 percent of the issues investigated- 'care and treatment' (55%), 'conduct' (43%), 'communication' (36%) and 'competence' (31%).

[A5.3] The proportion handed by AHPRA and NSW agencies for 'care and treatment' and 'communication' were identical; with small variations for 'conduct' and 'competence'. Issues referred for investigation varied between the professions, but were consistent with major complaint types for each profession: e.g. investigations of dental (75%) and medical practitioners (67%) were higher for 'care and treatment'; and those involving 'conduct' was higher for psychologists (55%) and nurses (51%).

5.1.4 Whether the complaint or notification was referred for disciplinary action

Fifteen percent of respondents said their complaint was referred for disciplinary action (Table 40) with NSW agencies (particularly the HCCC) referring fewer. The number of disciplinary cases was highest for pharmacists (28%) and nurses (20%); or when the respondent was an organisation (21%). It was lowest among medical and dental practitioners. A higher proportion of organisational respondents said they were not advised if their complaint involved any disciplinary action (35%).

Table 40: Survey 1: complaints/notifications referred for disciplinary action by agency, source (respondent) type and subject profession

Response by agency and by source of complaint							Response by practitioner subject of complaint						
	Yes		No		Don't know			Yes		No		Don't know	
	N	%	N	%	N	%		N	%	N	%	N	%
All	246	15	982	58	451	27	DR	122	12	654	64	247	24
AHPRA	191	19	553	55	263	26	<i>All other¹</i>	<i>124</i>	<i>19</i>	<i>328</i>	<i>50</i>	<i>204</i>	<i>31</i>
NSW	55	8	429	64	188	28	NMW	63	20	134	42	116	37
HPCA	40	14	152	54	90	32	PHARM	22	28	37	46	21	26
HCCC	15	4	277	71	98	25	DENT	21	14	90	59	41	27
<i>Consumer</i>	<i>140</i>	<i>13</i>	<i>681</i>	<i>62</i>	<i>276</i>	<i>25</i>	PSY	18	16	67	60	26	23
<i>Practitioner</i>	<i>55</i>	<i>16</i>	<i>201</i>	<i>58</i>	<i>91</i>	<i>26</i>							
<i>Organisation</i>	<i>51</i>	<i>21</i>	<i>100</i>	<i>42</i>	<i>84</i>	<i>35</i>							

[1] All other = All professions excluding medical practitioners

Excludes reported disciplinary action undertaken by employer (as identified by survey comments)

Twenty-two percent of complaints about medical practitioners referred for investigation resulted in disciplinary action; compared with 31 percent for the rest of the professions.

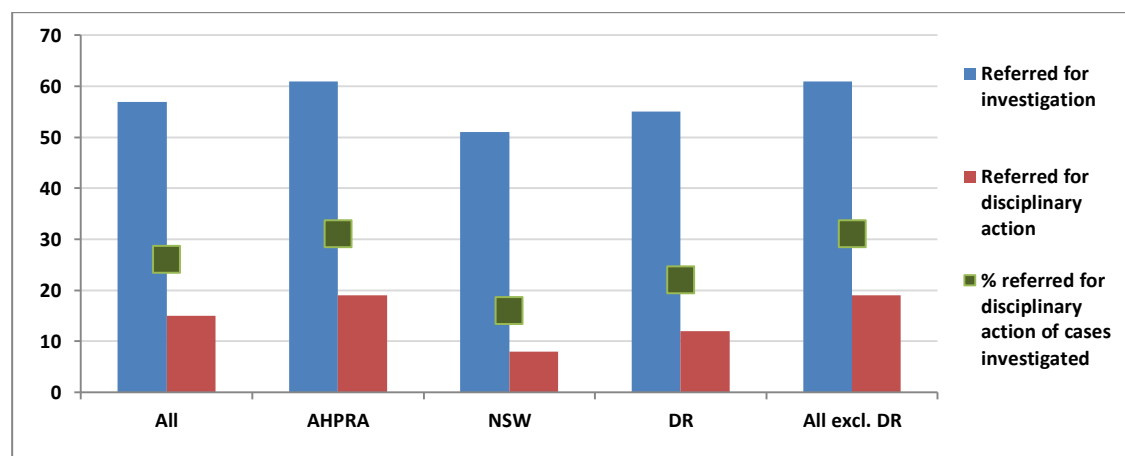


Figure 11: Survey 1: complaints/notifications referred for investigation and disciplinary action
All excl. DR = All professions excluding medical practitioners

5.1.5 Whether the complaint or notification was withdrawn at any point

Five percent (N=86) of respondents withdrew their complaint. Half of these were handled by the HCCC and 69 percent of them were consumer complainants. The majority involved doctors (66%) or nurses (20%); none involved pharmacists. [A5.4]

The most common reason for withdrawing was the health of the respondent (too sick, tired or distressed) or a belief nothing would happen (39%); and concern about repercussions (23%). (Table 41) In 10 percent of cases the respondent withdrew because the practitioner apologised or agreed to make improvements. In a similar proportion, the matter was reported as resolved.

Table 41: Reasons given for withdrawing complaint/notification

Reason	N	%
Too sick, tired, distressing or unhelpful to continue; saw no progress or results	35	39
Concerned about repercussions (including if identity revealed)	20	23
The practitioner apologised or made undertaking to make improvements	9	10
The matter was resolved	8	9
Withdrew on legal or union advice; other proceedings affected (police, tribunal, other complaint body)	8	9
Other, including raised awareness of or about the practitioner	6	7
Received or told would receive compensation	3	3

5.1.6 When events occurred, management times and reported delays

Over half of the events that led to the complaint occurred less than 12 months before the survey was completed; one-quarter occurred 12 to less than 24 months and the balance two or more years. (Fig.12) Four percent (N=58) were reported to have occurred five or more years before the survey was completed, over three-quarters involving medical practitioners.

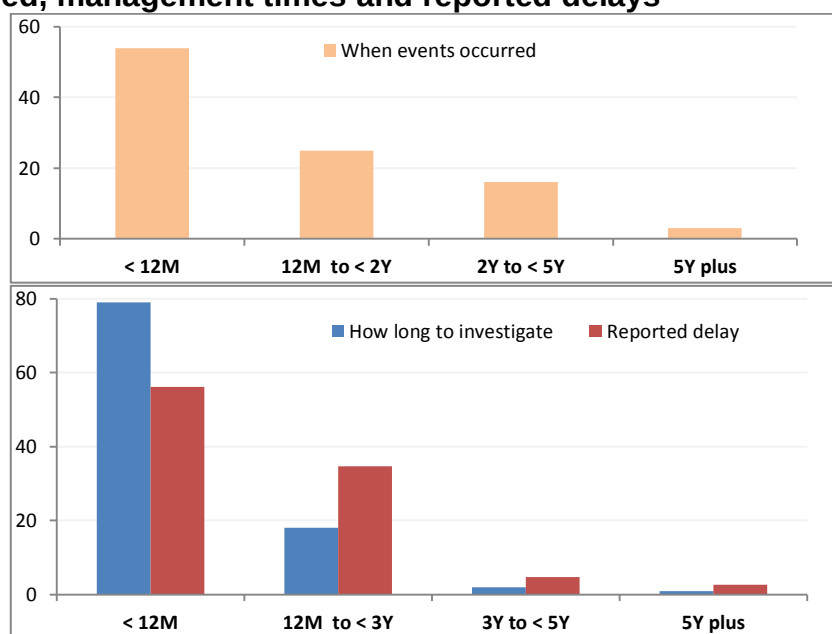


Figure 12: Survey 1: when events were reported to have happened, management times and reported delays

When events happened = time between events that led to the complaint and completion of the survey

Just over one-quarter of complaints were managed in two months or less, three-quarters less than 12 months and 89 percent less than 18 months. (Table 41) The HCCC managed a higher proportion of matters in two months or less (45%). Twenty-nine percent of AHPRA matters took 12 months or more compared with less than 10 percent in NSW. Complaints made by organisations (28%) had the highest proportion taking 12 months or more. [A5.5] The variability between practitioner groups is associated with small numbers. A more robust comparator – medical practitioners compared with all other practitioners - shows a high degree of similarity in reported management times. (Table 42)

Just over one-quarter of respondents reported delays; over one-third were uncertain. (Table 42) The proportion of delays was slightly higher for AHPRA and was similar for doctors (27%) compared with all other practitioners (24%); but was lower for both pharmacists (16%) and dentists (18%). (Table 42) [A5.5]

Fifty-six percent of delayed cases were managed by the agencies in 12 months or less (seven percent in less than two months) and a further 35 percent in 12 to 24 months. Seventy-five percent reporting delays had tried to resolve their issues before approaching the regulator (81% in the case of doctors and 71% for all other professions). Forty-nine percent said their case was referred elsewhere (rates involving doctors and all other professions being similar). Of those reporting delays, 75 percent said they were either kept 'very poorly' (40%) or 'poorly' informed (35%) during the process. The same proportion (75%) reported not being given reasons (45%) or being given minimal information only about reasons for decisions (31%).

Table 42: Survey 1: time taken for the complaint/notification to be dealt with and reported delays

	All		AHPRA		NSW		HPCA		HCCC		DR		All excl. DRs ¹	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Length of time														
2M or less	431	26	185	19	246	38	76	28	170	45	278	28	153	23
> 2M - < 12M	864	53	513	52	351	54	166	60	185	49	497	50	367	56
12M - < 18M	172	10	149	15	23	4	13	5	10	3	99	10	73	11
18M - < 3Y	129	8	106	11	23	4	15	6	8	2	82	8	47	7
3Y - < 5Y	25	2	17	2	8	1	4	2	4	1	17	2	8	1
5Y or more	14	1	13	1	1	<1	0	0	1	<1	10	1	4	1
Reported delays														
Yes	432	26	288	29	144	22	59	21	85	22	276	27	156	24
No	647	39	332	33	315	48	131	47	184	48	396	39	251	38
Don't know	587	35	383	38	204	31	89	32	115	30	335	33	252	37
Select outcomes when delay reported														
Don't know	90	21	56	20	34	24	19	32	15	18	58	21	32	21
No action	250	58	156	54	94	65	30	51	64	75	162	59	88	57

[1] All professions excluding medicine

Don't know' responses (N=6) not presented

5.2 Survey 1: outcomes of complaints and notifications

Respondents were asked about the results of their complaint, selecting any and all responses relevant to them from a 22 item menu including 'other'. This discussion refers to the full set presented at [A5.6] and a summary data set (with categories thematically grouped) at Table 43, expanded at [A5.7].

Sixty percent said that '*no action*' was taken. This was highest in complaints about medical, psychology or dental practitioners (66-67%); complaints made by consumers (66%); and those handled by the HCCC (72%). It was lowest among pharmacists and nurses (42-43%) and complaints made by organisations (34%). Fifteen percent said they did not know the outcome – identical for AHPRA and NSW, but higher among complaints handled by the HPCA (21%) or made by organisations (25%).

Table 43: Survey 1: outcome of complaint/notification by summary categories and agency

	Don't know		No action		Acknowledge communicate fees ¹		Referred ²		Retire or surrender ³		Actions excl. suspend cancel ⁴		Suspend, cancel ⁵	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
ALL	254	15	1032	60	335	20	53	3	47	3	322	19	38	2
AHPRA	153	15	599	58	152	15	30	3	35	3	234	23	29	3
NSW	101	15	433	64	183	27	23	3	12	2	88	13	9	1
HPCA	59	21	142	50	61	22	10	4	10	4	72	25	6	2
HCCC	42	11	291	73	122	31	13	3	2	1	16	4	3	1

[1] Acknowledge, communication, fees = apology, explanation, information or service provided; fees or costs waived, reduced or refunded; received compensation.

[2] Referred = referred to conciliation or to another agency.

[3] Retire or surrender = practitioner retired, did not renew or surrendered registration.

[4] Actions excl. suspend/cancel = conditions on practice; required to do a health or education program; caution or reprimand issued; practitioner made undertakings; practitioner counselled; fine imposed; public statement made; prohibition order issued.

[5] Suspend or cancel = registration suspended or cancelled

The proportion of complainants receiving an apology (8%), explanation (17%) or information (10%) managed by NSW agencies was twice that of AHPRA. Conversely outcomes involving conditions (10%); a health or education program (6%) or undertakings (6%) handled by AHPRA were twice that of NSW; and those involving a caution or reprimand (9%) four times. Differences narrow when comparing AHPRA and HPCA only. Only a small proportion of cases resulted in registration being surrendered (3%); suspended (2%) or cancelled (1%). The proportion of responses is representative with major categories for all complaints closed in 2013-14.(388)

Nursing complaints represented 19 percent of survey returns but roughly half the outcomes involving registration surrendered, suspended or cancelled or conditions placed on practice; and one-third of outcomes involving a health or education program. Surrender, suspension or cancellation of registration was most commonly associated with medication/pharmacy or conduct matters relating to theft or use of drugs and impairment issues.

While representing five percent of survey responses, 13 percent of pharmacist outcomes involved counselling; the same proportion a caution or reprimand.

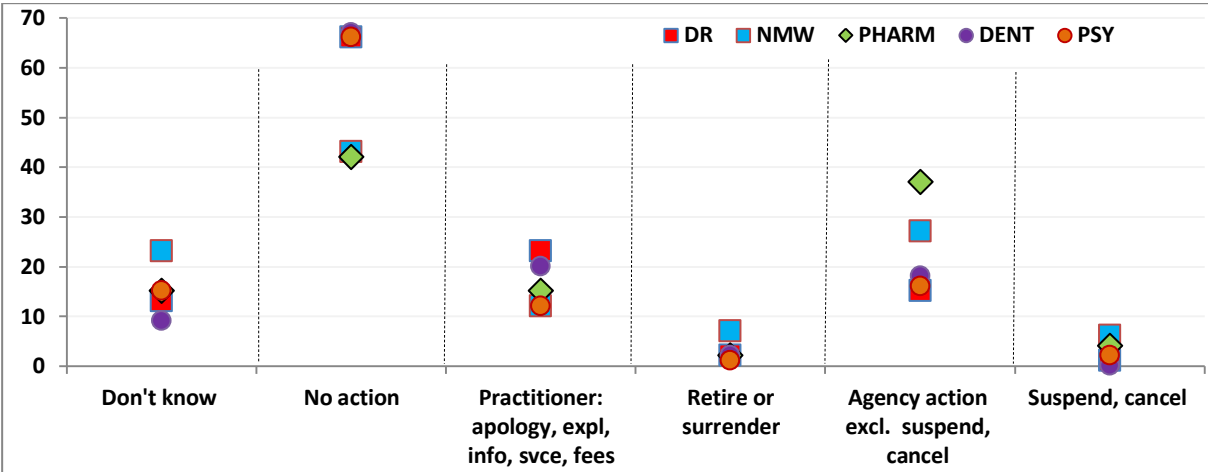


Figure 13: Survey 1: summary outcome categories by subject profession (%)
Includes all selected responses, ranked and non-ranked, for each outcome category for each profession – respondents could nominate more than one category

Although over half of respondents sought an explanation (54%) or apology (52%); only a small proportion received these, less so under the national scheme. (Table 44) The proportion of those who received an explanation (where sought) was approximately twice for those receiving an apology. In both cases, these occurred most frequently with matters managed by the HCCC.

Table 44: Survey 1: respondents that sought and received an explanation or an apology by agency

	All		AHPRA		HPCA		HCCC	
	N	%	N	%	N	%	N	%
Explanation								
Sought	936	54	549	53	154	54	233	58
Received that sought	205	22	88	16	35	23	82	35
Apology								
Sought	894	52	544	52	136	48	214	53
Received that sought	89	10	34	6	16	12	39	18

Other than for medical practitioners, numbers are low, making comparisons difficult. (Table 45) Compared with all other professions, the proportion of people who sought an explanation was higher for medical practitioners, although this is still only one-quarter of respondents that sought it.

Table 45: Survey 1: respondents that sought and received an explanation or an apology by subject profession

	DR		All excl. DR		NMW		PHARM		DENT		PSY	
	N	%	N	%	N	%	N	%	N	%	N	%
Explanation												
Sought	606	58	330		172	53	44	52	54	34	60	52
Received that sought	156	26	49	15	20	12	6	14	15	28	8	13
Apology												
Sought	607	58	287		99	30	46	55	87	45	55	48
Received that sought	69	11	20	7	11	11	5	11	3	3	1	2

All excl. Dr= All professions excluding medical practitioners

5.3 Whether issues were addressed, awareness of change and further action

The majority of respondents said their complaint was not addressed '*at all*' (57%) or '*partly*' (18%). Fewer reported issues were '*mostly*' (11%) or '*fully*' (11%) addressed. (Table 46) NSW attracted a slightly higher '*not at all*' response due to the HCCC (66%). (Table 46) '*Partly*' responses were similar across agencies.

Over 60 percent of medical, dental and psychology complaints attracted a '*not at all*' response in contrast with nursing and pharmacy (44-45% respectively). [A5.8] Nursing attracted the highest '*fully*' addressed (23%), in contrast with psychology and medical practitioners (6-7% respectively).

Nearly two-thirds of consumers indicated their issues were not addressed, in contrast with just over half of practitioners who made complaints and one-third of organisations. Conversely, 29 percent of organisations indicated their issues were addressed '*in full*', a response twice that of practitioner complainants and four times that of consumers.

Table 46: Survey 1: extent to which issues were addressed

	Not at all		Partly		Mostly		In full		Don't know	
	N	%	N	%	N	%	N	%	N	%
ALL	958	57	304	18	180	11	177	11	46	3
AHPRA	561	56	185	18	114	11	109	11	32	3
NSW	397	60	119	18	66	10	68	10	14	2
HPCA	134	50	47	18	36	13	38	14	12	5
HCCC	263	66	72	18	30	8	30	8	2	1

A further 8 cases were reported as being under review relating to medical or dental practitioners

Total may exceed 100% due to rounding

5.3.1 Survey 1: awareness of improvements following complaints or notifications

Sixty-nine percent (N=1,181) of respondents were unaware of any service or practice improvements planned or implemented as a result of their complaint; 12 percent (N=189) said that improvements were planned or made and 20 percent didn't know. (Table 47)

The proportion between AHPRA and 'all NSW' was similar, with small numbers limiting further comment. Issues involving nurses had a higher proportion of improvements made. The key difference between respondents was a higher proportion of organisations reporting improvements made (15%) compared with consumers (3%).

Table 47: Survey 1: respondent awareness of service or practice improvements

	Planned		Made		No		Don't know	
	N	%	N	%	N	%	N	%
All	94	6	95	6	1181	69	345	20
AHPRA	55	5	72	7	697	68	206	20
NSW	39	6	23	3	484	71	139	20
DR	54	5	40	4	733	71	207	20
All excl. DR	40	6	55	8	448	66	138	20
NMW	20	6	40	12	204	63	61	19

All excl. Dr= All professions excluding medical practitioners

Total may exceed 100% due to rounding

Two-thirds of the improvements related to professional education, skills and employment practices (36%) or treatment practices and policies (30%). (Table 48) The majority of all reported improvements planned or made related to doctors (50%) and nurses (36%).

Table 48: Survey 1: type and frequency of improvements planned or made as a result of the complaint/notification

	Information provided	Professional education, skills & employment practices	Treatment practices & policies	Services & documentation	Other
ALL	29	90	75	37	16
AHPRA	12	67	46	27	10
NSW	17	23	29	10	6
DR	18	39	38	18	10
NMW	9	41	24	12	3

Participants could select more than one response. Due to small numbers, limited data presented and as frequencies

The majority of improvements occurred in public hospitals (40%) and group practice (17%); and where improvements were planned (29% and 24% respectively). However, the highest

level of 'don't know' responses (if improvements resulted) were also reported in group practice (30%); followed by sole practice and public hospitals (18% each). (Fig.14)

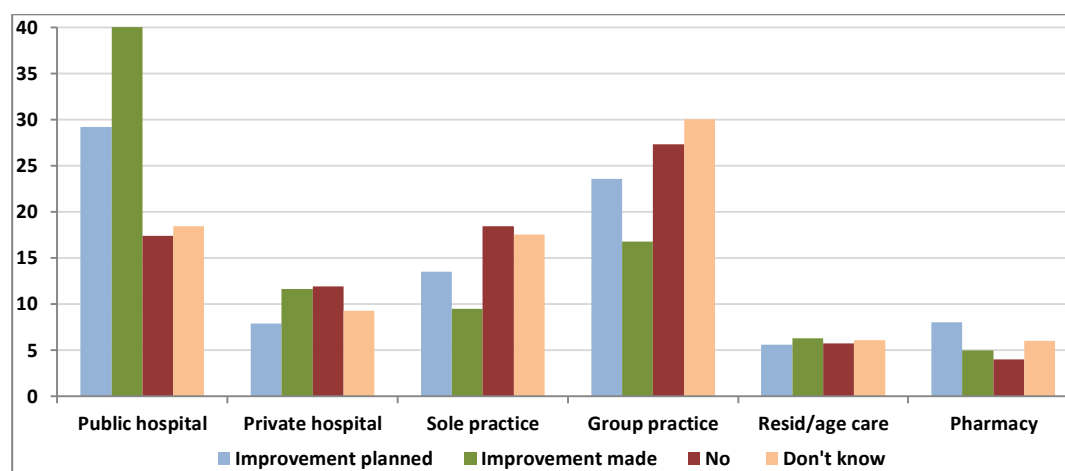


Figure 14: Survey 1: awareness of improvements by location of original events

5.3.2 Survey 2: awareness of improvements following complaints or notifications

In Survey 2, community (population and consumer) and professional organisations were asked whether they were aware of complaints leading to service or practice improvements (including improvements to patient access; to information provided to patients; to practitioner education and how the professions practiced). Respondents were asked about the care setting where identified improvements occurred (sole/individual practice; group practice; hospital or major service; and across a profession). Identical questions were asked about improvements resulting from the organisations' policy and advocacy work.

Reported improvements were most commonly associated with policy or advocacy work, except where a health professional was in sole/individual practice. (Figs 15-16)

Only a small proportion of community (population and consumer) organisations were aware of improvements – 20 percent or less. Improvements were more commonly associated with policy and advocacy work.

A higher proportion of professional organisations reported improvements as a result of complaints compared with community organisations. These improvements were most commonly associated with professionals in individual/sole practice; and related to how they practiced or their education. (Fig.15) In addition, 35-40 percent of professional organisations reported improvements at the profession wide level as a result of policy and advocacy work.

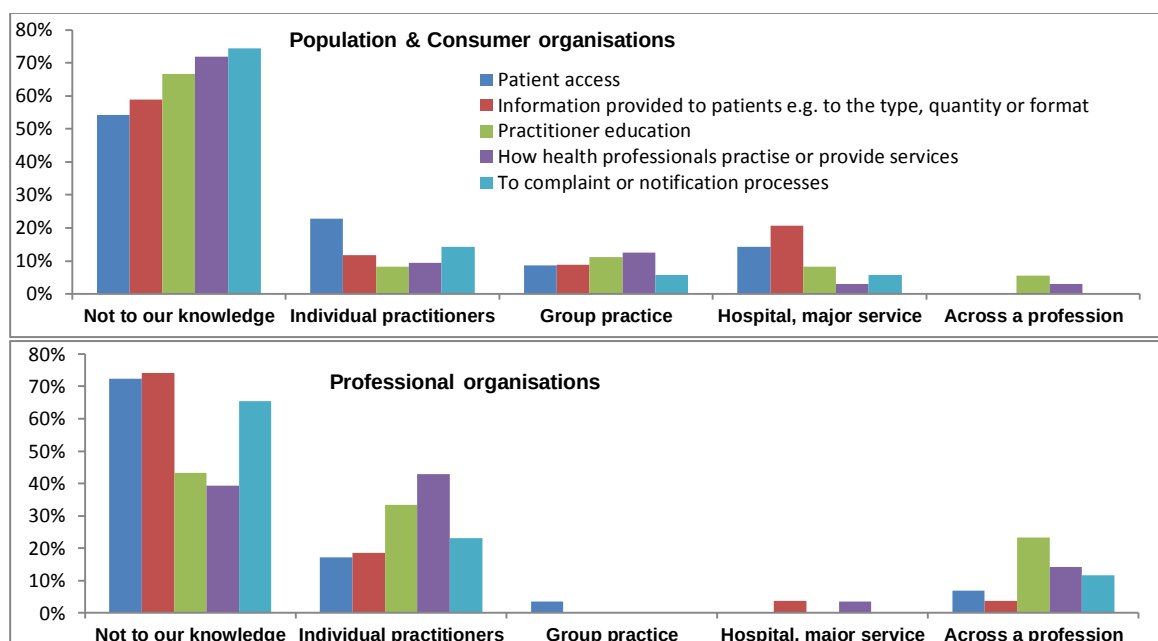


Figure 15: Survey 2: improvements resulting from individual complaints/notifications

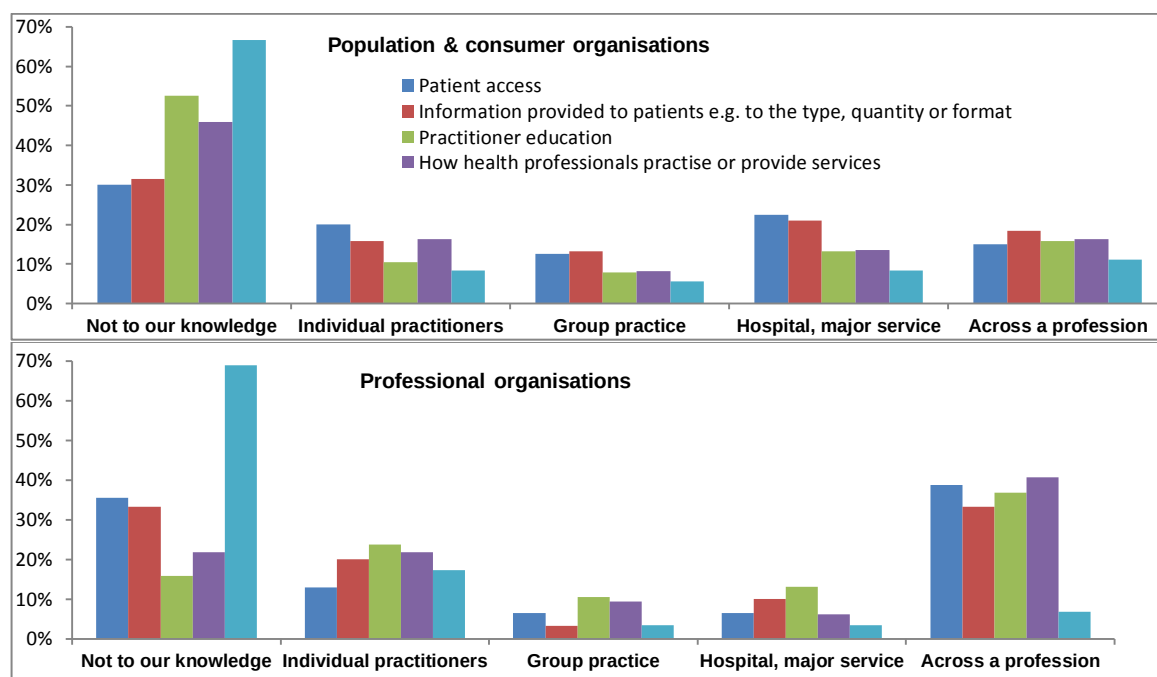


Figure 16: Survey 2: improvements resulting from policy or advocacy work

These organisations were asked whether complaints or trends in complaints were used to identify broader risks or issues. There was not much difference in responses about the two systems, although this was slightly higher for the HCCC.¹¹³ (Fig.17) [A5.10] Notable was the very high uncertainty levels. There was however interest:

“we have been pressing AHPRA for some years to provide statistical information about complaints in a form that can be used for the education of the professions and the benefit of the public. No luck so far.” (Ref 55)

¹¹³ Responses were adjusted to include only non-NSW responses for national bodies and only NSW responses for NSW bodies.

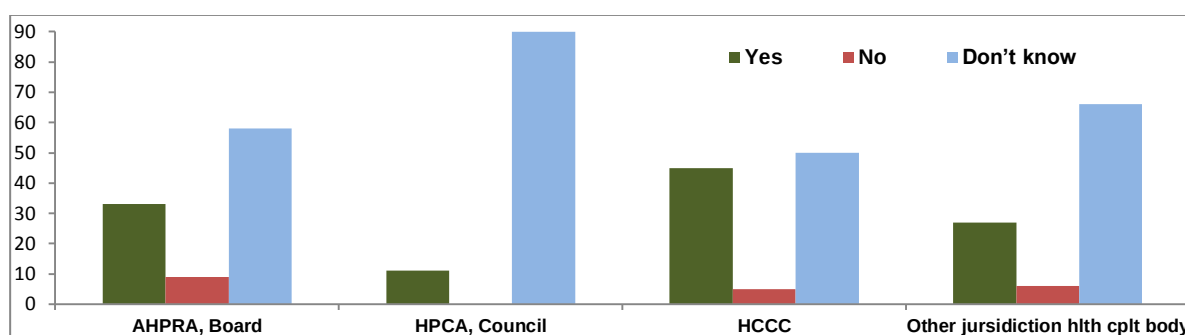


Figure 17: Survey 2: use of complaints to identify risks or practice issues

5.3.3 Survey 1: actions planned or taken by respondents after closure

The majority said no further action was planned or taken in relation to their issues after the case was closed by the agency (58%). (Table 49)

One-quarter said further action was either planned (16%) or had been taken (10%); and 16 percent were uncertain. AHPRA and 'all NSW' responses were similar as were responses comparing 'medical' and 'all other' professions; nursing matters accounting for a slightly higher proportion of action taken. The most common action planned or taken was to seek a review of the decision (this being slightly higher for complaints involving medical practitioners) or to complain to another agency.¹¹⁴

Table 49: Survey 1: whether further action was planned or taken by the respondent, and if so, type of action

	All		AHPRA		NSW		DR		All excl. DR		NMW		Consumer	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Planned	270	16	158	15	112	16	184	18	86	13	35	11	202	18
Taken	170	10	101	10	69	10	95	9	75	11	47	15	102	9
Not planned, taken	992	58	591	58	401	59	603	58	389	57	169	52	651	58
Unsure	281	16	177	17	104	15	153	15	128	19	72	22	165	15
<i>Type of action planned or taken</i>														
Review	193	11	105	10	88	13	136	13	57	8	152	13	152	13
Complain to other agency	135	8	93	9	42	6	88	8	47	7	101	9	101	9
Legal action	72	4	53	5	19	3	43	4	29	4	60	5	60	5
Approach MP	133	8	76	7	57	8	89	9	44	6	11	10	11	10
Raise publicity	69	4	47	5	22	3	49	5	20	3	56	5	56	5
Other action	117	7	64	6	53	8	67	6	50	7	60	5	60	5

Summary of Chapter 5

Chapter 5 addressed study Objectives 2 and 3, reporting how complaints were managed; and any significant variation in responses between complaint systems or professions.

Most did not know about the regulators or what to expect prior to approaching them. A significant level of referrals was reported; over half from one complaint body to another;

¹¹⁴ Some respondents indicated they had sought or intended to seek a review from AHPRA, notwithstanding reviews are not provided for under the national scheme.

adding to respondents' confusion. Reported delays appear related to referrals and attempts to resolve matters directly; and lack of agency communication.

Resolution occurred in less than ten percent of matters, three-quarters not proceeding or attempted without result. Respondents express a lack of powerlessness in the process; anger and disappointment in the ability of practitioners to avoid or undermine the process and its apparent lack of independence. Conversely, many respondents who were not offered a meeting or resolution service felt it would have been helpful; and some thought it should be mandatory.

Referrals for investigation or regulatory action were most common in matters involving pharmacists – a profession with dedicated jurisdictional investigatory units; and nurses – most of whom worked in institutional settings, with a higher proportion of medication, substance misuse and mental health issues reported. A lower rate of investigation was reported for the HCCC, which may be associated with a lower rate of returns from organisations and the higher rate of investigations reported by organisations (67%) compared with consumers (53%). Similarly, disciplinary action (15%) overall was lowest if handled by the HCCC (4%).

In contrast with their stated interests and intentions, the majority reported issues were either not or only poorly addressed; this figure significantly higher for consumers. Less than one-quarter that wanted an explanation and only ten percent that wanted an apology received one. Less than ten percent were aware of any resultant changes. Survey 2 results show professional organisations had a higher level of awareness of changes that result from complaints than did community organisations.

The level of '*no further action*' outcomes is high, more so for the HCCC. The level of '*don't know*' responses is also notable in terms of whether a complaint is referred for investigation, referred for disciplinary action or in relation to the outcome given; more so given the significance of information for respondents. Interviews indicate how emotionally unhelpful the process was for many in relation to events that were profoundly personal and distressing.

The lack of transparency and disjunct between outcomes sought and achieved is reflected in experience and satisfaction rankings and comments reported in the next chapter.

Chapter 6. Results: key experience measures

This chapter addresses study Objectives 3 and 4 by reporting on perceptions of purpose, efficacy and suitability of the processes and the factors that underpin these perceptions; and any significant variation in responses between complaint systems or professions.

In Survey 1 respondents were asked about the complaint process by ranking their answer out of 5; and giving the main reasons for their answer. This chapter examines responses to questions in the following five domains: understanding of the system; engagement and communication; balance of approach; impact; and global measures of satisfaction. (Table 50) Responses to Survey 2 questions and feedback from interviews are included as relevant.

Sections 6.1 – 6.6 discuss responses associated with the five domains. Section 6.7 reports on the most negative and positive responses in Survey 1. Given the length of the chapter, short summaries are given at the end of each section.

Table 50: Survey 1: experience domains and questions

Domain	Questions	Ranking ("Rate your answer out of 5")
Understanding of the system	Were the role and powers of the body handling the complaint clear?	1= Not clear at all; 2= Unclear; 3= Neutral (neither clear or unclear); 4= Clear; 5= Very clear
	Were the criteria used to assess the complaint clear?	
Engagement and communication	How well were you kept informed about what was being done?	1= Very poorly: no information provided; 2= Poorly: minimal information provided; 3= Neutral: no opinion either way; 4= Well informed: reasonable amount of information provided; 5= Very well informed: full information provided 1= Very poorly: reasons not given at all; 2= Poorly: given minimal information; about reasons for decisions; 3= Neutral: no opinion either way; 4= Well: given reasonable amount of information about reasons; 5= Very well: reasons very well explained
	How well were reasons for decisions explained?	
Balance	Did you think you were treated respectfully?	1= Not shown any respect; 2= Minimal respect shown; 3= Neutral: no opinion either way; 4= Reasonable amount of respect shown; 5= Treated very respectfully 1= Very unfair; 2= Unfair; 3= Neutral: no opinion either way; 4= Fair; 5= Very fair
	How fair was the process?	
Impact	Did the process affect your health?	1= Health not affected at all; 2= Slight effect (impact) on health; 3= Some effect (impact) on health; 4= Significant effect (impact) on health; 5= Very significant effect (impact) on health
Global measures: overall satisfaction and the 'family and friends' test	Rate your overall satisfaction with the complaint process	1= Very dissatisfied; 2= Dissatisfied; 3= Neutral: neither satisfied or unsatisfied; 4= Satisfied; 5= Very satisfied
	Rate your overall satisfaction with the result (outcome)	
	If someone had a concern or complaint about a health practitioner, would you recommend this process to them?	1= Definitely wouldn't recommend it; 2= Probably wouldn't recommend it; 3= Neutral: no opinion either way; 4= Probably would recommend it; 5= Definitely would recommend it

6.1 Understanding the complaint and notification systems

Respondents interviewed were asked about their knowledge of the process when they first approached the agency. Most had no prior experience except those associated with a jurisdictional board or who handled a large number of complaints (such as a Director of Nursing or Medical Services in a hospital). This applied equally to consumer and practitioner complainants. Many learned of the agency through the internet; family, friends or health provider; a brochure; others only after lodging the complaint.

6.1.1 Survey 1: understanding of agency role and powers

The proportion of respondents who said the role and power of agencies was '*not clear at all*' or '*unclear*' (Ranks 1-2) was similar to those who found it '*clear*' or '*very clear*' (Ranks 4-5). (Table 51) [A6.1.1]¹¹⁵ The proportion of responses for AHPRA and NSW across all ranks was similar. '*Not clear at all*' was highest for complaints handled by the HCCC (31%) and those relating to medical practitioners (30%). [A6.1.2]

Table 51: Survey 1: whether the agency's role and powers were clear: Likert scale responses

	Rank 1 Not clear at all		Rank 2 Unclear		Rank 3 Neutral		Rank 4 Clear		Rank 5 Very clear	
	N	%	N	%	N	%	N	%	N	%
ALL	441	26	280	17	349	21	380	23	241	14
AHPRA	258	25	166	16	216	21	222	22	155	15
NSW	183	27	114	17	133	20	158	23	86	13
HPCA	59	21	55	20	55	20	71	26	38	14
HCCC	124	31	59	15	78	20	87	22	48	12
DR	305	30	181	18	207	20	212	21	119	12
All other excl. DR [1]	136	20	99	15	142	21	168	25	122	18

[1] All professions except medical practitioners

Thirty-nine percent (N=661) gave reasons for their ranking, of which 99 percent related to an agency; the remainder to the original events or practitioner. Comments were consistent with ranked responses (Fig.18) except for the HPCA, with a higher proportion of lower ranked comments [A6.1.3]

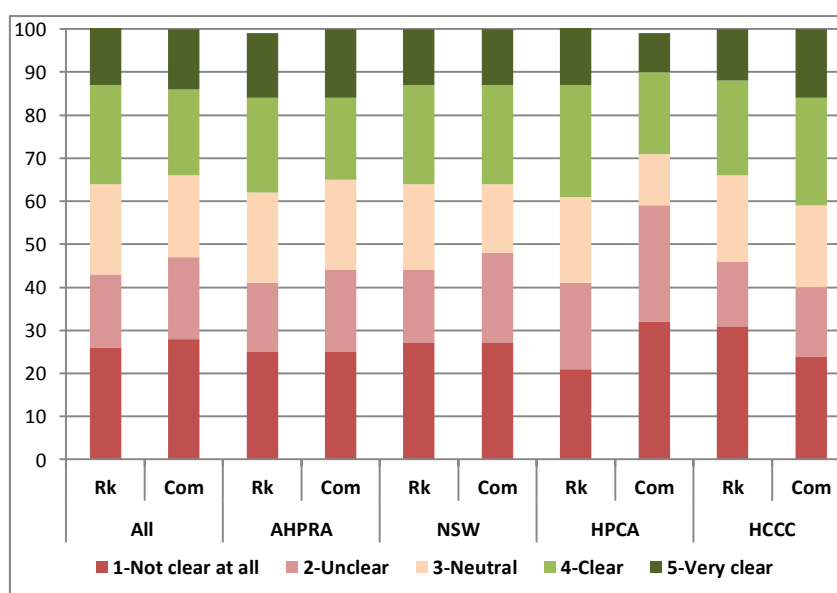


Figure 18: Survey 1: role and powers: comparing the proportion of ranked responses (Rk) to comments (Com)

¹¹⁵ Additional tables contained in the appendices appear in brackets e.g. [A6.1.1] is Appendix 6, Table 1.1

Four main themes were identified using thematic analysis. (Table 52) [A6.1.4]¹¹⁶ Of note are adverse comments and reservations provided by respondents even when they gave a high ranking; primarily reflecting confusion regarding responsibilities and respondent views about the adequacy of the regulator's remit or capacity and how they discharged their functions.

Table 52: Survey 1: thematic categories of survey comments: whether agency role and powers were clear

1. Explanation, information, guidelines	2. Exercise of role & powers	3. Adequacy of role & powers	4. Relationships & accountabilities
1A= information or level of contact generally 1B= understanding of role or powers-generic comment 1C= understanding of role or powers-specific comment	2A=actions, reasons, outcome 2B= attitude and balance (probity or bias)	3A= capacity (skill; knowledge; able to address; system issue) 3B= powers (to provide information; review; other)	4A= regulators and other health complaint entities 4B= employers; mandatory reporting 4C= other complaint and investigation processes

A high degree of consistency in the reasons for rankings emerged when comparing the agencies at a thematic and sub-thematic level; notable variations typically associated with smaller numbers, limiting conclusions drawn. (Fig.19) [A6.1.4]

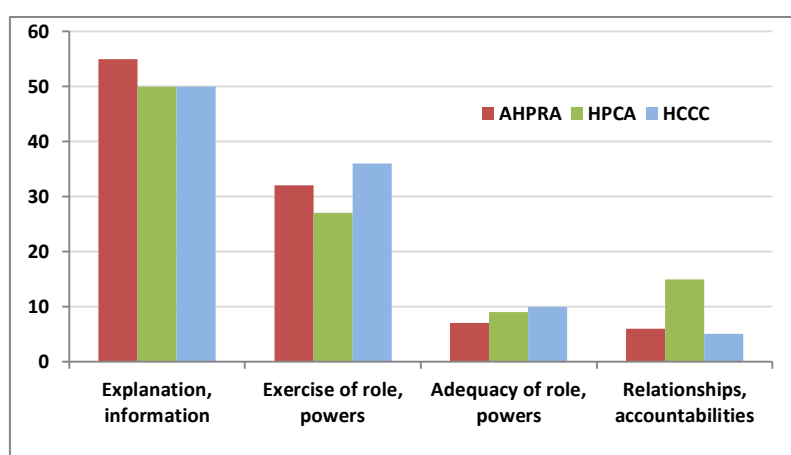


Figure 19: Survey 1: role and powers: comment themes by agency

6.1.1.1 Theme 1 comments: explanation, information, guidelines

Theme 1 accounted for 53 percent of responses (N=376). Eighteen percent related to information or communication about the process; comments ranged from receiving no information or not being contacted (Rank 1) to observations of very clear communication and being kept informed (Rank 5). [A6.1.5]

The majority of comments (76%) were general observations, including whether explanations about role or powers were provided; about the independence of agencies (both from government and professions); or whether respondents' expectations were met in terms of the agency remit. A recurring feature in adverse comments is the lack of explanation; clarity or level of detail provided – reflected in phrasing such as '*generic*', '*stock*' and '*ambiguous*' explanations from agencies; with some (negative) comment on the use of pro-forma letters. Some respondents were aware of the roles or powers through other experiences.

¹¹⁶ Frequencies of response by agency, theme and sub-theme are given at A6.1.4.

Only seven percent made specific comment on an agency's role or powers; such as public protection; upholding standards; investigating impairment or poor performance and assessing suitability to practice; registration and disciplinary functions (subtheme C). Lower ranking responses reflect a mismatch between respondents' understanding of information initially provided and their experience of the process. [A6.1.5] These views align with comments about the exercise of role and powers, discussed in the following section.

Respondent understanding of agency roles was tested further at interview, with a diversity of responses. (Box 10) Some weren't sure; others spoke of protective functions in different forms including reference to a 'watchdog' role and protecting the public; many referring to how this would be achieved such as '*adequately assessing*' or '*investigating complaints*'; '*investigating thoroughly*'; or '*looking into things*'. Some who experienced harms referred to improved education to prevent errors. Enabling people to '*voice concerns*' for the benefit of the profession and public; providing a voice and information to those who are '*unrepresented*' or disadvantaged; providing acknowledgement of the legitimacy of a complaint and a consumer advocacy role were also identified.

Box 10: Select responses to interview questions: about the role of complaints processes

What is the complaint system there for? What do you think is its most important function?

Probably to rigorously investigate the issue. To, I'd probably suggest; to give better client service than I got. Probably to be able to provide unrepresented people, who I would dare say would be the majority, more information as to what actually happens, what they can expect, what is done. Because for me that was what was lacking. I am a fairly well educated person. I can pretty much find the process for anything. Getting information out of them – nearly impossible.
Well I was under the impression that it was to be, to advocate for the public, the healthcare customers.
For people to be able to voice concerns for the betterment of the medical community and to ensure the safety and wellbeing of the public.
To investigate thoroughly and to be aware of things, that are missing or out of order.
Basically there's the more serious end of spectrum where people receive injuries or have been assaulted and but also I guess to maintain professional standards.
There's not a lot of communication about the complaint process really. You occasionally hear about the very high profile cases but we're not particularly clear about their role, how they go about how about things, I don't know what the principles are, or how they prioritise what they do.
It has been effective in cases of gross malpractice and I know there has been other high profile cases e.g. Doctor death' - cases where there has been terrible medical practice and I think it's the starting point for uncovering cases like that. Like any watchdog it's a vital check and does have an important watch dog role just like ICAC or ASIC but like most of these watchdogs as well it doesn't have as strong a - doesn't have the teeth it should have and maybe doesn't have the resources to fully investigate complaints as thoroughly as it could either.
Sounds like from their site maybe they are looking to see if people have done something criminal or something that caused further detriment or damage - maybe injured somebody or more harm.
To make you feel that you are valued as a person. That what you are complaining about is real to you. Just to say that I accept that how you feel is valid to you. And then to look at and say " <i>what the doctor did was wrong</i> " or " <i>you need to understand what happened</i> ". We've all got to be reasonable and sometimes I make mistakes too but I feel the job is to validate you and validate your feelings ... but it's not to say that what happened [what is complained about] is valid; is negligence - it could just be that this is what happens.
Adequately assess complaints by people who are qualified who have the time and adequate resources to thoroughly review them. Whether in investigations they use other medical practitioners ... for me the most important [thing] is to protect the public therefore, not to be complicit in helping doctors who have been completely unconscionable or unscrupulous - they should have recourse, whether it is compensation or other.
Well I initially thought it was there so it could improve some of the training procedures of some of these doctors. And I know money is being taken out of the medical system and I really do feel that as a member of the public we need to try and improve and maybe get more money put into the system so the conditions of training can be improved and mistakes like this don't happen.
To make health care providers; whether medical or in whatever field, to be accountable for how they interact with patients; and for the level of care that they provide. Because otherwise, I don't know what other processes that there would be if there wasn't something like that to address complaints from patients about their care.

6.1.1.2 Theme 2 comments: exercise of roles and powers

How agencies exercised their role or powers accounted for 32 percent of responses (N=228). Comments fell broadly into two sub-themes: describing actions, outcomes or reasons for decisions; and the perceived level of balance and attitude of the staff and agencies managing the complaint. [A6.1.6]

Key management dimensions were the perceived thoroughness of the assessment and investigation process, including whether the complainant and witnesses were interviewed; timeliness; opportunity to respond to the account provided by the practitioner (subject of complaint) and explanation of the process. Efforts made by regulators ranged from “*did nothing*” to “*they did all they could*”.

Whether issues were addressed, reasons provided or were seen as adequate also featured. Some respondents linked this directly to safety and/or the degree of harm that resulted, expressing concern about decisions to take no action or to allow the practitioner to surrender their registration without concomitant action. Others ranked role and powers “*very clear*”, but had reservations about the scope of effort e.g.:

“But they do nothing about the root cause of the complaint.” (Ref 65)

A significant range in views on the perceived balance and attitude of agencies was evident, although the dominant view was bias towards and protection of practitioners e.g.:

“Practitioners reviewing practitioners... I have little confidence of neutrality.” (Ref 1274)

This view linked to comment about how quickly practitioners’ responses were accepted; and not seeking further information from complainants or witnesses that would either confirm or negate the practitioner’s position. Positive comments noted fair and efficient processes; and officers being ‘*respectful*’, ‘*professional*’, ‘*understanding*’ and providing “*sound advice and support*”.

A different perspective from a small number of practitioner complainants, particularly dental and medical practitioners related not to agency independence, but lack of support from professionals:

“I made the notification of an impaired colleague as part of mandatory reporting...the cases I submitted were clear cut...I understand it is difficult for the HCCC to find an 'expert' to give a concurring opinion while colleagues are falling over themselves to defend.” (Ref 1240)

6.1.1.3 Theme 3 comments: adequacy of role and powers

A small proportion of comments (8%) related to the perceived capacity (clinical or regulatory) of personnel to undertake regulatory roles; and the powers of the agencies. [A6.1.7]

Observations about clinical capacity related to reasons for decisions demonstrating a lack of understanding of appropriate practice; lack of qualifications to judge areas of specialisation or failure to identify issues. These were made by individual, practitioner and organisational respondents:

"I had initially believed that they would be collecting evidence and using medical professionals to assess and address the entire complaint, however, I (a lay person) had to point out specific medical deficiencies and issues." (Ref 826, consumer)

"Hard to say - but those investigating lacked [the] necessary expertise to understand and address the issue." (Ref 783, practitioner)

"The investigator did not have a medical background and did not understand the context when [the] conducting interview." (Ref 1034, organisation)

Observations about operational capacity included impact of staff turnover on case management; inability to share information unduly delaying proceedings; an inability to remain anonymous; and deficiencies in prioritising and expediting serious cases.

A common source of dissatisfaction was lack of information, particularly about the process; (not) being provided with reasons for decisions or that information was not legally available:

"I wanted to know if the practice was legal. The person I spoke to told me I had to document my concern. I still don't know if the practice was legal." (Ref 104)

The absence of any review power under the national scheme and exclusion from Freedom of Information (FOI) also featured. Others wanted assurances and confidence their issues were addressed or serious threats to the safety of others dealt with. 'Unclear' ranked comments included:

"It was not clear because I did not know if the responsible person had acknowledged what they had done and [were] dealt with." (Ref 555)

"I am not interested in violating the doctor's privacy - I just want to be confident that an independent body is assessing his ability to practice, or not - no advice, nothing to say except "he is fine" - given the absence of communication, I have no such confidence that this is the case.... There was no communication or advice that the issue was being taken seriously." (Ref 985)

Some respondents questioned how issues that don't meet a specific threshold of seriousness are managed; including practitioners who commented on a 'gap' between what they thought should be reported as part of their professional responsibility and what was required:

"My own registration obliges me to report poor conduct, but the system can only deal with mandatory notifications." (Ref 1609)

Different views about the adequacy of regulators' powers were expressed. Points of dissatisfaction included an inability to compel responses or enforce recommendations to a hospital or practitioner:

"The dentist was asked to refund me for the extra work I had to have done but refused." (Ref 668)

“The issue is the hospital is not obliged to comply.” (Ref 1092)

“If all the power they have is to ask the dentist a question and he denies it- what’s the point?” (Ref 646)

Others ranked positively, report a different experience:

“If I had written a letter to the doctor, it may not have had much effect. With the help of the HCCC the letter had more clout.” (Ref 143)

6.1.1.4 Theme 4 comments: relationship and accountabilities

A smaller number of respondents (7%, N=49) commented about accountabilities and relationships between the agencies and other complaint, review or legal entities (e.g. Coronial processes); and implications for employers. This included observations about mandatory notifications.

Multiple agencies and cross-referrals created confusion and frustration, exacerbated by delayed notice of and little explanation for the referral; lack of communication about progress or outcomes; and length of time taken. [A6.1.8] Other concerns related to confusion about the role of different bodies; why certain complaints associated with other jurisdictions (e.g. Family Court) are not accepted; or how or why they reach different conclusions on matters investigated by other bodies.

Some employers noted a lack of familiarity with their own obligations in the process, including mandatory notifications. A few indicated a mandatory notification was straightforward since the practitioner or employer had already taken action that was effective. Others expressed frustration with the lack of timeliness, information or support during an investigation when issues were ongoing:

“The body is clear they will investigate. However there is no attempt to liaise with the employer who is managing a very difficult situation... it would be far better than the secrecy method currently employed. Having to check an unreliable website for conditions is ridiculous and uninformative.” (Ref 1196)

“AHPRA appears very distant and only able to respond slowly and quite cautiously so that the employer is faced with taking direct action, including investigating clinical practice and managing the situation without registration body advice. Given the considerable steps necessary to obtain registration in the first place, it seems rather a disconnect between bureaucracy and its practical application when practice standards may be in breach.” (Ref 1539)

6.1.2 Survey 2: understanding of agency role and powers

Following questions about their general knowledge about and contact with the agencies, respondents were asked more specific questions about involvement with individual complaints; and if this related to the systems or professions under study.¹¹⁷

¹¹⁷ ‘Respondents’ in Survey 2 being consumer, population and professional organisations.

Only 29% (N=23) of respondents reported making or assisting with a complaint to one or more of the agencies.¹¹⁸ Of these, 20 were about one of the professions under study. Of interest is the comparative response between community and professional organisations.¹¹⁹ Responses from outside NSW were dominated by professional organisations; those from NSW included a greater range of organisational types.

When asked to comment on a set menu of possible agency roles, '*protecting the public*' was most consistently identified by all respondents,¹²⁰ with the greatest uncertainty expressed about compensation, although the majority correctly identified '*assisting with compensation*' was not a role. (Fig.20) [A6.1.9]

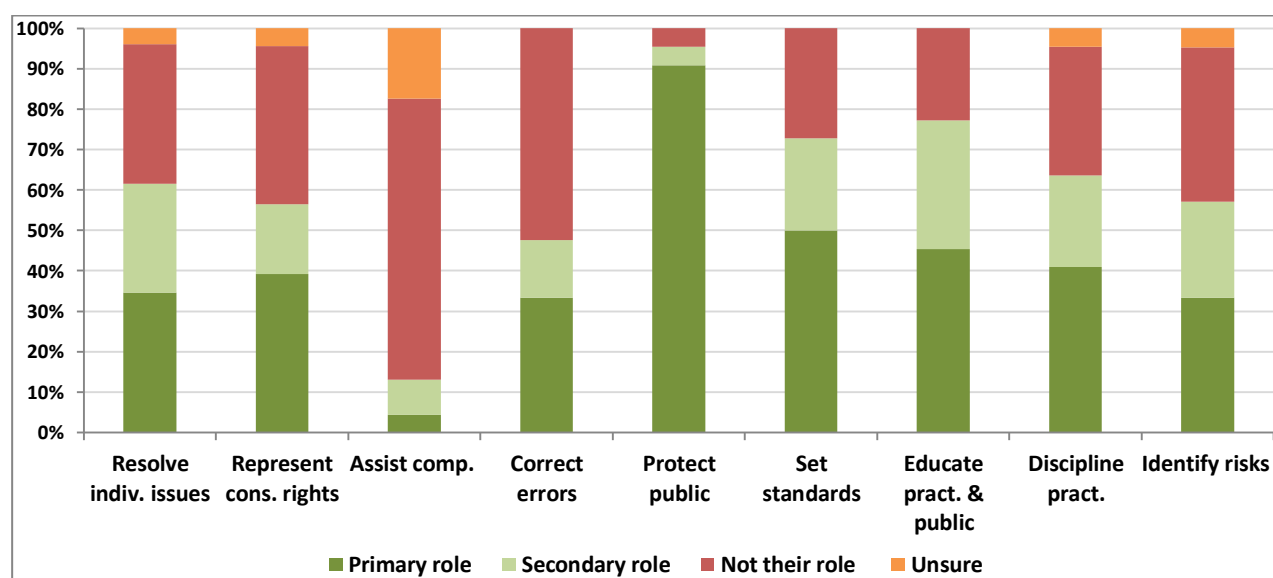


Figure 20: Survey 2: respondent understanding of agency roles, by proportion identifying each role as a 'primary' role, a 'secondary' role, 'not' an agency role or 'unsure'

Possible roles asked about: 'Resolve individual issues'; 'Represent consumer rights'; 'Assist with compensation'; 'Correct treatment or service errors'; 'Set standards of practice and care'; Educate practitioners and the public; Discipline practitioners; Identify risks in health practice or systems'.

Community (population and consumer) respondents identified '*representing consumer rights*' and '*correcting errors*' more frequently than professionals. (Fig.21) Resolving individual issues was a recognised role by all, but more frequently by consumer organisations, as was '*disciplining practitioners*'. A higher proportion of population and professional organisations identified '*setting standards*'; '*education*' and '*identifying risk*' as primary or secondary roles than did consumer organisations. The reasons for this difference are not clear.

¹¹⁸ These include AHPRA, the national Medical, Nursing and Midwifery and Pharmacy Boards, the HCCC and the NSW Medical Council

¹¹⁹ For convenience 'community' is used to refer to consumer and population organisations when combined.

¹²⁰ Respondents were asked for their views on nine potential roles for the agency which they were most familiar with and asked if they believed it to be a 'primary', 'secondary' or 'not' a role.

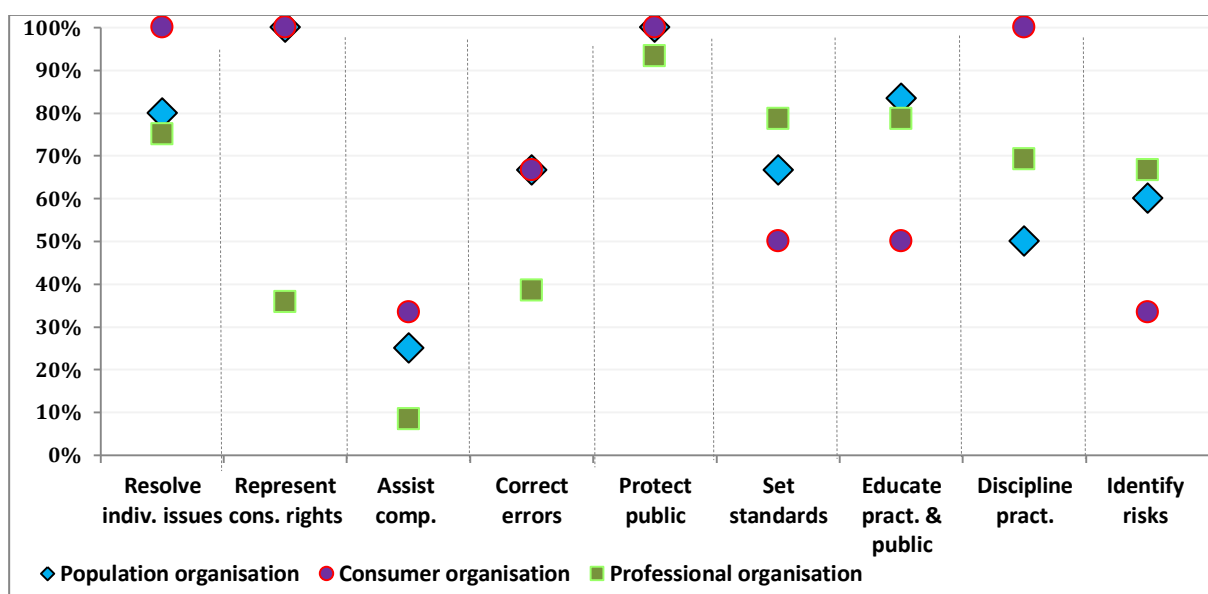


Figure 21: Survey 2: identification of agency roles by respondent type (%)
Proportion within each respondent category that identified a 'primary' or 'secondary' role

Responses about the adequacy of agency powers tended to cluster around '*adequate*' although there was a notable proportion of '*not enough*' and '*unsure*' responses. [A6.1.10] Powers post-complaint process - the ability to '*monitor and enforce compliance*' - attracted a lower '*adequate*' response (35%) from all respondents.

More professional than community organisations rated agencies ability to '*apply effective interventions or sanctions*' as '*adequate*' (64% compared with 29%); to '*initiate investigations and inquiries*' (69% compared with 29%); and to '*share information with other agencies*' (43% compared with 14%). Professional organisation responses were also higher for '*ability to refer [matters] to other agencies*' and to '*thoroughly investigate issues*'.

When asked about practices, NSW agencies attracted a more positive response in terms of perceived '*independence*' [A6.1.11] but more '*neutral*' and '*strongly disagree*' responses to perceptions of '*fairness*' and opportunities to '*provide information and respond to issues raised*'. Timeliness ('*complaints are dealt with promptly*') was a major point of dissatisfaction for all respondents and perceptions mixed in terms of whether matters were handled '*appropriately to the level of seriousness of the issues raised*'. '*Neutral*' responses dominated perceptions of communication, both to those involved in a complaint ('*about actions, decisions, outcomes*'); and to health providers or the general public about '*trends, risks or issues*' arising from complaints.

6.1.3 Survey 1: understanding of assessment criteria used

Forty percent reported that the assessment criteria were '*not clear at all*'; with a further 16 percent saying they were '*unclear*'. (Table 53) [A6.1.12] AHPRA and 'all NSW' responses

were similar; with a slightly lower '*not clear at all*' response for the HPCA. Doctors attracted a '*not clear at all*' response 10 percent higher compared with all other professions. [A6.1.13]

Table 53: Survey 1: whether the assessment criteria used were clear

	1=Not clear at all		2=Unclear		3=Neutral		4=Clear		5=Very clear	
	N	%	N	%	N	%	N	%	N	%
ALL	663	40	270	16	332	20	249	15	161	10
AHPRA	412	41	165	16	181	18	157	16	91	9
NSW	251	38	105	16	151	23	92	14	70	11
HPCA	94	34	50	18	60	22	41	15	32	12
HCCC	157	40	55	14	91	23	51	13	38	10
DR	440	44	163	16	187	19	130	13	90	9
All excl. Dr	223	34	107	16	145	22	119	18	71	11

Thirty-six percent (N=609) gave reasons; 98 percent related to the agencies. Compared with ranked responses, the proportion of comments rated '*not clear at all*' was 11-15 percent higher for AHPRA and the HPCA respectively. (Fig.22)

[A6.1.14]

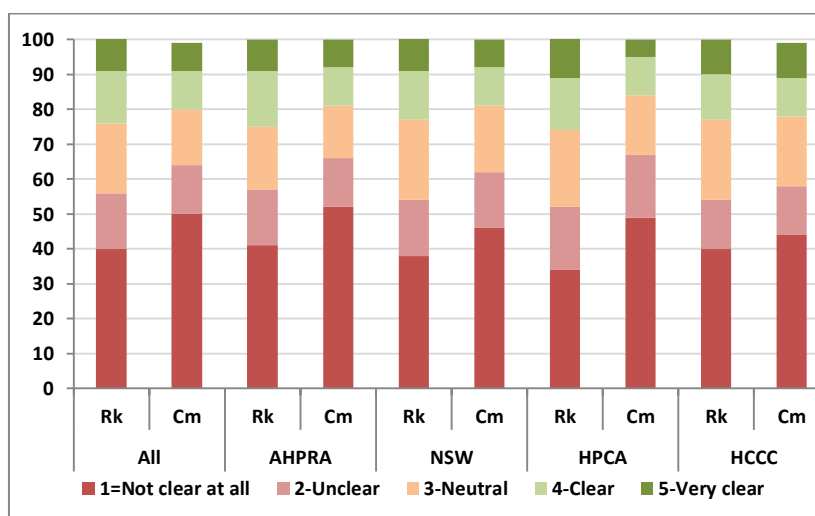


Figure 22: Survey 1: assessment criteria: comparing the proportion of ranked responses (Rk) to comments (Com)

Two main themes were identified. (Table 54) [A6.1.15] Of note are reservations or adverse comment even when a high ranking is given. These appear to primarily reflect confusion about agency responsibilities; and views about its remit, capacity or how it discharged its functions.

Table 54: Survey 1: thematic categories of survey comments: whether assessment criteria were clear

1. Explanation, information about assessment criteria and processes	2. Exercise (application of assessment criteria)
	A. Evidence, investigation, reasons and outcomes
	B. Balance: fairness and attitude

At a thematic level there is broad consistency in reasons given for the ranking when comparing agencies. (Fig.23)

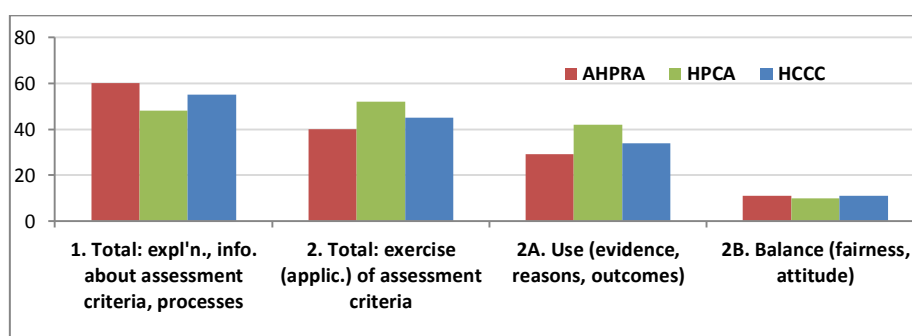


Figure 23: Survey 1: assessment criteria: comment themes by agency

The following sections report on analysis of these themes. Some raised multiple issues such as: the opacity of criteria used; agency philosophy and values; bias towards the profession and failure to adhere to commitments made. While the following extract relates to one agency, this type of response reflects comments about all agencies:

"There was no criteria listed in any correspondence, nothing along the lines of investigative 'values' was expounded in conversations, no explanations given with the exception of 'they' would read my complaint, hand it to the doctor for 'comment' - not even a please explain, just 'comment' and then he would give his side of story, it would go before an 'panel' of supposedly 'independent' medics/board members (doesn't say who or where from - another state perhaps, BET NOT, all [from name of jurisdiction] and v. small community). They would make a decision and give an opinion on outcome. Then I would be advised. I would be asked extra questions/information during the process and advised of progress. None of which happened and as explained before, info on outcomes, came from a 3rd person about a week before correspondence arrived...Given the distinct impression that regardless of outcomes, not a lot would happen. A list of possible sanctions was listed in correspondence, but in few discussions with 'investigator' impressions were that any sanctions would be applied with some 'reluctance'. This has proved to be so." (Ref 919 AHPRA Rank 1)

6.1.2.1 Theme 1 comments: information, explanation, communication

Forty-eight percent of comments relate to information or explanation about the assessment criteria or the process for assessing complaints. This was highest for AHPRA (60%) and lowest for the HPCA (48%). For all agencies the proportion of Rank 1 responses ('not clear at all') is high, ranging from 42 percent for the HCCC to 51 percent for AHPRA; with the nature of dissatisfaction consistent. Some did not receive any information about the assessment criteria other than 'send your papers in', one making the observation:

"The complainant has no idea what they think or are investigating." (Ref 409)

A number focused on the generic process rather than the criteria e.g. *"the process was straightforward and clear"* (Ref 863). Positive observations included that:

"The regulatory body understood very well the seriousness of the complaint." (Ref 801)

"Received a phone call explaining the criteria used." (Ref 62)

While the more negative referenced the paucity of detail:

"Other than it was referred to an 'expert panel.'" (Ref 803)

"I was just told that they did nothing wrong [not] how is that so." (Ref 799)

Others commented on the lack of appropriateness or relevance of the criteria used. [A6.1.16]

The ability to independently assess the veracity of information and how decisions are made also featured:

"I was not given any criteria, just told it would be done. The following section of an email correspondence show how hidden the process is [extract]... That is, the doctor I complained about does not have to show me his final submission about our dealing, hardly transparent or clear. I can only get the independent opinion of Dr [name 2]

through the FOI process. In a transparent situation, these should be available to me as a matter of right. How else can I judge what they have said is correct or not.”
(Ref 74 Rank 1)

6.1.2.2 Theme 2A comments: evidence, investigation, reasons, outcomes

Forty-three percent of responses were about the process. Of these, three-quarters commented on assessment of evidence, extent of inquiries or outcomes. More negative rankings were about whether issues were addressed or investigated and whether or not the rationale, where provided, was perceived as relevant to the issues and evidence raised.
[A6.1.17]

Respondents who did not receive an explanation found decisions difficult to understand or accept. This was especially acute and the source of profound grief and anger when a relative had died. Other comments related to assessor qualifications and whether the decision was consistent with relevant standards. Mid-ranked comments included the independence of the reasoning process and evidence on which decisions are made. Reference to professional standards and comparisons with other professionals in similar circumstances were also made:

“It was determined that the Dr had not acted outside of being “professional”, which I strongly dispute and would argue would result in a formal warning in most other professionalised workplaces in Australia. So my understanding of the criteria that constitute “professional” behaviour is “divergent”. ” (Ref 892 HCCC Rank 3)

Rank 5 (‘very clear’) comments were not always positive or about the agencies. For example, that it was ‘very clear’ the agency had no intention of acting on the concerns raised; or indicating that the information provided by the complainant was unambiguous regarding the issues at hand:

“I provided all evidence against practitioner.” (Ref 1269)

“I sent a signed statement of both episodes. How much clearer can you get.” (Ref 1018)

6.1.2.3 Theme 2B comments: balance (fairness and attitude)

One-quarter of theme 2 comments relate to fairness and attitude. These comments anticipate those appearing later in the survey to specific questions on fairness (discussed in section 6.3). The proportion is the same for all agencies, as is the high proportion (68%) of Rank1 (‘very unclear’) responses they relate to.

A consistent theme of negative responses [A6.1.18] relate to conflicts of interest – either at a higher level (one professional not ‘going against’ the word of another); or personal relationships between those with adjudication roles and the subject practitioner. Some specifically referred to the lack of patient perspective or the impact of perceived bias:

“If it was a Dr assessing another Dr then it would perhaps explain to me why they wouldn’t see a patient’s point of view. (Primarily because nobody would ever treat any Dr like I was).” (Ref 57, Rank 1)

“The process seemed very much aimed at protecting doctors as no adequate response or hearing was given to me and in the conversation I had with the case worker, the case worker appeared very dismissive of me and defensive of the doctor's behaviour.”
(Ref 1060; Rank 1)

“They were massively tilted and narrow to protect the practitioner and had no real interest in dealing with the actual complaint I FEEL COMPLETELY LET DOWN BY THE WHOLE PROCESS. JUST LIP SERVICE.” (Ref 1061, Rank 1)

Summary of Sub-section 6.1: understanding of the system

Respondent understanding about the role and powers of agencies varied. A similar proportion in Survey 1 ranked understanding of role and powers as “*very unclear*” and “*clear*”. However, ‘*clear*’ or ‘*very clear*’ comments were mostly generic and referenced activities (such as investigating), and were unspecific as to purpose. Few respondents appeared familiar with or referred to statutory requirements in either scheme. ‘*Public protection*’ consistently featured in Survey 2; however community responses also ranked ‘*representing consumer rights*’ highly and there were mixed responses in relation to other statutory roles. This variation was also noted in interviews.

Forty percent of Survey 1 respondents ranked the assessment criteria as ‘*very unclear*’.

Dissatisfaction with the assessment process and perceived unfairness was evident in both systems. In Survey 2 twice as many professional organisations than community respondents thought agency powers were ‘*adequate*’ for investigations and interventions. Only one-third of all respondents thought the ability to monitor and enforce compliance was ‘*adequate*’.

6.2 Engagement and communication

This section describes how well complainants in Survey 1 were kept informed and how well reasons for decisions were explained.

6.2.1 How well was the respondent kept informed?

Twenty-nine percent said they received '*no information*' and one-quarter '*minimal information*' about their complaint. (Table 55) [A6.2.1] The main difference between AHPRA and NSW was AHPRA attracted a higher proportion of '*minimal information*' responses and a corresponding smaller rate of '*very well informed*'. '*No information*' responses were 10 percent higher for complaints relating to medical practitioners compared with all other professions. [A6.2.1-2]

Table 55: Survey 1: how well the respondent was kept informed: Likert scale responses

	1=Very poorly: no information		2= Poorly: minimal information		3=Neutral: no opinion either way		4=Well: reasonable amount provided		5=Very well: kept very well informed	
	N	%	N	%	N	%	N	%	N	%
ALL	499	29	424	25	318	19	333	19	130	8
AHPRA	306	30	288	28	187	18	184	18	58	6
NSW	193	28	136	20	131	19	149	22	72	11
HPCA	75	27	57	20	53	19	69	25	27	10
HCCC	118	30	79	20	78	20	80	20	45	11
DR	341	33	242	24	182	18	185	18	81	8
All excl. DR [1]	158	23	182	27	136	20	148	22	49	7

[1] All excl. DR = All professions excluding medical practitioners

Thirty-eight percent (N=639) provided comment; mainly about the agencies (97%). AHPRA attracted a higher proportion of 'minimal' information responses. (Fig.24) [A6.2.3]

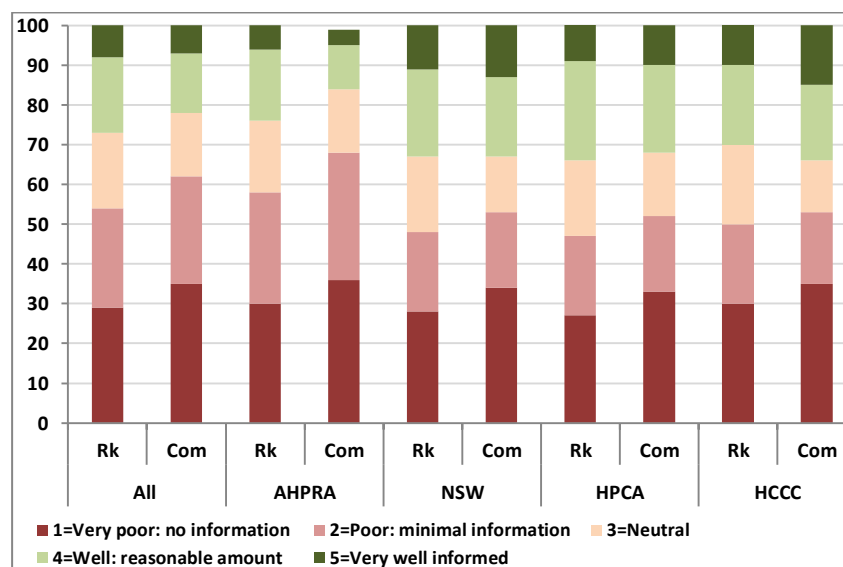


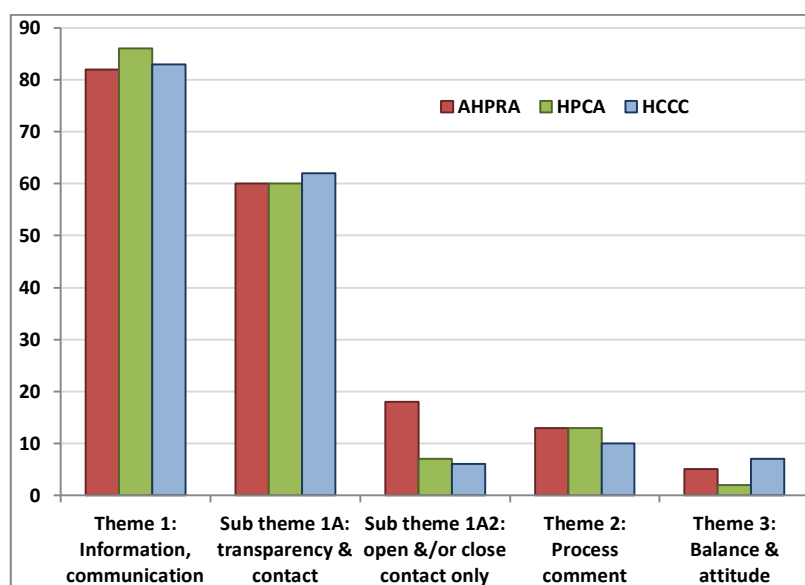
Figure 24: Survey 1: how well the respondent was kept informed: comparing ranked responses (Rk) and coded comment (Cm)

Three main themes emerged. (Table 56) [A6.2.4] Eighty-three percent referred to information and communication, including degree of transparency or contact; the need for the complainant to initiate contact and comment on outcomes; 12 percent to other process issues and five percent to fairness. (Fig.23)

Table 56: Survey 1: thematic categories of survey comments: whether the respondent was kept informed

1. Extent and adequacy of contact and information	2. Process	3. Balance (fairness) & attitude
1A1=No contact, information 1A2=Acknowledgement and/or final letter only 1A3=Other comment on transparency, contact, information 1B= Complainant/notifier had to initiate contact 1C= Information about outcome, reasons	2A=Timeliness 2B= Able to view, respond to practitioner statement 2C= Other process comment	3A=Level of seriousness, interest, courtesy, helpfulness 3B= Perceived fairness, assumption practitioner credibility

At the thematic level there is a high degree of consistency in comments across agencies. This also applies at the sub-thematic level with one exception (subtheme 1A2) discussed below. Other variations are typically associated with smaller numbers, so no conclusions are drawn. (Fig.25) [A6.2.4]

**Figure 25: Survey 1: how well respondent was kept informed: comment themes by agency**

6.2.1.1 Theme 1 comments: extent and adequacy of contact and information

Nearly three-quarters (73%) of Theme 1 comments relate to the level of transparency and contact (Subtheme 1A), ranging from 'no contact or information' to 'very good' or 'constant'. (Table 57) Nineteen percent had to initiate contact (Subtheme 1B). The remaining comments (9%) were about the information provided about outcomes or reasons (Subtheme 1C). Eight percent (N=33) of Subtheme 1 responders said they had no contact at all with the agency; some advising the survey was the first notice of closure they received:

"No contact at all from anyone!" (Ref 296)

"I had no idea it had been finalised until I received this survey" (Ref 598)

"I have received zero notification that I had even made a complaint. The first piece of notification I have received is this survey letter." (Ref 1313)

Table 57: Summary comment sub theme 1A1: no contact

1=Very poorly: No information ¹ First communication was receipt of survey; no acknowledgement; no/complete lack contact/information/communication; no information after submitted/about process; never heard outcome	2=Poorly: Minimal information Given no information at all; no idea it had been finalised until this survey

[1] There were no Rank 3, 4 or 5 comments in this subtheme

Twenty-three percent said an acknowledgement letter and/or a final letter were their only contact. AHPRA accounted for 83 percent of these, although similar comments were made about all agencies and spanned Likert rankings from ‘very poorly: no information provided’ to ‘well: reasonable amount of information provided’ [A6.2.5]:

“The only notification I have received from AHPRA through this whole process is a letter stating they had received my claim. There has been NO other contact.”
(Ref 944 Rank 1)

“After I sent original complaint to HCCC I never heard anything until the letter advising no action would be taken months later.” (Ref 137 Rank 1)

“I just received a letter stating that my complaint would not be pursued any further.”
(Ref 959; HPCA; Rank 1)

“I emailed the complaint and then the next response was to receive a letter stating there were no concerns.” (Ref 805 Rank 4)

Two described the type of information that would have been helpful:

“Letters telling me the matter was being looked into, then letter case closed – no further action. Not a lot of in between – no info on “how” it was being looked into.” (Ref 673)

“They didn’t give a lot of information; receipt of my complaint and then a few months later the complaint result; however I suppose looking back I’m not sure what else they could have provided. Perhaps the criteria against which the [practitioner’s] actions were assessed and exactly how the assessment would be undertaken. I was left unsure about how the complaint was assessed.” (Ref 1351)

The majority (69%) referred to inadequate contact or lack of detailed information. AHPRA had a higher proportion of comments ranked ‘very poorly’ and ‘poorly’ (51%) compared with the HPCA (29%) or the HCCC (36%); and a corresponding lower proportion of ‘reasonable amount of information provided’ and ‘very well informed’ comments (30%) compared with NSW agencies (55%). But the nature and focus of observations were similar for all agencies.

Critical commentary included: lack of information about what to expect; what was required; the process or procedures used; and in some cases, progress of their case. [A6.2.6] Others were told investigations were continuing but never what this involved or the findings; lack of requests for further information; or were asked for information, but received none in return:

“NO feedback at all. We cannot provide information or feedback to patients affected, staff escalating the complaint originally, as Executive of the organisation we have no idea of what direction the matter is taking, the RN affected has no natural justice at this level, any attempts to make inquiries are dealt with in a brusque bureaucratic manner.”
(Ref 791 AHPRA Rank 1)

“I made contact once or twice, asked what was happening, offered further info if required. Told not. No info forthcoming, except that the investigation was “ongoing”. No info provided; no contact made; no questions asked; was told nothing until final correspondence...” (Ref 919 AHPRA Rank 1)

“I think I received 4 letters over the period, but they provided little or no real information - just letting me know that the matter is continuing and will “continue to be conducted in

a timely way". Until the final letter which basically just told me that the matter was closed." (Ref 966 AHPRA Rank 2)

"Process just followed its own course, independent of the patient and without advising patient." (Ref 1688 HPCA Rank 2)

I received acknowledgement of receipt of my initial complaint, and subsequent requests for additional information, however I was not adequately informed of the progress of the complaint, or what actions were in train." (Ref 1185; HPCA Rank 2)

"I was contacted by the patient on numerous occasions as she felt that 'nothing was happening' so from this I can only assume she did not feel/was not sufficiently informed of status." (Ref 1538 HCCC Rank 2)

"I do not consider template letters "informative". The case manager was remote and I heard from her at best three times." (Ref 413 HCCC Rank 2)

Conversely, positively ranked survey comments, confirmed at interview (Box 11) conveyed greater clarity of process and more regular engagement:

"Initial phone call from person investigating the complaint. Letter acknowledging receipt of form. Letter stating appointed investigator and issues identified. Phone call requesting further information. Letter advising outcomes of investigation." (Ref 1388 AHPRA Rank 4)

"Phone conversations informing me of the process was consistently done by the resolutions officer." (Ref 29; HCCC Rank 5)

"Was called by Medicare, visited by the Pharmacy Council and written to by HCCC." (Ref 1499 HPCA Rank 5)

"I felt that the officer allocated to my case made sure that I was aware of any changes or progression with the complaint." (Ref 1390 HCCC Rank 5)

"Told me of the steps taken; talked to me on the phone; told me what to do." (Ref 1554 HPCA Rank 5)

"No complaints, if I asked a question it was answered, then if more information was needed to answer, they always emailed me back." (Ref 268 AHPRA Rank 5)

Box 11: Interview extract: being kept informed

Case 12

Respondent: The girl that I first spoke to was very helpful, very thorough and kept following up to let me know that "We haven't forgotten you". I also got a letter that said they were following up and also to say what they were doing. For example, they were waiting to interview the pharmacist.

Interviewer: Did you know what they were doing, how they were going about investigating the matter?

Respondent: Yes they told me they had to do an investigation and what they had to do and what the pharmacist had to do. It was a good process, not frustrating; they did say that it would take time. ...

However, higher ranked responses also contained reservations such as respondents having to seek information; these remarks again applying to all agencies:

"Kept up to date with progress- nothing else" (Ref 497 HCCC Rank 4)

"Investigation was ongoing. However at no time was I told what the investigation consisted of." (Ref 1235; AHPRA Rank 5)

Nineteen percent (N=113) of Theme 1 were about having to ask about progress or the outcome. Comments in Ranks 1 (*very poorly informed*) to 4 (*reasonably well informed*) were consistent on these points and applied to all agencies. [A6.2.7]

Nine percent (N=53) were about the outcome; covering issues similar to those raised in more detail in Section 6.2.2; including inadequate explanation of decisions; nil information about the outcome; or in the case of AHPRA, being given a list of 'possible actions'; confusing information; and dissatisfaction with the result. [A6.2.8] Three-quarters of comments related to AHPRA, but the issues were consistent across agencies:

"Very poor communication. I found out the outcome from my patient during debrief. She was extremely distressed and it would have been helpful to understand why the response to this complaint was so minor." (Ref 1671 HCCC Rank 2)

"Just the letter saying issue resolved with no indication of impairment management program for clinician- who was considered ?"unimpaired." (Ref 1471 HPCA Rank 1)

"Only received a phone call...to say complaint was "over" and no disciplinary action would be taken against the [doctor]. Said he had been ?"flagged" And they would be aware of any future issues." (Ref 160 HCCC Rank 3)

"Information has been provided about where the complaint is up to. But the final closure of the case stays a bit unclear." (Ref 1141 HPCA Rank 4)

"Outcome letter was ambiguously worded, and overly technical. I sought clarification twice, the response remained confusing and my second email was ignored. (As a side note - I am a Masters level health practitioner, and not a lay member of the public, and I still struggled with understanding the wording of the outcome)." (Ref 1168 AHPRA Rank 1)

6.2.1.2 Theme 2 comments: management of the complaint or notification

Process comments accounted for 12 percent (N=89) with over three-quarters (77%) about timeliness, including reference to significant timeframes (up to 18 months and in one case, years). [A6.2.9] Commenting on a six month gap, one suggested that "a brief generic email/postal letter would be helpful" to keep people appraised; noting:

"[as] the agency did have my email address, I would have expected an interim update, also simply for the fact that one does not know how long the process might take." (Ref 1146)

Lack of explanation for delays, compounded by a lack of engagement with complainants also featured in responses:

"Had odd letter saying still in progress but never told me why it took so long and as [there was] no attempt to verify facts in dispute with third parties or to seek further documents of information from me, I would expect to be told why it took 18 months with them to read my complaint, read her response and decide." (Ref 523 Rank 2)

In contrast, candour appears to have influenced the ranking in another case:

"The HCCC gave information when requested and was open and candid as to the reasons for the delay in the investigation." (Ref 1715 Rank 4)

A few commented on their inability to view or respond to practitioner statements made in response to their complaint; these generally but not always attracting a lower ranking. [A6.2.10] Other concerns included not being fully understood; poor management, including not prioritising serious matters (threat to self or community); and information gathering. Broader

system issues included directing responses to individuals rather than employing organisations and the rate of investigator turn-over.

6.2.1.3 Theme 3 comments: fairness (attitude and balance)

A small proportion of comments (5%) related to the attitude of the agency, particularly in relation to fairness. [A6.2.11] Issues are consistent with later questions about balance (section 6.3). Most but not all believe the complaint body was disinterested, remote or favoured the practitioner, although one noted:

“I was treated with respect and felt they were doing their best.” (Ref 1370; HCCC)

6.2.2 How well were reasons for decisions explained?

Thirty-five percent (N=593) received ‘no reason’ for their complaint decision; and over one-quarter (27%) received only ‘minimal information’. (Table 58) [A2.12] When comparing agencies and responses about medical practitioners with ‘all other’ professions little difference was noted. However, ‘no reason given’ was higher for complaints about medical practitioners when handled by AHPRA (41%) compared with NSW agencies (34%). [A6.2.13]

Table 58: Survey 1: how well reasons for decisions were explained

	Rank 1 Very poorly: Reasons not given at all		Rank 2 Poorly: minimal information provided about reasons		Rank 3 Neutral: no opinion either way		Rank 4 Well: reasonable amount of information provided about reasons		Rank 5 Very well: reasons very well explained	
	N	%	N	%	N	%	N	%	N	%
ALL	593	35	461	27	267	16	263	16	107	6
AHPRA	377	37	292	29	142	14	156	15	50	5
NSW	216	32	169	25	125	19	107	16	57	8
HPCA	93	34	62	22	50	18	51	18	22	8
HCCC	123	31	107	27	75	19	56	14	35	9
DR	387	38	293	29	140	14	146	14	57	6
All excl. DR ¹	206	31	168	25	127	19	117	18	50	7

[1] All professions excluding medical practitioners

Thirty-seven percent (N=620) gave reasons; nearly all about the agency (99%). AHPRA attracted the highest ‘minimal information’ response although all agencies were over-represented relative to ranking in this regard. (Fig.26) [A6.2.14]

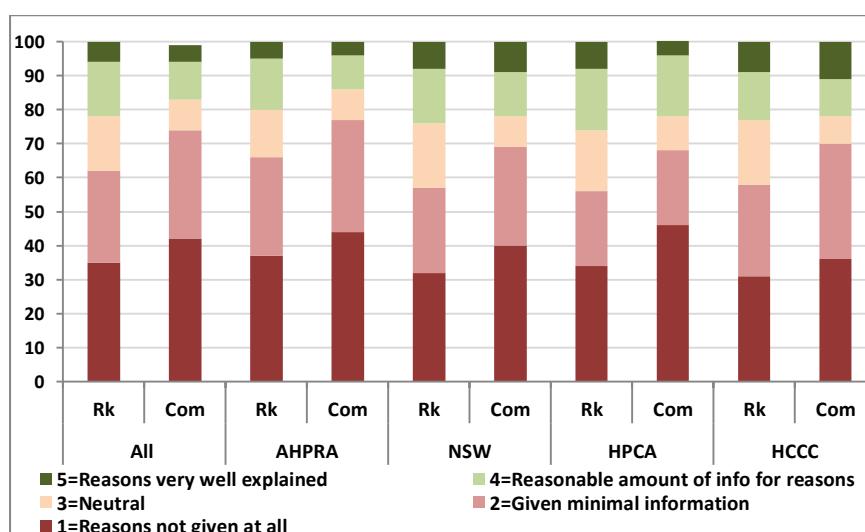


Figure 26: Survey 1: how well reasons for decisions were explained: comparing ranked responses (Rk) and coded comment (Cm)

Of the three main themes (Table 59) [A6.2.15] the majority (75%) concerned inadequacy and lack of detail associated with the reasons given (Theme 1); 20 percent perceived balance and attitude (Theme 2); with the remainder (5%) referring to other processes (Theme 3).

Table 59: Survey 1: thematic categories of survey comments: how well reasons for decisions were explained

1. Adequacy of explanation provided	2. Balance & attitude	3. Process
1A=No reasons provided 1B= Adequacy or level of detail of explanation 1C= Assessment of evidence; adequacy of investigation; issue(s) addressed 1D= Outcome	2A=Level of seriousness, interest, courtesy, helpfulness 2B=Decision based on false information from practitioner 2C= Perceived agency probity; whether parties treated equally in process	3A= Able to view, respond to practitioner statement 3B= Other process comment

When comparing agencies, the main difference was associated with a lower proportion of ‘no reasons’ comment about the HCCC; which attracted a higher proportion of comments about ‘balance and attitude’.

(Fig.27)

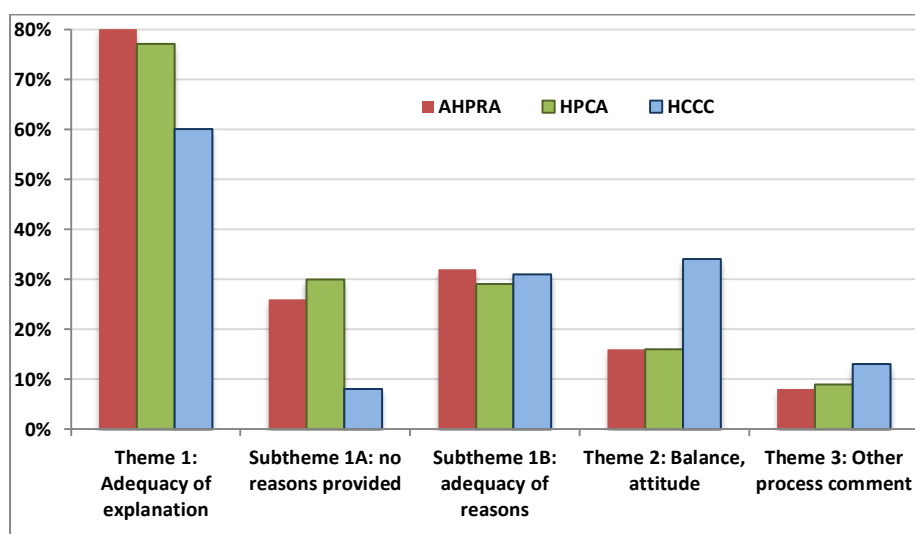


Figure 27: Survey 1: how well reasons for decisions were explained: comment themes by agency

6.2.2.1 Theme 1 comments: inadequate information provided about reasons for decision

Seventy-two percent of comments ranked information ‘very poorly: no reasons provided’ (40%) or ‘poorly: given minimal information for reasons’ (32%). The proportion of lower ranked comments was higher for AHPRA (77%) than the NSW agencies (both 62%); although the HCCC had a better ranking for information for ‘very poorly’ responses (29%).

Of Theme 1 comments, 30 percent (N=138) received no reasons for the decision in their complaint. [A6.2.16] AHPRA accounted for three-quarters of these:

“No information given. They couldn’t tell me why they came to the conclusion- too much red tape!” (Ref 583)

Five made reference to limits of information able to be provided under the National Law:

“Due to AHPRA staff understanding of the legislation, they are unable to provide meaningful information to the notifier” (Ref 580 consumer)

"AHPRA do not discuss incidents or issues, just speak broadly. Tightly bound by confidentiality with little care given to organisations who need to deal with non-compliant or risk staff members" (Ref 579 employer)

Some commented on the unsatisfactory nature of the communication in cases when further action was indicated; and those where it was not:

"No reasons given – simply stated that the practitioner would be counselled over what MAY have been poor procedure!" (Ref. 1105)

"Doctor failed to retrieve medical history which documented extreme hypersensitivity to [type] drugs. Doctor refused to stop [name drug]. Death from fatal response could have been avoided. AHPRA took no action. No reason given." (Ref 775)

"Short letter – found practices were unsatisfactory, but no reasoning whatsoever." (Ref 297)

For others, legal references rather than reasons impeded resolution:

"I was quoted a section of law which did not give me any closure or explanations as to what the outcome of my complaint was." (Ref 1216)

"I was given a legal reference, but I am not legally trained. Considering I nearly died, I would have liked a few lines of text to explain their decision at least." (Ref 525)

Forty-two percent in Theme 1 (N=195) commented on the adequacy of the agency explanation. Some characterised their views more generally – ranging from negative ("very poor", "partial", "superficial", "unclear", "contradictory", "minimal", "irrelevant to complaint" and "unconvincing") to neutral or positive ("sufficient", "clear", "easy to understand", "fully" and "thoroughly"). [A6.2.17] An exception to the trend, one commented:

"Detail was not provided, nor should it have been." (Ref 246)

A few others received detailed information or had the opportunity to discuss their case:

"Letter outlined major points of complaint and the practitioner's responses." (Ref 1084)

"Lengthy discussion over phone with investigator after case concluded was helpful." (Ref 1467)

While some referred to very good communication and explanations for reasons, others referred to form letters or use of jargon:

"Was given a standard script of response." (Ref 930)

"Can't understand all this jargon - I don't know what it means." (Ref 1712)

Seventeen percent (N=78) of Theme 1 concerned issues being addressed (or not); assessment of evidence or inadequate investigations. [A6.2.18] AHPRA accounted for 70 percent of comments, 90 percent of which were negative ('no' or 'minimal information' for reasons provided). However, issues were similar across agencies, including whether key concerns were understood or addressed:

"Not all matters raised in my complaint were addressed, including the main issue..." (Ref 1385)

"As the complaint bodies missed the most important aspects (of the complaint), the decision-making process was irrelevant." (Ref 697)

"After the assessment was made the report was not sent to myself... I contacted AHPRA and they stated that there was deficits found in the RNs knowledge base and practice competency ... Of the little information I received part of the decision made was the RN should attend a form of ...study day - but there was nothing in writing about assessment of knowledge after this study day - my main issue ...was retaining information and knowledge. I do not believe the board took this into account." (Ref 944)

Decisions made without seeking additional advice and the adequacy of inquiries appeared in other responses:

"Poorly explained: Board acknowledged "serious issues" but requested no proof or further information." (Ref 67)

"There was an investigation that was lacking in substance. A lot more is needed to be done to address the core of the complaint." (Ref 706)

Whether evidence was accepted or seen to be assessed also featured:

"I was sure no one even assessed the complaint or looked at all the cross-substantiating evidence." (Ref 1289)

"Told from documents supplied, don't see anything wrong; 'case closed'- but there were things e.g. stitches opening; sponges left in- these weren't picked up." (Ref 1611)

"I was informed that the staff member's signed statement about the incident could not be considered as it was hearsay evidence." (Ref 955)

Evidentiary issues associated with medical records, including completeness and accuracy was raised in several responses:

"Doctors don't write down everything you tell them, only what they believe to apply." (Ref 880)

"[was told] "there is little likelihood of the commission achieving successful disciplinary action based on the information on file". In writing this, I realise how very convenient it is that he destroys his original notes." (Ref 82)

"I was told decision made according to the Medical records. And I was arguing that they were not kept up to date- but I was not allowed to see them." (Ref 343)

The challenge of securing evidence when consultations are often solely one practitioner and one patient was raised by others:

"No reason other than "not enough evidence". But I ask how can there be evidence of [name] in a one-on-one situation other than notes made and counselling received?" (Ref 271)

"Reported that they could not make judgement as to what happened as they weren't there and it wasn't written in the notes." (Ref 329)

"I was told that I should have taken a tape recorder with me when I visited the doctor as it was my word against hers." (Ref 967)

Eleven percent (N=49) of Theme 1 related to the outcome. [A6.2.19] Some positive rankings indicated they received a reasonable amount of information even if they did not agree with the rationale or accept the outcome:

"But I disagreed with their reasoning, especially after I had discussed the issue with a senior colleague from the College [name]" (Ref 25 Rank 4)

Although others did not share this view:

"Hard to accept decision - continues to remain unclear why, when practitioner engaged in a practice that is not professional and through [their] legal representation basically acknowledged this, no action taken." (Ref. 783; Rank 2)

"I was...advised that a breach had occurred and that the Doctor had been cautioned - but [no] further explanation on why only a caution was issued and also as to why this caution is not recorded against the Doctor to flag if this is a reoccurring practice." (Ref 1490 Rank 2)

Another respondent raised the issue of how accountability is determined:

"No reason was given. I was told "when there are systemic issues, then individuals shouldn't be held responsible" and "When there is more than one individual who did the wrong thing, then they shouldn't be held accountable..." (Ref 364)

Health practitioner complainants also questioned processes and standards applied in decision-making:

"Poor correlation to medical competency standards of practice." (Ref 495)

"It was unclear whether or not the practitioner was advised that what he had done (and acknowledged) was appropriate or advisable." (Ref 1032)

"Decisions explained as 'having faith' in nurses to act independently without the supervising [or] authorising doctor knowing, seeing [or] examining [the] patient."

Information about improvements was important to individuals e.g. *"I received a letter outlining what changes had been made how things were improved."* (Ref 987; Rank 4) However, generalisations rather than specific information about claimed improvements and ongoing oversight featured in lower ranked responses from individuals:

"We were left unsatisfied with the Board's decision to issue only a caution to the doctor with their reason based simply on a doctor's apology (to AHPRA, not us) and acceptance of responsibility. The decision did not incorporate any follow up by AHPRA to ensure the doctor implemented improvements to his systems for the review and follow up of results." (Ref 917 Rank 2)

"I was simply advised that improvements to practices had been made to ensure that this would not occur again but I was not advised what these improvements were. The reasons were not detailed enough as to why they chose to simply caution the doctor rather than take other disciplinary action." (1531 Rank 2)

"The decision advises me that "system improvements" have been identified "that are to be developed and implemented". Such as what? I identified several issues which have not been addressed...." (Ref 1332 Rank 2)

The lack of reasons was a particular concern for complainants who sought to address broader (profession-wide) as well as individual practice issues. This was explored in greater depth during interviews; one example provided at Box 12.

Box 12: Interview extract: raising profession-wide as well as individual practice issues in complaints; adequacy of reasons for decisions

Case 13

In this case, the respondent reports she repeatedly spoke with medical and nursing staff in two separate facilities that she believed the physical deterioration and behaviour of her relative, for whom she was guardian, was due not to their medical condition; but the medication they had been prescribed and that she wanted the medication withdrawn. This did not occur and it was not until her relative collapsed and had to be transferred to hospital that medical staff there confirmed an association with and reaction to the drug. In her complaint, Rachel raised issues relating to the wider use of the medication as a restraint; lack of consent for its administration; and failure of the initial treating specialist to respond to her concerns about its effect. She undertook extensive research into the drug; clinical guidelines for its use and the law of consent, which she documented and submitted with her complaint. She says she was never contacted by the investigator about her case; and although she was given the doctors' responses was told only that she could either go to a resolution meeting or ask for a review. Following a request for review, Rachel was contacted by the reviewer; who acknowledged the substantive body of research she had undertaken but that only one of the issues raised would be referred to the [Medical] Council. Rachel says she was not told what the Council had done as this was "*private*" information; but that if it recurred the doctor would be '*interviewed*'. Like other respondents, she questions whether the issues raised are being appropriately framed; and is scathing of the paucity of information provided to her in light of the substantive issues and material provided. She expresses the need to increase transparency about how decisions are reached. She is concerned she received no indication that any action had been taken about her wider concerns about standards and the use of the drug, which had prompted the complaint in the first place.

Respondent [The HCCC reviewer] rang me and said that she was very impressed with the calibre of material that I had sent; that it was incredibly comprehensive. And it was an advocacy appeal; on a class level – i.e. it wasn't just about [my relative] but about anyone in this situation. It was about that right of consent; and it was about the validity of administering the [drug name]. And by then I had pulled out the pharmaceutical standards in administering the drug because the doctor had said they had abided by them. And so I looked those up. And I couldn't find anywhere that they said that they should be given [it]. And admittedly I can't necessarily access everything that a psychiatrist can. However it still occurred to me that if there is such extensive research being done internationally that points out that the drug doesn't work; that it is a danger; that [legal action] was taken about mis-claims about what it could and couldn't do; and that there are psychiatrists touring the world that are appealing against its use, that there would be some questioning of any standard that a psychiatrist utilises. And that it was quite insulting [for him] to tell me that he had gone by the guidelines... But she [the reviewer] indicated that, and it had to do with the medical expertise that they were getting, that it was unlikely that they could move forward on the drug issue; and it was more likely on the issue of consent that clearly hadn't been given [to administer the drug].

Interviewer: Did the HCCC act on this?

Respondent: The impression I got was that it was serious enough for them to refer to the Medical Council. And people said "*congratulations; it has gone to the Medical Council, that's good.*" And then it was like ok, what's next? And then it was a letter from the Medical Council; and it's Monty Python-ish really. It was like '*oh you've made it; you've got past the complaints commission. And they have actually referred it on, isn't that wonderful.*' And then the Medical Council, with no explanation no discussion, no nothing; in their letter simply said the case has been closed and it has been dealt with.

Interviewer: What did they mean when they said it was dealt with?

Respondent: Well, exactly. And so I rang and I was given a patronising discussion about how her mother had [disease] too and yes it is terrible dear and blah, blah, blah. And I said look: "*My issue is not about chasing one doctor. My issue is about the fact that this can happen.*" And I said one doctor isn't going to bring her back. Nothing will bring her back, but we can stop this from happening to other people. And it really, really concerns me that this is endemic; and that nothing is being done about it.

Interviewer: And what was the response to that?

Respondent: She was just patronising, and I said "*Well, what is it that has been dealt with? What has happened?*" And she said, "*Oh well that's under privacy dear. But I can tell you that if it happens again that the doctor will come in for an interview.*" And I thought '*oh my god*'. All of this and if he's a bad boy again, what happens? He gets an interview. And I thought '*this is a joke*'. All that effort; and it was like a massive piece of research, providing evidence, providing [photographs] and I could show her before the medication and after the medication. Admittedly, it is difficult to separate, how much of the deterioration is the disease and how much was the medication. Except for the speed - in a period of months she was ok - lively, talkative, demonstrative, humorous, still giving advice; and then ...major, major deterioration in a matter of weeks; major deterioration.

....

Interviewer: Can you tell me, as you went through the HCCC review process; what if anything was different to when you first made the complaint?

Respondent: The person who was doing the review actually rang and spoke to me. And that made a big difference.

Interviewer: How was this different?

Respondent: Because I could see the consideration that she was taking and I could see the obstacles that she was dealing with. And it seemed to me that one of the obstacles was they had to get advice from someone from the medical profession, to the extent that it is possible to be unbiased. So I saw that could be a stumbling block, but at least she was trying. But the question that she raised was "*would it be wrong for a doctor to be using [name of drug] in such a circumstance*"; and the expert doctor obviously said '*this is common practice*'. To me, yes it is common practice, but that doesn't make it right. And there is something to do with, if this is normal common practice, then it is harder to question the illegitimacy of it, if it is common usage; common practice. And I still have difficulty with that given that it is illegal. And from what [expert acquaintance] was saying if you increase the medication, if you do not listen to the person who is asking you to remove the medication and if you do not consider that as withdrawal of consent; that is illegal under the law. So what they are effectively saying is because it is common practice, there is some kind of exemption from consideration under law... I think they, the doctors claimed that they had lowered the medication. And what I provided them with is the prescriptions; so they hadn't lowered it. They had been increasing, increasing, increasing. Not just increasing specifically, they had also said take it at any time that it is needed; which is open-slatheer for abuse.

....

Interviewer: Thank you, you have described the steps and what happened in detail... it would be helpful if you could reflect on what you would have liked to have seen

Respondent: I think I got the impression that the Commission didn't have many teeth. That it was, it wasn't a very powerful body. I would have liked them to provide an acknowledgement that what happened had been inappropriate. I would have liked a consideration of the use of [drug name] and further research to be undertaken on [its] impact on the elderly. I would like to see a full investigation of the use of these drugs - it is being used as a chemical restraint; I have absolutely no doubt about that. And chemical restraint is illegal.

Interviewer: Did you get any sense from the HCCC that they might refer or send this experience anywhere else?

Respondent: I would have liked them to, to have some sort of an orange to red light button that says 'this is a major issue' and we need to do something about it. Or even this is possibly an issue with major repercussions that needs to be investigated. Some acknowledgement, that this drug is actually very harmful. And, I didn't get any acknowledgement that that was the case.

...

Interviewer: Do you have any other comment about the process?

Respondent: There is probably a **hidden area about how a decision is made**. There is that area where we are told 'this is the decision' but then there is the politics of decision-making within an institution. And what draws an organisation towards a particular decision-making channel. And the fact that they weren't willing or didn't have the teeth- **one can only conclude that either they didn't have the power or need a decision-making process that is transparent to the public**. I want to know in terms of process, how, in the face of the evidence that you are giving, do they arrive at a decision; and that needs to be transparent and accountable back to the public. I made about, I had about 20 paragraphs of issues in my correspondence, of issues, and I would have thought that each of those issues needed to be dealt with. So that it's not a 'behind the doors' political response, it's a transparent response with a pathway of due process, where consideration is taken. 'This is the outcome where there is a case'; 'this is an outcome where there isn't a case'.

6.2.2.2 Theme 2 comments: fairness (attitude and balance)

Twenty percent (N=120) who commented on the perceived attitude underlying the decision reached or reasons relate mainly to AHPRA and the HCCC, but again they are similar across all agencies; these issues canvassed in section 6.3.

A small proportion (7%) perceived a lack of interest by the HCCC, with most saying the decision was based on false information from the practitioner (subtheme 2B, accounting for 20% of comments in this theme). A significant number said the regulator failed to treat both parties equally (subtheme 2C), accounting for 73 percent of comments in this theme. [A6.2.20] With one exception, and regardless of ranking, these perceptions are negative; and although medical practitioners feature most commonly, the views apply to all professions.

A number of factors underpin perceptions of bias, including quoting the practitioner in the closing letter:

"Merely quoted statements by dentists it appears." (Ref 1662)

"The first part of the letter is repeating the false information given by the doctor." (Ref 168)

"HCCC just repeated information from statements and did not offer solid reasoning." (Ref 535)

Secondly, a lack of information explaining decisions:

"I have no idea why AHPRA didn't pursue the issue other than, I assume, they take the word of the practitioner over the client." (Ref 462)

"The steps and rationale that led to this decision [to take no action] were not clear and transparent. This therefore, made me question the neutrality and subjectivity of the Commissioner's decisions." (Ref 785)

The adequacy of agency inquiries; whether evidence was verified or issues addressed also featured:

"Doctors statements taken as fact even though evidence provided to contrary. AHPRA do not appear to take patient claims and evidence into consideration, only the doctors!" (Ref 212)

"I felt the doctor's letter was given a lot of credence, and that the many things she addressed were taken into account when they did not really address what the complaint was actually about." (Ref 1496)

Privileging of the profession; the standing of the practitioner subject of complaint; or the relationship between regulators and profession also featured, including references to "a boys club" (Ref 552) and "doctors covered doctors" (Ref 195):

"I believe she was believed because she was the doctor and she adjusted her responses to make it look like she had behaved professionally." (Ref 274)

"No adequate reason, I suspect because the dentist had a reputation and was a Professor. No genuine respect was given to my account." (Ref 1575)

"I felt my complaint had not been considered properly by the experts who was [sic] seeking not to find adversely against the practitioner who was known to them." (Ref 921)

Some went further, saying they or their complaint was regarded by the agency as dishonest:

"Whatever I said was a lie. Whatever the doctor said they believed." (Ref 824)

For others, it reflected a 'disconnect' between their concerns and regulators' interests:

"[they] misrepresented my complaint to suit their own needs, so the reasons did not match the complaint anyway." (Ref 885)

The view that reasons and outcomes might be different with the inclusion of more lay people in the process was also expressed; a view reiterated in interviews:

"I always asked how many non-medical people on the board, but never got an answer I believed. More ordinary people should be there – not all medical." (Ref 391)

6.2.2.3 Theme 3 comments: other process issues

A small proportion (9%) concerned the inability to review a practitioner's response; lack of a right of review; positive or negative observations about the adequacy of communication; and risks associated with delays in managing cases. [A6.2.21] Although some associated a low ranking with an inability to view the practitioner's response; others received a copy of the response, but flagged other concerns around the adequacy of the investigation or outcome. Reference to a lack of review process is linked to issues raised in Theme 1 regarding a lack of contact for clarification or particulars at the start of the process:

"I was never contacted for information [impairment, errors complaint]...I complained to AHPRA who told me they acted fairly and no their decision could not be reversed, but I could complain to the Ombudsman." (Ref 194)

Summary of Sub-section 6.2: engagement and communication

Over half of respondents said the information they received from the agencies was ‘*very poor*’ or ‘*poor*’; with two-thirds receiving ‘*no reasons*’ or only ‘*minimal information*’ about why a decision was made. This response was higher for medical practitioners compared with all other professions.

AHPRA had a higher proportion of comments ranked ‘*very poorly*’ and ‘*poorly*’ (51%) compared with the HPCA (29%) or the HCCC (36%); and a corresponding lower proportion of ‘*reasonable amount of information provided*’ and ‘*very well informed*’ comments (30%) compared with NSW agencies (55%). But the nature and focus of observations were similar for all agencies. The HCCC had a lower rate of ‘*no reasons provided*’; but a higher proportion of perceived unfairness associated with information provided.

Respondents expected to be contacted for further information at the start, when responses from the subject were received or expert reviews provided. They could not understand how or why this did not occur or why they were denied access to material collected about or provided by the practitioner when it concerned them and the latter received their complaint information in full. Dissatisfaction and mistrust were heightened when facts in dispute were left unresolved and/or witnesses or other evidence sources were provided but not followed up by investigators.

Lack of transparency; perceived inadequacy of investigations; not having the opportunity to review or respond to practitioner statements and not receiving reasons for decisions contributed to perceptions of bias in the process in both systems. This is explored in more specifically in the following section (‘Balance’).

6.3 Balance

This section reports on Survey 1 questions about whether the process was fair and whether complainants were treated with respect. No definitions of these concepts were given, it being left open to respondents to interpret them in their own terms.

6.3.1 How fair was the process?

A significant 58 percent found the process to be ‘*very unfair*’ (39%) or ‘*unfair*’ (19%); and just under one-quarter were neutral. (Table 60) [A6.3.1] While the overall AHPRA and NSW responses were similar, the proportion of ‘*very unfair*’ or ‘*unfair*’ responses was higher for the HCCC. The perception of unfairness was also higher for doctors compared with all other professions. [A6.3.2]

Table 60: Survey 1: whether the process was perceived as fair: Likert scale responses

	Rank 1 Very unfair		Rank 2 Unfair		Rank 3 Neutral: no opinion either way		Rank 4 Fair		Rank 5 Very fair	
	N	%	N	%	N	%	N	%	N	%
ALL	647	39	315	19	382	23	205	12	122	7
AHPRA	395	39	179	18	234	23	131	13	68	7
NSW	252	38	136	20	148	22	74	11	54	8
HPCA	85	31	42	15	81	29	41	15	27	10
HCCC	167	43	94	24	67	17	33	9	27	7
DR	443	44	224	22	194	19	101	10	50	5
All excl. DR ¹	204	31	91	14	188	29	104	16	72	11

[1] All professions excluding medical practitioners

Forty-two percent (N=696) gave reasons; of which 98 percent were agency related. The proportion of adverse comment (‘*very unfair*’ or ‘*unfair*’) was over-represented relative to ranked responses; particularly for AHPRA and HPCA. (Fig.28)

[A6.3.3]

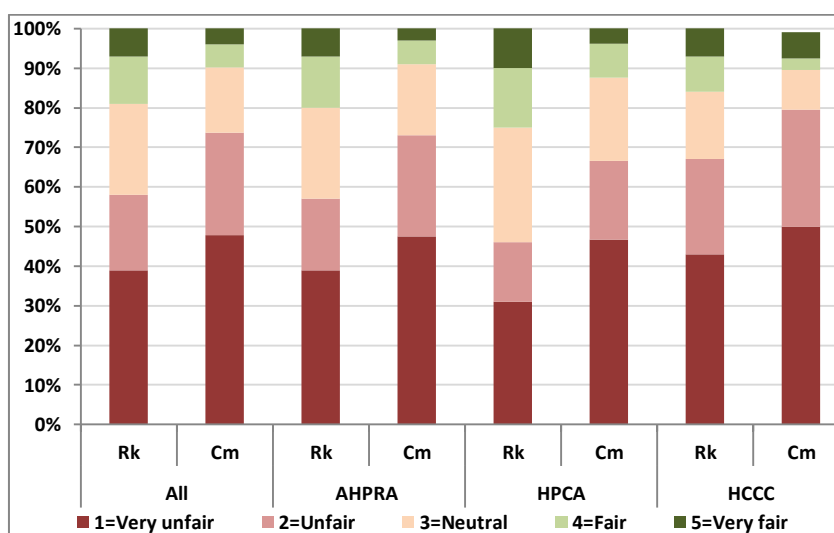


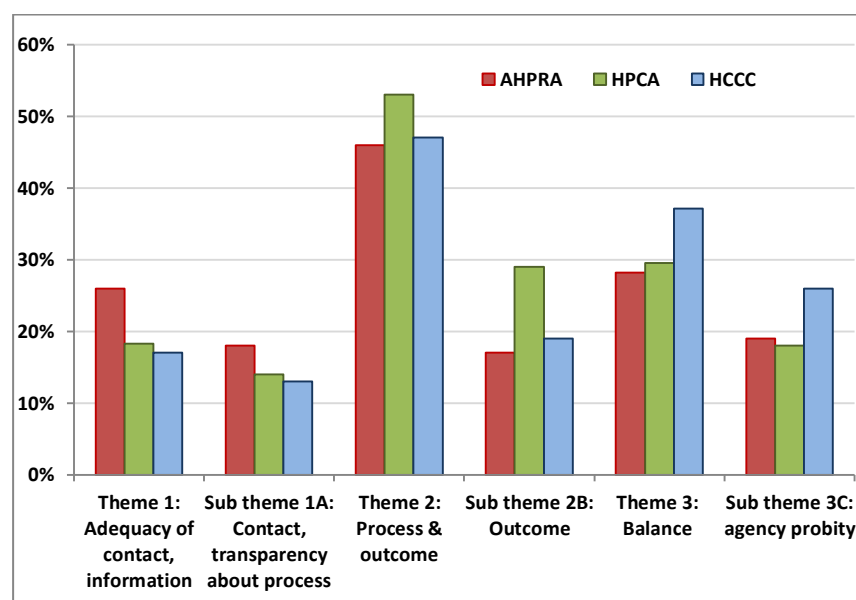
Figure 28: Survey 1: how fair was the process: comparing the proportion of ranked responses (Rk) and coded comment (Cm)

Three main themes emerged (Table 61) [A6.3.4] with 22 percent of comments about the extent of contact and information (Theme 1); 47 percent about the process or outcome (Theme 2) and 30 percent about the balance or attitude of the agency (Theme 3).

Table 61: Survey 1: thematic categories of survey comments: whether the process was fair

1. Adequacy contact; information	1. Process & outcome	2. Balance & attitude
1A=Level of transparency, contact, engagement about process 1B= Adequacy or detail of information provided about decisions and reasons	2A= Assessment of evidence, understanding of issues; adequacy of investigation 2B= Outcome 2C=Able to view, respond to practitioner statement; appeal 2D=Process other comment including timeliness	3A=Level of seriousness, interest, courtesy, helpfulness 3B=Decision based on false information from practitioner 3C=Perceived agency probity; assumption practitioner credibility

A modest degree of variation was found in the reasons (Fig.29) with AHPRA having a higher proportion of comments about transparency and communication; HPCA to outcomes; and HCCC to agency probity and assumed practitioner credibility.

**Figure 29: Survey 1: how fair was the process: thematic comment by agency**

6.3.1.1 Theme 1 comments: adequacy of contact and information

Nearly three-quarters (N=124) of comments related to transparency, contact or information about the process. Over half (58%) ranked this theme ‘very unfair’ or ‘unfair’ and one-third neutral. [A6.3.5] The majority (70%) concerned AHPRA and included reference to the exclusion of the complainant from the process:

“The process was more or less divorced from the person(s) affected by the doctor’s conduct. Undoubtedly inquiries would have been made with the subject doctor; however, there was no engagement with the aggrieved party and just a receipt and vague outcome email to the informant.” (Ref 1347)

“I was told that once I made my notification, I was just a witness. This is very unfair. This was about me, I was the victim but I was completely excluded.” (Ref 1001)

However, comments about inadequate information about the process applied to all agencies:

“How can you really say when no one communicates the process?” (Ref 559 AHPRA)

“It is impossible to tell; how would you ever know? On the basis of lack of transparency though, I would have to say it wasn’t fair.” (Ref 1039 HCCC)

“How would you know if the process is secret?” (Ref 409 HPCA)

In contrast, some of the higher ranked responses noted the clarity of process or opportunity to make input [A6.3.1]:

"Both parties were given a good opportunity to comment." (Ref 1421)

Some commented on the need for contact at the beginning of the process:

"A telephone interview should be mandatory so that I could clearly state my case. Some things were lost in jargon or misinterpreted or misunderstood because of the confines of writing factual information on a report." (Ref 1216)

"I think the Commission should have contacted me as well, paper information can't get across all the information." (Ref 444)

For others, the opportunity to ask questions at the end was important:

"I would say unfair as you were given a cursory response and had no opportunity to ask and have provided answers to the questions posed to AHPRA." (Ref 1525)

The balance of comments (27%) in Theme 1 related to the adequacy or level of detail provided about outcomes or reasons for decisions.¹²¹ The majority of comments (76%) again related to AHPRA but the nature of commentary was consistent across agencies. Lower ranked (negative) responses centred on inadequate information about reasons for decisions or a combination of dissatisfaction with the process and outcome reasons:

"The reason for failure of process [procedure] not given. If not incompetence or negligence, then what?" (Ref 1662 Rank 2 AHPRA)

"No CLEAR (sic) explanation given as to why no action to be taken... the steps and rationale that led to this decision were not clear and transparent." (Ref 785 Rank 2 HCCC)

"I never had the opportunity to address the Board in person. I am still unaware of the precise rationale behind the Board's decision. It was a long process, culminating in a short 'verdict letter.'" (Ref 1103 Rank 2 AHPRA)

This type of comment is also seen in mid-range comments e.g.:

"We don't know how fair the process was because we don't know reasons or criteria used to reach the decision." (Ref 1242 Rank 3 HCCC)

However, mid-ranked responses also include observations about processes being fair notwithstanding dissatisfaction with not being provided with reasons for decisions. This occurred even in cases when action may have been taken:

"The investigative process was thorough and appeared to rigorously investigate the complaint, but as I have not been allowed a copy of the report I have no idea what recommendations if any were made." (Ref 276 Rank 3 AHPRA)

"The process of me making the complaint, the doctor responding and me being able to counter respond was fair, however I have no opinion as to whether the decision was fair as I have not been given enough information about why the board made the decision to caution the doctor." (Ref 1531 Rank 3.AHPRA)

"The process may be fair but this does not mean that the results of the process are well communicated." (Ref 1480 Rank 3 HPCA)

Only two comments made in this sub-theme were ranked 'fair' – one commenting on the lack of information about the outcome; the other that reasons were provided.

¹²¹ Comment on outcomes (as opposed to information about outcomes) is discussed in Theme 2.

6.3.1.2 Theme 2 comments: process and outcomes

Nearly half (47%) of all comments about fairness related to the process or outcome; nearly three-quarters (73%) ranked 'unfair' or 'very unfair'. Two-thirds relate either to the adequacy of the assessment or investigation process (N=102); or the outcome (N=140). The balance concerned the ability to see or respond to the practitioner's response; to appeal outcomes; or other process issues.

Assessment of evidence and adequacy of investigation

Concern about evidence not being tested; inadequately investigations or failure to seek submissions from the complainant featured in 29 percent of comments [A6.3.6]:

"I was not given the chance to submit supporting evidence where there was conflict between my statement and the doctor's." (Ref 1393 Rank 1 HCCC)

"How fair can it be if the practitioner denies complaint and AHPRA simply accepts that without consideration to evidence provided to [the] contrary or request for more information or clarification from notifier?" (Ref 212 Rank 1 AHPRA)

One 'very fair' comment noted: *"They got all the information and investigated."* (Ref 875)

In contrast, comments ranked negatively referred to evidence being ignored; witnesses not being contacted; and issues not being understood or addressed:

"At no point was I interviewed to discuss my complaint and the wrong questions were investigated due to misinterpretation of my complaint statement." (Ref 1082)

"When I got my letter of no further action, the questions they had assessed and put to the practitioner was only part of my original complaint - they left out the major concerns...and these were not assessed." (Ref 1352)

"The reasons provided in the 'Outcome of investigation' letter reflect bias in favour of the practitioner, a lack of understanding of the situation and issues, and unfounded conclusions." (Ref 1388)

One respondent suggested a strategy to address this:

"Good but limited by a missing step in the process. A complaining candidate should have a form to sign to say that they have been adequately heard." (Ref 1726 Rank 4 AHPRA)

Another commented that:

"The complaint listed almost [number] witnesses, none of whom were ever spoken with or contacted during the complaint. I was asked to provide a lot of explanations in writing which I did but witnesses were uncomfortable and instead asked to be phoned. The process would be fairer if it was made clear that no one would be interviewed." (Ref 91 Rank 3 AHPRA)

Outcomes

Thirty-nine percent of comments concerned outcomes. Similar comments were made across the agencies; these appearing in Rankings from 'very unfair' to 'very fair'. [A6.3.7] Some related to a perceived disconnect between the seriousness of the issue or evidence and the outcome; others were concerned about the safety of others:

"The final outcome...does little to satisfy my main objective – to ensure safe and "good" standards of care to patients of this practice. The process has been "unfair" in failing to address this concern." (Ref 500)

"The practitioner was under supervision at the time of the breach, and was required to be under supervision in the future. I don't see how this will protect future patients. The committee commented on his lack of remorse and empathy." (Ref 1671)

Some said they did not understand why the agency took 'no action' when significant adverse outcomes had occurred:

"AHPRA process fair, but result was a slap on the wrist for a death." (Ref 206)

"How could so much information be supplied spanning many, many incidents [over 3 years] and not one single item identified as a concern? After a death?" (Ref 569)

"Despite all the documented proof, no action was going to be taken. My life has been changed by a negligent specialist and nothing is being done. I am treated disrespectfully and his actions have no consequences for him. I am afraid many of his patients may be in a similar situation but nobody gives a damn." (Ref 1203)

Others noted the perceived inadequacy of outcomes and accountability:

"I don't think the specialist was held accountable for patient's lack of care and trainee doctor received a slap on the wrist" (Ref 149)

"Altering treatment records; hiding X-rays...causing patients' money and tooth loss is CRIMINAL (sic). Putting a condition on registration is really a joke." (Ref 648)

"I was surprised and unhappy to learn that both practitioners were still working, and that though they were given warnings/suspended for an amount of time, this was not public knowledge and they were able to work elsewhere without any repercussions." (Ref 38)

Some were more equivocal about the result e.g. *"At least they looked into the matter though I don't think the psychologist got enough to stop them"* (Ref 1636); or could see an impact of the process- *"The case was hard to prove but the offender at least knows now he is being watched."* (Ref 1499) Others however, regarded the outcome as appropriate:

"I don't know what the findings were, but ...if [the pharmacist's behaviour] was inappropriate then I think a warning is a fair response." (Ref 1144)

"Outcome for staff members appeared to be reasonable and take all matters into consideration." (Ref 1183)

"I had a good outcome and happy with the process." (Ref 1534)

Others thought the result appropriate given the limited information available to them:

"If I read the outcome right and relevant actions were taken (from what was stated might occur), then yes I think it was fair." (Ref 901)

Opportunity to read the subject practitioner statement and respond or to request a review

Thirteen percent concerned the ability to read and respond to the practitioner's statement. The majority (89%) of comments were ranked 'very unfair' or 'unfair' with AHPRA accounting for three-quarters of them. Only one respondent said they had the opportunity to view or respond to the practitioner's statement. [A6.3.8]

Timeliness

Six percent of Theme 2 comments related to timeliness; the majority (86%) to AHPRA.

[A6.3.8] Most time-related feedback concerned delays and the length of time taken by the process; some observing this was unfair to both complainant and subject practitioner:

"As [the] person making [the] complaint and experienced I accept the known time to complete investigation and process. If I was under investigation the timeline from complaint to outcome would be unacceptable." (Ref 604)

"Bureaucratic delays in the complaint handling process imposed significant hardship on the complainant and the practitioner." (Ref 975)

"The process was probably fair, but the major time delays badly impacted on the life of my patient, and their mental health." (Ref 432)

Some reported insufficient time to respond:

"The process felt rushed. It was like information was thrown at me, with no explanation or time for me to consider it before my case was closed." (Ref 359)

Others however were more accepting:

"A long process, but to obtain a good result for all involved it will naturally take time." (Ref 242)

Lack of timeliness was associated with both unfairness and risk:

"The delay in responding to my concerns was unreasonable, and the delay in taking any action with the practitioner resulted in continuation of potential harm to the community and did not deal with an allegedly failing practitioner in a fair and timely manner." (Ref 1505)

Other comments about the process

Both consumers and practitioners found the process challenging for a range of reasons

[A6.3.8]:

"It was complicated, confusing and took a lot of effort to even find out where and who I needed to lodge the complaint with initially...this is why many don't bother because it's all too hard." (Ref 1495)

"Once the case was taken to the tribunal, the experience, which was already overwhelming, became much more so. Once lawyers were involved the process became much more difficult to understand." (Ref 1390)

"I think that the process of reporting a colleague is very intimidating as there is no opportunity for anonymity. This prevents, I think, some worthwhile complaints being made." (Ref 1084)

"It is unfair that doctors who have illness issues are treated to a different set of standards than any other member of society. The forms required to be completed were

poorly designed for sick doctors. The emphasis is on "complaint" and "complaining" - there should be an alternative process for reporting sick doctors and how this is dealt with..." (Ref 1371)

The influence of other systems was also raised, such as Family Court jurisdiction that impact on whether a complaint will be accepted; and access to resolution or conciliation processes. That practitioners or their employers could ignore or not respond to requests for information were concerns expressed about the national and NSW systems:

"The hospital is not obliged to comply unless they want to. The process by HCCC is satisfactory, but it is incredible that the hospital cannot be called to account for his [the doctor's] actions." (Ref 1092)

In contrast, others were more positive about their experience with the process:

"Fair in that the process both addressed my concerns and gave the practitioner the opportunity to address these concerns in the early stages of the complaint. Therefore, fair for both parties concerned." (Ref 1151)

Finally, some referenced fairness in terms of their decision to make the report to the agency:

"Mandatory report. Consider that I did the correct thing for the doctor involved and [the] general public." (Ref 1029)

"I was concerned about the health practitioner's state of health and disappointed with their inability to co-operate with me as the employer. I didn't think the practitioner was well enough to practice and needed to be independently assessed." (Ref 1381)

6.3.1.3 Theme 3 comments: perceived balance and attitude of agencies

Nearly one-third (N=226) commented on balance and attitude; with the majority of remarks ranked 'very unfair' (59%) and 'unfair' (26%). Twenty percent related to whether the complaint or the complainant was taken seriously [A6.3.9]:

"The issues I raised (which were important to me) were of no interest to those I complained to." (Ref 1019)

"I was treated like dirt. My complaints [were] misunderstood and then I was blamed for the lack of cogent understanding displayed by the individual's assessing my complaint." (Ref 980)

There were also positive comments:

"[they] took the complaint very seriously and they work hard to try solve the issues." (Ref 283)

Others communicated that the agency displayed a lack of sensitivity regarding the events:

"No consideration for the psychological impact of hearing that the matter is closed and no action taken after you've had trauma. No kindness." (Ref 271)

"Assessor did not consider all relevant information and informed me that I should "Just get over it and move on"." (Ref 364)

Eighty percent of comments related to two closely related points- decisions based on false information provided by the practitioner or their representative (12%); and more commonly, the agencies lacked balance or were biased (68%).

Two-thirds of comments about false information related to medical practitioners; most referring to 'lies' and 'false information', some linked to a lack of opportunity to respond to the information provided by the practitioner; and all but three were ranked 'very unfair' or 'unfair'; even one of the higher ranked commenting:

"Based on the Doctor's reply to the complaint the outcome was fair. However, the answer he gave was inconsistent with the truth." (Ref 1173; Rank 4)

The proportion of comments about a balanced outcome was higher for the HCCC (26%) than the other two agencies (18-19%). However, perceived bias and the favouring or protecting of practitioners applied to all:

"There was an inbuilt assumption that everything that was said by the doctor was true." (Ref 130 Rank 1 HCCC)

"Their preferred [approach is] to believe the word of a respected doctor and not a mentally ill and chronically disabled individual." (Ref 509 Rank 1 HCCC)

"It was word against word. It appears to me that that the practitioner's representatives held a higher value than mine." (Ref 1470 Rank 2 HPCA)

"Extremely dissatisfied with the process. The doctor's denial of facts is expected. The committee accepts the doctor's denial. It is evidence and medical practitioner's submission is accepted as having substance over and above a notification. There is no enquiry or recourse for the complainant." (Ref 393 Rank 1 AHPRA)

"AHPRA liaison admitted during phone conversation that they "assumed" his claim...was true and correct. This opinion was based on the belief that this was standard practice, rather than an actual audit, visit or check of any kind." (Ref 846 Rank 1 AHPRA)

Others raised questions about public safety in terms of whether the process was fair:

"Fair to whom? This should have been about the safety of the public/and this patient. Only fairness considered was to the doctor." (Ref 173 Rank 3 HPCA)

"Protecting the doctor could mean it will happen to others. Fair for the doctor but not the patient." (Ref 300 Rank 1 AHPRA)

"AHPRA were very supporting of the pharmacist throughout the case and did not want to take corrective action of poor practice. If this activity/lack of activity occurs across the country then the Australian public are at major risk." (Ref 1528 Rank 1 AHPRA)

The extent to which outcomes are available influenced some responses:

"I had fair opportunity to document my complaint, the doctor was able to respond and I believe they investigated the complaint. The fact that the caution against the GP is not recorded is particularly fair to the doctor - not so sure it is fair on future patients though." (Ref 1490 Rank 3 AHPRA)

Concerns of this type featured in complaints made by health practitioners as well:

"I felt that the main emphasis of the investigation was to protect the practitioner, not to reach an objective assessment of their practice. The concerns I raised were about patients who had had very poor outcomes from procedures. As I am in the same field I could compare my patients' outcomes and they were much better. I do not think this was taken into account. I think the investigation and decision depended far too much on what the practitioner replied. I never received any feedback regarding what the practitioner had answered, even though [they were] given a copy of my complaint." (Ref 921 Rank 2 AHPRA)

However, others identified problems with the profession itself and not necessarily the agencies:

“How can it be fair when the HCCC is so limited in this field and relies on the use of peers – how many peers speak against their own profession?” (Ref 743 Rank 1 HCCC)

“Very fair to the [practitioner] concerned. The HCCC is fighting with one arm tied up as the profession won't support an HCCC initiated complaint against a colleague, and few are prepared to support a complaint.” (Ref 1240 Rank 3 HCCC)

6.3.2 Was the respondent treated respectfully?

Forty-two percent reported that they were treated either *reasonably*- or *very*- respectfully by the agency handling their complaint, with a similar proportion reporting no or minimal respect being shown. (Table 62) [A6.3.10] Responses were similar for AHPRA and the NSW agencies, with a slightly higher ‘*very respectful*’ response given for the HPCA. ‘*Not shown any respect*’ was higher for complaints relating to medical practitioners. [A6.3.11]

Table 62: Survey 1: whether the respondent was treated respectfully: Likert scale responses

	Rank 1 Not shown any respect		Rank 2 Minimal respect shown		Rank 3 Neutral: no opinion either way		Rank 4 Reasonable amount shown		Rank 5 Treated very respectfully	
	N	%	N	%	N	%	N	%	N	%
ALL	388	23	267	16	330	20	346	21	357	21
AHPRA	249	25	173	17	192	19	206	20	197	19
NSW	139	21	94	14	138	21	140	21	160	24
HPCA	53	19	36	13	63	23	52	19	74	27
HCCC	86	22	58	15	75	19	88	22	86	22
DR	275	27	173	17	181	18	198	20	189	19
All excl. DR ¹	113	17	94	14	149	22	148	22	168	25

[1] All professions excluding medical practitioners

Thirty-three percent (N=565) gave reasons for their ranking; 94 percent relating to the agencies. The proportion of comments compared with rankings was larger in Ranks 1 or 2; although comparable in the case of ‘*very respectfully*’ treated. (Fig.30) [A6.3.12]

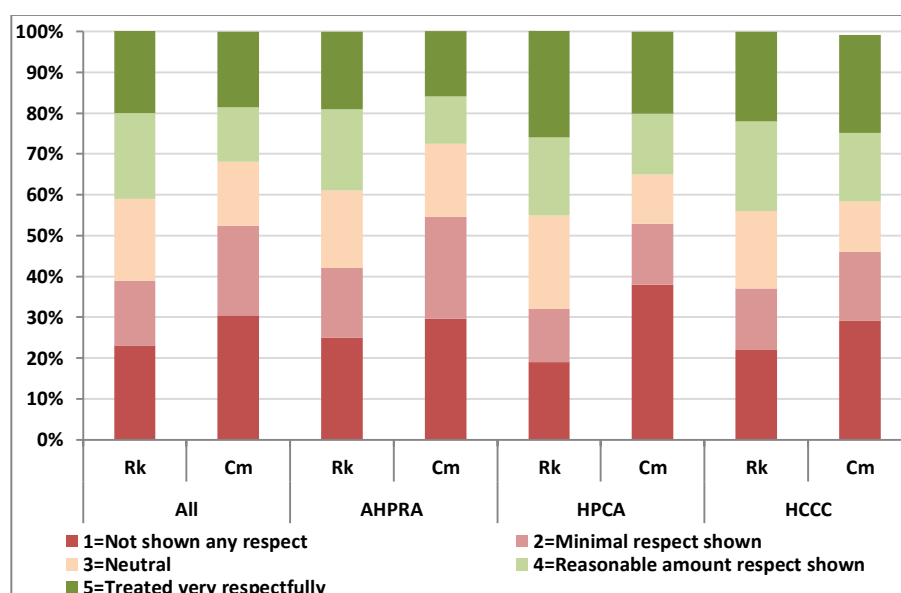


Figure 30: Survey 1: was the respondent treated respectfully: comparing the proportion of ranked responses (Rk) and coded comment (Cm)

Three main themes were identified. (Table 63) [A6.3.13] Twenty- three percent concerned the extent and adequacy of contact and information (Theme 1); 20 percent the process or outcome (Theme 2) and 57 percent balance or attitude (Theme 3).

Table 63: thematic categories of survey comments: whether the respondent was treated respectfully

1. Adequacy contact; information	2. Process & outcome	3. Balance & attitude
1A=Level of transparency, contact, engagement about process 1B= Adequacy or detail of information provided about reasons, decisions	2A= Assessment of evidence, understanding of issues; adequacy of investigation 2B= Outcome 2C=Other process, including ability to view practitioner statement; appeal	3A=Level of respect, seriousness, interest, courtesy, helpfulness 3B= Agency probity; whether parties treated equally [1]

[1] A separate category was not created for *false information from practitioner* as in other questions as this accounted for only a few responses

Thematic responses were similar for all agencies except the HCCC had a higher proportion of ‘*balance and attitude*’ comments and fewer ‘*adequacy of contact.*’ (Fig.31)

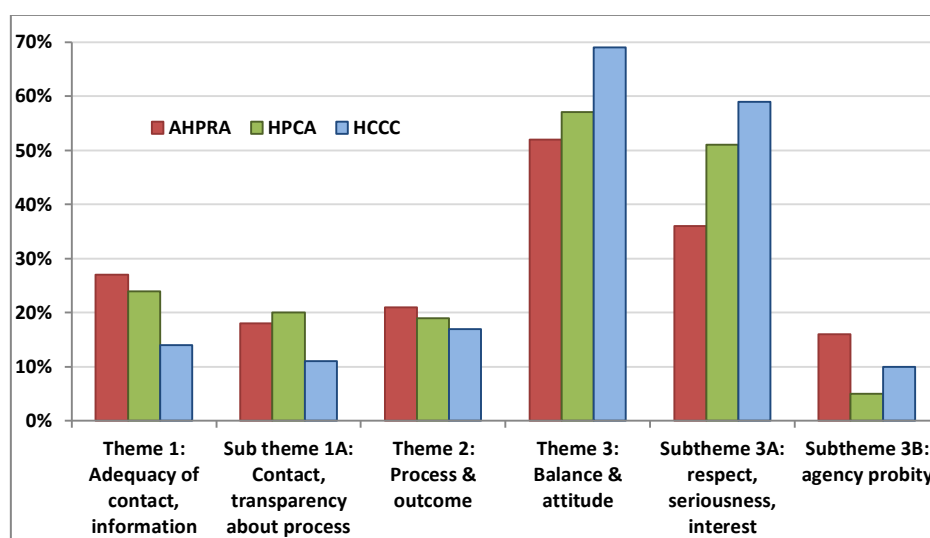


Figure 31: Survey 1: was the respondent treated respectfully: comment themes by agency

6.3.2.1 Theme 1 comments: extent of contact and adequacy of information

Over two-thirds (70%) of Theme 1 comments related to transparency and adequacy of contact [A6.3.14]; with approximately half ranked ‘*minimal*’ or ‘*no*’ respect shown:

“It was an effort by AHPRA staff to even speak with complainants.” (Ref 666)

“Communication was so minimal and rare as to be insulting.” (Ref 130 HCCC)

“I wasn’t shown even the respect of a response to my complaint” (Ref 1530 HPCA)

“The lack of communication was disrespectful, though the occasional communication I received was respectful enough.” (Ref 432 AHPRA)

These issues were also raised by those who were ‘*neutral*’ in their ranked response, but others reported a more variable experience in relation to AHPRA:

“I was treated very well with my telephone interview, but then poorly in regards to not being advised the board was sitting and not being given the result until I asked about it.” (Ref 1531)

“The case updating was poor (this being contrary to the initial meeting where the opposite was promised).” (Ref 1103)

In contrast, respondents indicating they were treated ‘reasonably’ or ‘very’ respectfully reported:

“I was notified of the ongoing investigation through letters that were written in a professional manner, showing consideration for how I may be feeling.” (Ref 1295)

“I was shocked at how well it was handled and how I was treated excellently.” (Ref 875)

Some focused on a lack of follow up or clarification of issues:

“I was not informed or called to verify vital information during the whole process.” (Ref 167)

“I was never consulted and yet told my ongoing issues were not related to surgery...and the surgeon always acknowledged the issues were as a result of surgery.” (Ref 1403)

“No attempt was made to talk to me to discern whether my interest was simply in bagging a Dr or looking at broader systemic issues in her practice that could lead to patients being damaged.” (Ref 388)

The balance of comments in Theme 1 (30%) concerned information about decisions [A6.3.15], with the majority referring to AHPRA (79%). Responses ranked from ‘no respect’ to ‘reasonably respectful’ expressed similar concerns about all agencies:

“My family and I put countless hours in compiling submissions in support of our complaint, only to be reciprocated by thin responses by AHPRA.” (Ref 1103)

“I am a pharmacist...at least the committee should give some information on why they think it is appropriate to use such a combination [of medications]. Not just saying they think it is appropriate and that's it.” (Ref 1113)

“It was a very limited response to a complex issue that was a comprehensive complaint. I wouldn't be surprised if it was a template style response.” (Ref 836)

“AHPRA never give any information about incidents or persons involved, hiding behind the guise of confidentiality but expecting organisations to divulge all.” (Ref 579)

Two related to a more positive experience:

“All letters were polite, to the point, and to my mind told me everything that a lay person would need to know.” (Ref 1144)

“All questions I asked were answered with full explanation and in detail.” (Ref 242)

6.3.2.2 Theme 2 comments: process and outcome

Twenty-five percent of comments covered the assessment of evidence or adequacy of the investigation; 32 percent about the outcome and 43 percent about other aspects of the process. [A 6.3.16]

Some very positive comments were made about actions and outcomes:

“Yes, AHPRA did a good job.” (Ref 1726)

“The matter was dealt with appropriately and undertakings given to remain in hospital [to receive treatment].” (Ref 528)

But other comments were more mixed:

"The HCCC staff were always polite, courteous and helpful. I just think that it is a bureaucracy that doesn't have any real power and doesn't want to upset the status quo." (Ref 1715)

"Only some issues were addressed - those that he could use records to justify his actions (even though the records did not truly reflect his treatment of me)... I felt like my concerns were trivialised then dismissed or ignored." (Ref 1142)

"No respect, no empathy, no consideration, no appreciation of what I had endured or the energy and effort expended for [to make a] complaint mainly to protect other patients from harm." (Ref 1583)

Some reported a lack of support during the process; although others identified challenges associated with their own circumstances rather than the agency per se:

"I was humiliated, confused and intimidated at the panel presentation." (Ref 1269)

"Too ill at times to fully understand some issues." (Ref 53)

"The AHPRA people were miffed that I did not get the patient's consent to make the report about the psychologist, even though they [the patient] were [outline of serious condition] and about to be admitted to hospital for [name of procedure]." (Ref 780)

Others reported on the negative impact of the process:

"Absolutely not [no respect], left absolutely devastated. Our family are still undergoing extensive counselling regarding this incident including how our complaint was handled which caused further distress." (Ref 771)

"It took great courage to speak out against the doctor but would I go through this process again? No!" (Ref 296)

Some practitioner complainants said their experience put them off ever making a complaint, particularly when 'counter complaint' was made:

"The irony of this notification was that I ended up being notified to AHPRA." (Ref 926)

"Treated poorly- asked to respond to unfounded allegations the practitioner [complained about] made about me." (Ref 1926)

"The complaint made against me by the practitioner I complained against was clearly vexatious. It was solely made in response to my original complaint. This was not acknowledged by AHPRA. I was not supported or even contacted in making my response to it. I had to inform AHPRA that the complaint against me was entirely responsive to my complaint." (Ref 1164)

Different experiences of anonymity were also reported:

"I did not realise making an anonymous mandatory report that it would be harder to investigate as I declined to write a letter re the incident. I work in a small unit. Had I made myself known this would have made working there very difficult." (Ref 567)

"Initially I was told that my name as reporter had to be revealed, which would have put me in a very difficult situation in relation to the practitioner, but later I was told that my name would not be revealed." (Ref 1689)

6.3.2.3 Theme 3 comments: balance and attitude

Over three-quarters (77%) of Theme 3 related to perceptions about the degree of seriousness, interest and respect shown, with half of the responses ranked positively (treated ‘reasonably’ or ‘very’ respectfully); one-third ‘very’ respectfully. [A6.3.17] These were made about all agencies:

“The person who handled my complaint was fantastic. Very good to talk to and understanding.” (Ref 1491)

“Absolutely, and professionally. Very, very helpful in stressful circumstances” (Ref 1344)

“From the first phone call put at ease and shown most respect. Didn't feel like I was making trouble for anyone.” (Ref 640)

One noted in relation to the national process:

“Staff are pleasant and helpful during phone calls. They appear to be frustrated by the legislation that prevents them from providing feedback.” (Ref 580)

Others’ responses, with neutral and positive rankings were mixed – reporting different experiences according to personnel involved; others distinguish how they were treated personally from the process:

“Lady I spoke to who handled my case was lovely but the man in the resolution Centre made me not want to continue.” (Ref 450)

“Some people treated me respectfully, others showed no respect. It depended on the individual.” (Ref 370)

“I was treated with respect, however the matter was not treated with respect.” (Ref 785)

Those who reported receiving ‘no’ or ‘minimal’ respect said they experienced a non-empathetic or disinterested response; others felt “dismissed”, “fobbed off” or “talked down” to; these views applying to all agencies:

“They were polite. Did they display urgency or empathy?, no” (Ref 413)

“Treated like an old fool.” (Ref 345)

“I was not taken seriously at all.” (Ref 735)

“I felt like a bug on a windscreen, nothing. I felt the only way to get credibility would be to gain a PHD.” (Ref 736)

Others said they felt that their complaints were (inappropriately) considered as symptom of their emotional state or illness:

“Said I was emotional; [their] reason conflicted.” (Ref 251)

“I object to my complaint being treated as a symptom of a “distressed and emotional circumstance”. My prime objective was and is to ensure that lessons have been learned from my [relative’s death] and that no other family will suffer through the misinterpretations and inattentions of attending medical staff. I have no such confidence.” (Ref 1332)

“I feel that because I had a psychiatric illness it is assumed that I have little intelligence, however my GP who was involved in my treatment throughout can attest

that I was not your typical tranquilised depressed person, I was and still am very high functioning.” (Ref 82)

The remainder of comments in this theme (23%) related to whether the process was balanced. [A6.3.18] Regardless of ranking (*‘no respect’* to *‘very respectful’*) the perceptions were primarily indicating bias of the agency:

“I was never given the feeling that they were taking my complaint seriously and were too mindful not to upset the doctors.” (Ref 1312)

“Dismissive, arrogant, total presumption doctor is correct, simply because he has a “right” – which should never be questioned.” (Ref 338)

“I do not consider the bodies review of the complaint done in a professional manner. Trying to remain objective it reads as best as: forward complaint to Doctor; very loosely relay Doctor's response as accepted investigation of complaint and conclusion of complaint therein.” (Ref 1211)

Some linked perceived bias to the seniority of the practitioner involved:

“Superficially professional. AHPRA Board had little regard for my complaint; possibly due to the very high management role of the offender.” (Ref 570)

Others felt the presumption in favour of practitioners meant they were regarded as untruthful:

“No respect when you are assumed to be lying.” (Ref 913)

“The final letter says it all. As I said I appear to have been assessed as a liar or stupid.” (Ref 920)

“I believe I've been politely called a liar.” (Ref 1527)

Summary of Sub-section 6.3: balance

A significant 60 percent of respondents rated the process as *‘unfair’* or *‘very unfair’*. These responses were similar for AHPRA and NSW although more marked for the HCCC; and complaints about medical practitioners (two-thirds) compared with all other professions (less than half).

Components of fairness included whether parties were treated equally; assumption of practitioner credibility; and the level of seriousness or interest demonstrated. Other factors included accepting inaccurate or false information from practitioners without challenge or opportunity for the complainant to comment on or refute the information; and amount of information provided to complainants.

Rankings for the level of respect shown are more positive, with over 40 percent of respondents indicating they were treated with a *‘reasonable amount of’* or *‘very’* respectfully. However, comments reflect concerns expressed in previous questions, including lack of or insufficient contact and information, including reasons for decisions; inadequate inquiries and investigation; and perceived unfairness.

6.4 Impact on health and barriers to making complaints

Respondents in Survey 1 were asked if the process had an effect on their health. Even though organisations were requested to select '*organisation- not applicable*', 94 percent of organisational respondents answered this question; with only 10 percent indicating the question was not applicable. Therefore organisational responses are also presented.

Just over one-third reported no ill effects ('*not affected at all*') but some 40 percent said they were '*significantly*' or '*very significantly*' affected. Over one-quarter said it had a '*slight*' or '*some*' impact.¹²² (Table 64) [A6.4.1] The AHPRA and total NSW responses were similar; however, the HPCA attracted a higher '*health not affected at all*' response. Doctors accounted for three-quarters of responses indicating a '*very significant*' impact on health and over two-thirds reporting '*significant*' impacts; both in the national and NSW schemes. [A6.4.2]

Table 64: Survey 1: impact of the complaint/notification process on health: Likert scale responses

	Very significant impact on health		Significant impact on health		Some impact on health		Slight impact on health		Health not affected at all		Not applicable organisation	
	N	%	N	%	N	%	N	%	N	%	N	%
IND & PRACT¹	360	25	231	16	272	19	181	13	401	28	NA	NA
<i>Including orgs.</i>	362	22	236	14	282	17	199	12	570	34	23	1
AHPRA	208	21	140	14	166	17	118	12	354	35	16	2
NSW	229	21	162	15	183	16	131	12	390	35	18	2
HPCA	54	20	34	12	40	15	31	11	110	40	6	2
HCCC	100	25	62	16	76	19	50	13	106	27	1	<1
DR	268	26	161	16	191	19	122	12	266	26	7	1
All excl. Dr ²	94	14	75	11	91	14	77	12	304	46	16	2

[1] Individual and practitioner respondents only

[2] All professions excluding medical practitioners

Twenty percent (N=122) who reported a '*very significant*' or '*significant*' impact experienced an adverse outcome; and accounted for nearly half of cases identified as involving a death (N=50 of 104) and those involving a medico-legal matter (N=53 of 110).¹²³

Those reporting '*very significant*' impacts selected '*complaint responses*'¹²⁴ more frequently than other respondents (39% compared with 23%); and to a lesser extent, issues involving '*care or treatment*', '*conduct*' and '*communication*'. (Table 65) [A6.4.3] The only notable outcome difference was a higher proportion of '*no action*' reported (77% compared with 60% for all respondents).

¹²² The figure for '*not affected at all*' was lower (28%) when organisational responses are excluded. For the remaining categories of responses however (had '*slight*' to '*very significant*' impact on health), excluding organisational responses resulted in similar outcomes.

¹²³ A specific question was not asked about death, cases identified through survey comments. Similarly 'medico-legal' matters were identified through survey comments and included workers compensation and Family Court related matters.

¹²⁴ Examples of '*complaint responses*' included lack of complaint process; being listened to but having no further action; not receiving any response; receiving a hostile or angry response; being punished for complaining.

Table 65: Survey 1: main issues raised by all respondents and by respondents reporting health impacts

Issues	Care, treatment		Conduct		Communication		Competence		Complaint response	
	N	%	N	%	N	%	N	%	N	%
All responses	984	57	806	47	692	40	538	31	393	23
All resp. DR only¹	693	66	484	46	482	46	330	32	261	25
Very significant impact	253	70	200	55	190	53	128	35	140	39
Significant impact	157	67	118	50	112	48	81	34	70	30
Slight, some impact	301	63	218	45	211	44	158	33	108	23

[1] DR only included given high proportion of 'significant' and 'very significant' effect responses involving medical practitioners

Of the 50 percent (N=829) of respondents providing comments; 60 percent (N=496) related to the agencies; the balance (N=333) to the practitioner or original events.¹²⁵ The proportion of agency-related comments reporting 'very significant' (33%) or 'significant' (20%) impact is similar to those reporting 'some' (27%) or 'slight' (20%) impact. In contrast, three-quarters of comments about original events or the practitioner report 'very significant' (49%) or 'significant' (26%) impacts.

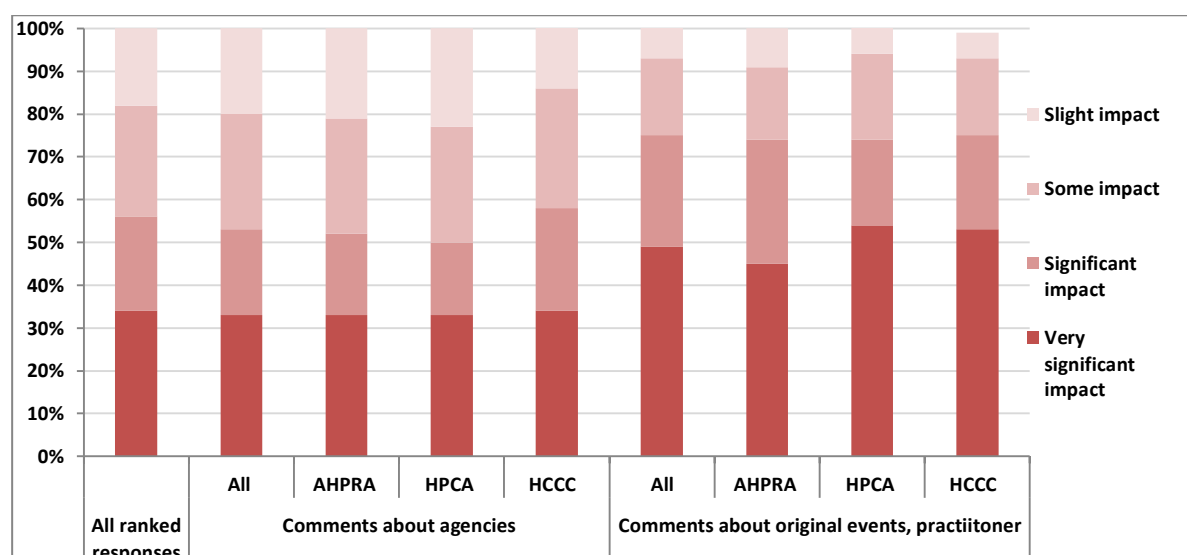


Figure 32: Survey 1: coded comment for impact on health excluding 'not affected at all' responses: comments about agencies compared with comments about original events or subject practitioner

[1] Seven percent of comments from respondents who said their health was not affected were about the agencies and another seven percent about the original events or practitioner subject of the complaint

6.4.1 Survey 1: comments about the agencies

Two main themes emerged with 58 percent describing impacts (Theme 1) and 42 percent describing how the process or outcome affected the respondent. (Table 66)

Table 66: thematic categories of survey comments: whether the process affected the respondent's health

1. Affected self or other - comment on manifestation	2. Process and outcome
1A=Physical or mental symptoms reported	2A1= Fear or experience of repercussions
1B= Process exacerbated original symptoms or recalling original events	2A2= Mandatory reports
1C= Acting for or impact on other	2B= Outcome

¹²⁵ In most indicators, over 95% of reasons given for ranking ('comments') relate to the regulatory agencies (i.e. are 'in scope'); with the balance relating to original events or the practitioner subject of complaint. 'Impact on health' is an exception. Of total responses (N=1698), 47 percent provided comments, with only 60 percent relating to the regulatory agency. However, including only rankings where comments were in scope results in a similar distribution of 'very significant impact on health' responses. [A6.4.4]

There was little variation in the overall comments when comparing the three agencies (Fig.33) [A6.4.5] but emerged when comparing AHPRA and NSW comments ranked ‘very significant’ impact on health (Fig.34). NSW attracted a higher proportion of ‘symptom manifestation’ comments; AHPRA comments relating to process or outcome. The type of comments ranked ‘significant’ and very significant’ impact was similar, as discussed in the following sections.¹²⁶

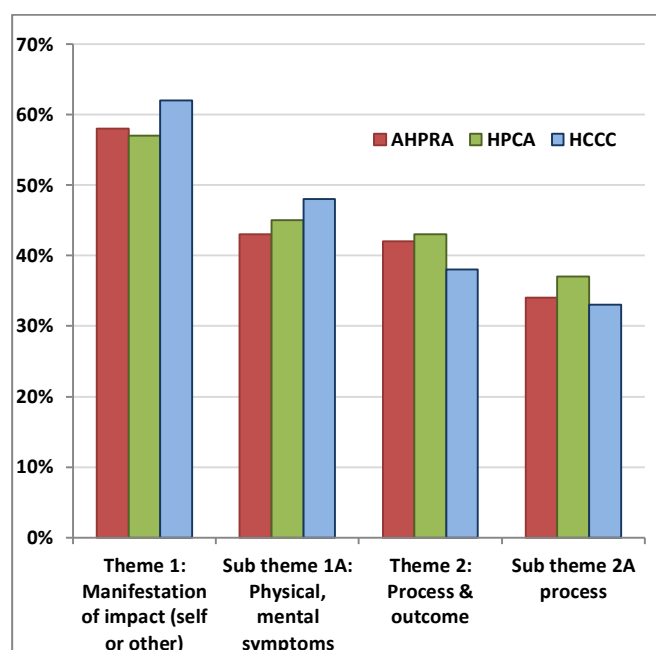


Figure 33: Survey 1: comment themes: health impact by agency

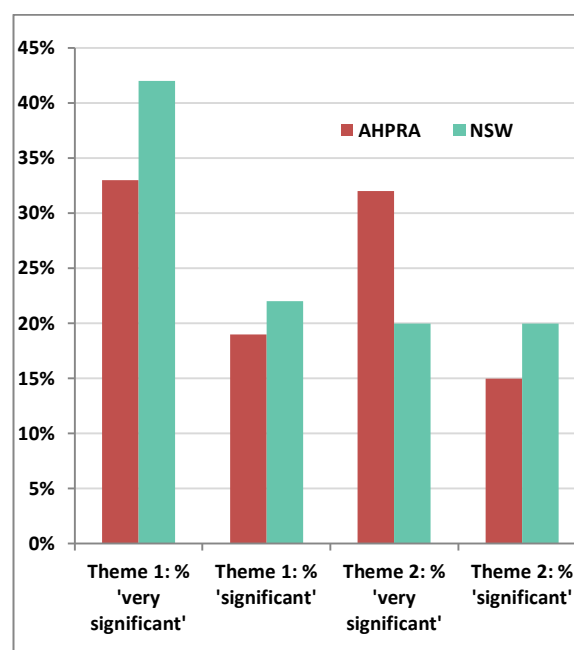


Figure 34: Survey 1: comment themes: ‘very significant’ and ‘significant’ health impact by AHPRA and NSW

6.4.1.1 Theme 1 comments: how the process affected the respondent

Three-quarters of comments were about the experience of physical or mental symptoms (N=217); and another 10 percent (N=51) said the process or recalling events exacerbated their existing conditions.

‘Stress’ was mentioned 273 times, of which 212 (78%) related to an agency; and which appeared across all ranking levels.¹²⁷ (A6.4.6) Similarly ‘anxiety’ appeared 120 times in this question, the majority (77%) again relating to an agency:

“Very stressful and frustrating, I could not sleep and it is obvious that these issues take a toll on people’s lives.” (Ref 1318)

In addition to insomnia, health impacts included anxiety; raised blood pressure; depression; skin conditions; and interference with family and business relationships and ability to work. Reports ranged from minor to debilitating effects; the most severe being suicidal ideation,

¹²⁶ Total NSW (rather than HPCA and HCCC) figures are presented due to the small numbers involved.

¹²⁷ Stress is cited 425 times in survey responses; anxiousness or anxiety 139 times; depression 157 times; frustration 58 times; anger 151 times; and disappointment 80 times.

attempted suicide, stroke and exacerbated auto-immune, mental health and heart conditions requiring additional medication and/or surgery. [A6.4.6]

For some, the practitioner response exacerbated the situation:

"I was stressing as I did not wish [them] bad. Then [they] contacted me by phone twice after I had complained, and tried to blame everyone around [them], which stressed me further." (Ref 127)

For others, the need to recount events raised painful and distressing memories or challenges arising from the original events:

"It was very emotionally stressful because I had to raise lots of issues concerning my [relative's] treatment and [their] death by suicide." (Ref 519)

"The process was very upsetting and caused loss of sleep and difficulty concentrating - it brought back memories of all the demoralising, ineffective, frustrating post-operative consultations...anger and frustration at not being given adequate information about new and unproven surgery...restrictions on my activities and personal and working life, subsequent treatment and expenses." (Ref 1142)

The process also resulted in loss of confidence in health care and/or regulatory processes:

"Sleep, peace of mind, trust in bodies and processes to which I'd previously confidently referred clients- all disrupted." (Ref 1696)

"I lost confidence in the Health system. I feel more depressed." (Ref 825)

While infrequent, some commented on the positive benefits that raising concerns provided:

"Initially the decision to make the complaint [affected health]. Felt better after making the complaint regardless of the outcome." (Ref 133)

"Positive effect – helped me move on emotionally." (Ref 1123)

"It allowed me to get the complaint 'off my chest' and concentrate on getting healthy again." (Ref 1615)

A small proportion (8%) said their responsibilities included complaint management or they were acting on behalf of others. Respondents acting for others commented on 'small' to 'very significant' effects on relatives, patients or clients or other health professionals; making comments similar to those outlined above. [A6.4.7]

6.4.1.2 Theme 2 comments: process and outcomes

Most comments related to the process (82%); including concerns about actual or potential repercussions. These were reported by all respondents including employer complainants and covered concerns about impact on services; and reprisal in the form of harassment, counter-claims or legal action. [A6.4.8] Some health professionals said they were not affected by the process as the complaint they made was mandatory under the *national law* and part of their role or professional obligation. Others found this challenging still, notwithstanding the intent of the legislation. (Box 13) However, others commented on the adverse effect mandatory

reporting had on themselves or their relationship with a patient when they were a treating practitioner.

Box 13: Interview extract: barriers to making complaints: practitioner

Case 14

Respondent: It didn't go anywhere because I didn't want to identify the person who told me as he works at the practice. This is a really small industry, and he was afraid for his job. I called around to find out who I should complain to. The Health Department said I should contact the HCCC. I did the complaint on the Internet. A very snappy woman called me back. The HCCC had an issue about identifying the person – unless the original informant who told me could be identified, they wouldn't or couldn't pursue the matter. This was difficult as it was important for public health – not sterilising equipment. But it is hard to look into even though the Department of Health seemed interested. I understand that they [the HCCC] have to work to guidelines, but then when I thought about it and you realise the implications for public health, and it isn't good enough. What do you do when you can't identify the complainant - in this case they would have lost their job so they can't be identified, but there is a public health issue?

Other comments related to lengthy timeframes; inadequate contact and information; lack of support and perceived interest of the agency [A6.4.9]:

“Stressful when being interviewed and waiting for updates without knowing.” (Ref 1421)

“Caused me significant stress being given a life threatening medication (by mistake) and then trying to sort through such a complicated complaints process.” (Ref 1495)

“The mental trauma of the process was indescribable. Not being able to respond to arrogant statements from the doctor and not getting any closure made the whole process seem like a total waste of time.” (Ref 1216)

Practitioner complainants raise similar issues:

“Continually frustrated by the inefficiencies and lack of accountability of our national body.” (Ref 582)

“Stress and anxiety: following notification, information pertaining to my practice was called into question, a process that took eight months to conclude ‘nothing to answer’.” (Ref 67)

Complainants highlighted the complexity of issues giving rise to complaints and the mixed feelings and additional burden it placed on those who report, including significant hours and stress of compiling a complaint:

“It was one more battle I had to fight, one more stressor...there has been some tragedies in my life...and I found myself spending time thinking about something I shouldn't have had to think about... I felt violated, got advice from professionals... thought about the consequences of making a complaint vs consequences of not making a complaint.” (Ref 1355)

“I've had some serious health problems recently. The frustrations of trying to get the HCCC to take action against harmful practitioners and having to spend time chasing up communications when I should have been resting did not help.” (Ref 1208)

“When making any complaint guilt attached as to the impact on the other person. The staff member involved is well respected and valued; you were hoping that this was not going to have a negative effect on them.” (Ref 814)

A smaller group (18%) commented on the outcomes and associated feelings of anger, distress, depression and a loss of trust. [A6.4.10] Concerns about lack of learning or continuing risk were expressed by individuals, practitioners and employers alike:

“The complaint was about my [partner] who died so the effort of documenting the initial complaint, being interviewed and trying to refute doctor's response was debilitating. I did not want an apology, compensation etc., only hopefully an improvement in medical services and communication especially in regional areas. I am dismayed that the events were considered worth investigating and some communication issues were identified but no indication of any process for improvement.” (Ref 1384 consumer)

“Enormous amount of effort to lodge complaint and keep ongoing information being provided to AHPRA. 18 months later and little if no outcome- practitioner still practicing and very unlikely for there to be any change- no point in the complaint process really.” (Ref 819 practitioner)

“Although AHPRA took no action [as abuse too difficult to prove]... practitioner was suspended for ... [number] months and reprimanded... when [they] returned to work [they] skited to witnesses they had the best holiday on full pay. [Witnesses who were worried about repercussions] have been advised that the issue has been dealt with but would not know [the practitioner] had been reprimanded [by the employer]. They now feel there is no point in making reports because nothing happens. I do not believe the practitioner has learned anything at all from the process.” (Ref 1066 employer)

6.4.2 Survey 2: barriers to making complaints and notifications

Community and professional organisations in Survey 2 were asked about barriers to making complaints. Approximately 70 per cent of population and consumer organisations reported similar concerns. (Fig.35) The requirement to put concerns in writing; the levels of evidence required and perceived or actual power imbalances were noted. While proportionately less than community respondents these factors were also significant for organisations that represent health professionals.

Fear of retribution and the time involved were also very significant for population (100%) and consumer organisations (80%); and also featured in over 40 percent of professional responses. A concern shared by all was the need for complainants to be identified.

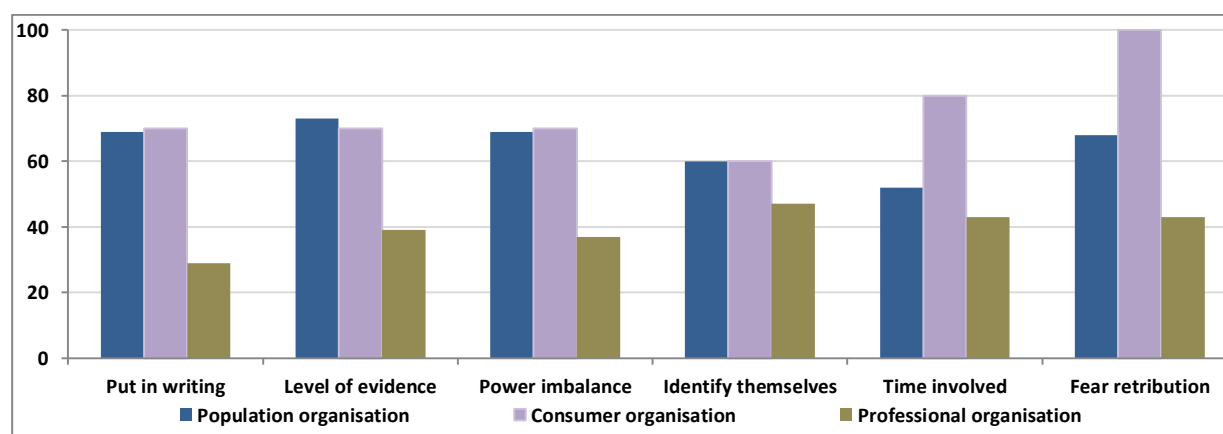


Figure 35: Survey 2: factors affecting the willingness of respondent members/service users to make a complaint/notification

‘Population’ organisations= community organisations representing specific demographic groups e.g. Aboriginal and Torres Strait Islander peoples; older or younger people; people living in rural or remote areas

‘Consumer’ organisations= community organisations representing public or specific consumer health interests

‘Professional’ organisations= profession associations or insurers (indemnity and defence organisations) representing health practitioner interests.

Stress associated with making a complaint and fear of retribution or reprisal were commonly commented on. Two professional organisations commented on past experience of lack of action or follow up, including for serious matters; two consumer groups on member perceptions:

“Many make comment that nothing will happen to change circumstances and that the medical profession close ranks so what's the point of doing anything.” (Ref 9)

Professional organisations commented on a poor understanding of mandatory reporting requirements within the profession and reluctance to complain due to collegiality. One professional organisation commented:

“We do not MAKE (sic) complaints, we defend them.” (Ref 80)

For population and consumer organisations, knowledge about complaint processes and knowing who, where and how to make a complaint remained barriers.

Also relevant were language barriers and lack of interpreters for Indigenous Australians¹²⁸ and people of non-English speaking background; lack of literacy and numeracy skills; and availability of an independent support person or advocate able to assist with the process. These issues were affirmed in some interviews with Survey 1 respondents. (Box 14)

Survey 2 respondents also made specific comment about barriers facing people with disabilities to lodge or pursue a complaint; who consequently are less likely to do so.

One health consumer organisation outlined why people were prepared to raise concerns with them, and by inference, factors influencing their preparedness to approach the agencies:

“Independence – their opinions won’t be skewed or mistreated”; “anonymity – their care (or the person they’re caring for) won’t be affected”; public [online] – “harder to ignore”; “safe- for them and health providers to respond”; “constructive - doesn’t feel like the type of place where people just whinge or cause trouble; “accessible - not intimidating or difficult to use.” (Ref 35)

¹²⁸ ‘Indigenous Australians’ refers to Aboriginal and Torres Strait Islander peoples

Box 14: Interview extract: barriers to making complaints: consumer

Case 15

Interviewer: Did you have other comments about the process that I haven't asked about?

Respondent: My understanding was, and this is from years ago, so I could have it wrong, but that for Aboriginal people, they could make a spoken complaint to the HCCC. But when I rang up, that wasn't available and I had to do it on line. Now I know that there are many other people who don't have internet, but many Aboriginal people, particularly in remote areas, don't have access to the internet. They [the HCCC] can send out the paperwork, but then again, literacy levels can be low, we know that from statistics, so it limits their ability to make a complaint and have their issues resolved with a health service provider. So when I rang, I thought I would be able to do it by phone. And I am quite capable and able to do it over the internet or in writing, but I was just trying to find out, and they said no, that wasn't at all available, and I had to do it on paper or online. And I thought that was very limiting.

Interviewer: Did they say that they could take it over the phone and write it down for you?

Respondent: No that option wasn't given.

Interviewer: And for the reason you have given, you think that is quite important?

Respondent: Absolutely. There used to be an Aboriginal Liaison Officer who worked for the Commission. I don't know if they still have that position. She used to do a lot of promotion of the service. And that is how I first heard about it, I knew one of the people that worked there. And I heard that they did it by phone. Now whether that has changed or whether that was wrong at the time, or whether I have remembered it wrong. I don't know.

Interviewer: Did you feel hesitant or daunted about making a complaint?

Respondent: No, because I was very angry about what had happened and I needed some action and I just couldn't get it from the people who were providing medical care to get anything done...

Interviewer: Do you think other community members would be daunted?

Respondent: I think a lot might be daunted, that there could be repercussions from their doctors, particularly if they live in an area where there are few doctors, or one doctor and they have to make a complaint. That could be really daunting for them, to make that complaint; really hard.

Interviewer: Are there mechanisms that might help get over that?

Respondent: I think if they could do it anonymously in a way. Maybe there are some complaints that could be investigated without letting them know who it was. Particularly when there is only one doctor in a town, or within a one hour radius. And if there was that role so people could talk things through - whether it should even be a complaint, or how they could handle it. Or if someone could come out and sit with the doctor and help them – that liaison might be really helpful, rather than having to lodge a full complaint.

Summary of Sub-section 6.4: impact and barriers

Survey 1 respondents reported the experience of making a complaint was an onerous, time consuming and a profoundly difficult and stressful experience. Some 40 percent stated they were 'significantly' or 'very significantly' affected. This applied whether the person was a consumer, a practitioner or employer. Significant physical and mental health effects were reported that interfered with work, family and social relationships. Events and recounting events contributed to these conditions, or exacerbated-pre-existing ones. Many reported being concerned both for themselves and the practitioner subject of complaint.

Fear of repercussions and retribution was substantial and was an identified barrier to raising concerns by both consumers and practitioners. The experience was reported as not only distressing, but undermining confidence in care relationships and regulatory processes.

Survey 2 respondents reinforced these reports. Fear of retribution and the time involved were very significant for population and consumer organisations (80-100%); and also featured in substantially (40%) in professional responses. A concern shared by all was the need for complainants to be identified. These respondents also identified lack of information about complaint processes, lack of support to make complaints and literacy as barriers to raising concerns.

6.5 Global measures - satisfaction with the process, the outcome and preparedness to recommend the process to others

Survey 1 respondents rated their overall satisfaction with the complaint process and outcome and gave reasons for their ranking. They were also asked the “family and friends’ test- i.e. if someone had a concern or complaint about a health practitioner, would they recommend the process to them.

6.5.1 Satisfaction with the process

Two-thirds of respondents were either ‘*very dissatisfied*’ (46%) or ‘*dissatisfied*’ (20%) with the complaint process. (Table 67) AHPRA and NSW were similar, although the HPCA attracted a lower proportion of ‘*very dissatisfied*’ responses. Medical practitioners attracted a higher proportion of ‘*very dissatisfied*’ responses compared with all other professions.

[A6.5.1-A6.5.2]

Table 67: Survey 1: satisfaction with the process

	Rank 1 Very dissatisfied		Rank 2 Dissatisfied		Rank 3 Neutral		Rank 4 Satisfied		Rank 5 Very satisfied	
	N	%	N	%	N	%	N	%	N	%
ALL	783	46	339	20	255	15	219	13	108	6
AHPRA	484	47	198	19	147	14	139	14	58	6
NSW	299	44	141	21	108	16	80	12	50	7
HPCA	100	36	53	19	59	21	47	17	22	8
HCCC	199	50	88	22	49	12	33	8	28	7
DR	525	51	213	21	138	13	105	10	50	5
All other professions	258	38	126	19	117	17	114	17	58	9

[1] All professions excluding medical practitioners

Forty three percent (N=734) gave reasons; of which 98 percent related to the agencies. The proportion of negative (‘*very dissatisfied*’ and ‘*dissatisfied*’ comments was higher than ranked responses for all of them. (Fig.36) [A6.5.3]

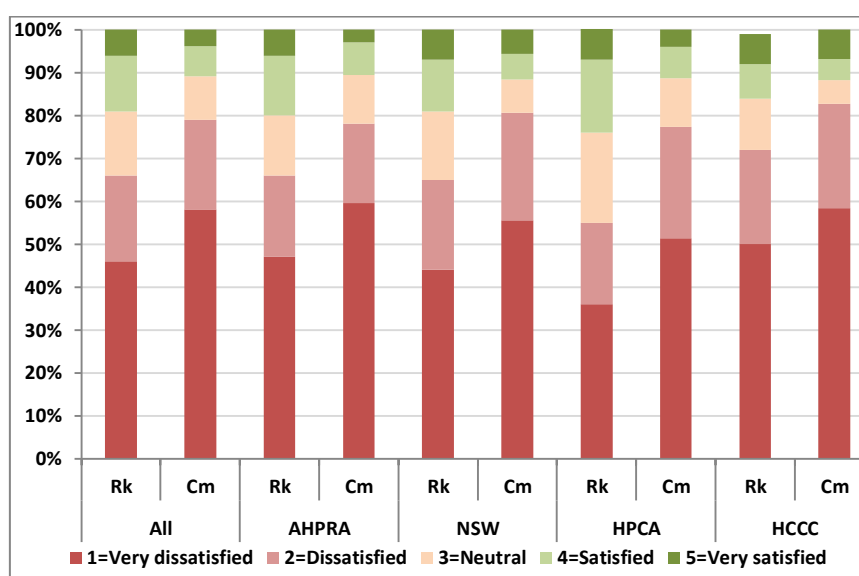


Figure 36: Survey 1: satisfaction with the process: comparing the proportion of ranked responses (Rk) and coded comment (Cm)

Eight themes were identified. [A6.5.4] A similar proportion related to perceived fairness (19%), level of engagement and information provided (18%) and adequacy of the inquiry process- including use of evidence and adequacy of assessment and investigations (15%). Nine

percent concerned timeliness. Nearly one-quarter related to reasoning and outcomes. The balance related to the impact of the process or outcome on the complainant or broader community (6%) general positive or negative observations (7%) and a small proportion to the availability of review rights (1%). Comments reflected and expanded on views expressed in previous specific questions about how concerns are managed; the most commonly expressed issues applying to all agencies.

Some respondents focused on a single issue; these particularly relating to operational processes, such as whether they were contacted to clarify issues or timeliness; and perceived fairness. More commonly, a mix of factors was cited as influencing levels of satisfaction and confidence in the process. For some, the opportunity to raise a concern or issue is sufficient:

"I am satisfied because I mainly wanted to bring my concerns to someone's attention which has been accomplished" (Ref 1213, Rank 4)

For others, the process in itself may suffice. Case 16 was selected for interview because of very positive survey responses notwithstanding a '*no further action*' outcome, which was relatively unusual. In this case, '*no further action*' was not a disappointment as the goal was achieved- making the practitioner reflect, and account for their actions in a way that had been attempted directly (unsuccessfully).

Box 15: Interview extract: positive Likert scale ranking notwithstanding '*no further action*' outcome

Case 16

Interviewer: *In the survey, you appeared quite positive about how the Commission handled your matter. Can you tell me what it was about the process that you thought worked well?*

Respondent: Well, I went to a specialist who would give me tablets, and in fact I went to [number] different specialists, and then two weeks later, this doctor would change it [the medication] again. And I didn't know if I was coming or going. And then he put me on a medication I was allergic to. And I'm a nurse. And I questioned it. And he said well, yes, but it's only a little bit [of a reaction]. He also took me off [name of drug] without any warning, and I went into [name of condition and adverse effects].

I had a good doctor-patient relationship with him, but the problem was I questioned him. There is an old joke about God and doctors, and it goes: what's the difference between God and a doctor? God knows he's not a doctor. Look, doctors are very important and they do a very good job but they need a little reminder every now and again that they're not God. Anyway I changed doctors and I'm very happy with my new doctor. I wrote to the Commission because I thought the doctor needed to think about what he had done. And I got a response pretty quickly, a reply 2 to 3 weeks later.

Interviewer: *What did they do?*

Respondent: Well they didn't do anything. They never do.

Interviewer: *But you were still positive about the process?*

Respondent: Well yes, I am quite happy about it. They wrote to him and he had to write back. He had to think about it. And for me that was enough. That's really all I wanted.

However, most respondents, whether in positive or negative terms, emphasised the importance of being engaged and informed; including contact from the outset.

The following shows a range of perceived inadequacies that span the thematic categories including access to information; a failure to cross-check the practitioner response with the complainant; perceived unfairness, and an understanding (absent detail) that while significant issues were identified there was insufficient evidence to proceed further. The references to being disadvantaged and requesting information about the personnel involved highlight the

commonly expressed expectation that the complainant has an active role in the process as well as critically appraising it:

"I feel the process has disadvantaged me because I do not have access to [name] response... There were paraphrased responses in the decision letter sent to me.... containing untrue statements...to which no reply from me was sought. Thus, his response did not reflect the true events... Dr [name] had requested an extension [which] was granted. I then requested an extension because I was unable to see the specialist until a later date ... [as] I did not believe a fair assessment with full information would eventuate otherwise. This...was rejected yet seems to be both a fair and reasonable request. Why was the request by the dentist but not the consumer given the extra time requested? I requested further information regarding the process ... who assessed my complaint i.e. number of individuals, their qualifications... [whether] a group discussion where professionals review the evidence together...or a recommendation by one person...this... received no response (twice)... It sounds as if there was not enough evidence to sustain my complaint yet my [outcome] report obviously suggests there has been a significant breach of professional standards."
(Ref 1263 Rank 1)

The link between being respectfully engaged and informed and confidence that regulatory action has been triggered to avoid recurrence and achieve protection beyond their individual case is reflected in rankings:

"I listed in my complaint what I wanted to achieve through the complaint process. 1. Acknowledgement that my doctor should have monitored me. Three other doctors have informed me based on my questionable pathology I would have been closely monitored. 2. I also wanted an assurance this would not happen to anyone else. None of this happened. Doctor was interviewed; my complaints were discussed with him. No follow-up with me. I was dismissed saying the matter is now closed."
(Ref 105 Rank 1 HPCA)

"By having a meeting with the hospital and doctors I was able to discuss and see how the changes have taken place and given a clearer picture of the events surrounding my admission." (Ref 29 Rank 5 HCCC)

Timeliness is significant. In higher rankings, it is typically associated with factors such as communication, responsiveness and level of seriousness with which the matter is taken, and is expressed in positive terms. However, where timeliness alone is referenced in 'satisfied' (Rank 4) responses, comments are negative. This also appears in 'neutral' responses where the process and/or outcome was otherwise viewed as satisfactory. Those ranked negatively sometimes refer to timeliness alone. However, timeliness was also linked to concerns about safety and accountability. [A6.5.5]

Whether ranked positively or negatively, similar factors were mentioned about the adequacy of the process, reasons given and outcomes. This included having a clear point of contact; clarification of issues and discussion with the complainant at the outset; whether issues were understood and addressed and whether an investigation process was undertaken and regarded as adequate. The importance of communication was not confined to consumers:

"Earlier this year I filed a complaint with the Aged Care Complaint System. The management and process to resolution of that complaint was a completely different

experience. The Resolutions Officer was careful to manage my expectations to what was essentially a negotiated solution. There were no procedural errors or omissions. Dialogue continued until there were no misunderstandings.” (Ref 1494 consumer)

“If professional are forced to make a mandatory report which is: 1- time consuming; 2- unpleasant and [a] difficult situation to be in; I think we deserve feedback, otherwise why should we be involved.” (Ref 1191 practitioner)

Survey responses and interviews highlight quality and consistency issues: being sent outcome letters that appear ‘*cut and paste*’, poorly drafted or with pages missing; while organisational respondents reported variable experiences over time in terms of responsiveness and communication ranging from ‘*outstanding*’ to ‘*very poor*’. In places, the process may start well but is then let down:

“I appreciated the intake officer who met with me and guided me to the notification (application) process. [But] after I logged the notification, there was not a consistent system in place or officer to do the follow up or no designated officer who really knew the case or what was going on so I have to explain my story over again each time I called.” (Ref 823 Rank 3)

Lower rankings reflect the effort to make the complaint including gathering evidence and a belief that their evidence was not considered or used; and inadequate investigative efforts by agencies. [A6.5.6] This was particularly the case when no more than what was termed a “*he said-she said*” model of inquiries ensued. The extent to which additional inquiries were made also featured, including whether previous complaints were taken into consideration. In contrast, more positive rankings reflected an experience of being listened to; a ‘straightforward’ process; having issues addressed; with action or acknowledgement legitimising issues raised.

Perceived adequacy of decisions and appropriateness of outcomes is reflected in rankings. Influential factors included safety issues; whether disciplinary action was taken; whether insights, improvements or oversight followed in relation to the specific practitioner or were applied more broadly. [A6.5.6] Reservations or uncertainty about the extent to which potential ongoing risks are monitored or managed featured in responses from all sources. Finally, some complainants were concerned with standards. This included whether an appropriate standard was applied; whether the standard was appropriate to the circumstances of the case; or whether the standard should change in light of emerging evidence or comparative (international) standards.

6.5.2 Satisfaction with the outcome

Over 70 percent were ‘*very dissatisfied*’ (53%) or ‘*dissatisfied*’ (18%) with the outcome. (Table 68) The responses for AHPRA and ‘all NSW’ were similar, although the ‘*very dissatisfied*’ response for the HCCC was higher; as was the response for medical practitioners compared with all other professions. [A6.5.7-A6.5.8]

Table 68: Survey 1: satisfaction with the outcome

	Rank 1 Very dissatisfied		Rank 2 Dissatisfied		Rank 3 Neutral		Rank 4 Satisfied		Rank 5 Very satisfied	
	N	%	N	%	N	%	N	%	N	%
ALL	897	53	308	18	200	12	186	11	92	6
AHPRA	361	54	133	20	78	12	60	9	36	5
NSW	536	53	175	17	122	12	126	12	56	6
HPCA	122	44	58	21	43	16	34	12	19	7
HCCC	239	61	75	19	35	9	26	7	17	4
DR	603	59	187	18	109	11	80	8	41	4
All excl. DR ¹	294	44	121	18	91	14	106	16	51	8

[1] All professions excluding medical practitioners

Forty three percent (N=731) gave reasons, all but one being about the agencies. The proportion of negative (‘*very dissatisfied*’ and ‘*dissatisfied*’) comments was approximately 10 percent higher than ranked responses for all agencies, more markedly for the HPCA. (Fig.37) [A6.5.9]

Seven thematic categories emerged [A6.5.10], and are similar to those identified for process satisfaction. Forty-two percent related to whether issues were addressed and reasons for outcomes, comments included reference to inconsistency between the decision relative to standards; and views on the appropriateness of action taken. Twenty-two percent related to fairness; and 17 percent to the impact on the complainant (45 percent of the latter relating to the complaint process). Themes reported on previously won’t be repeated.

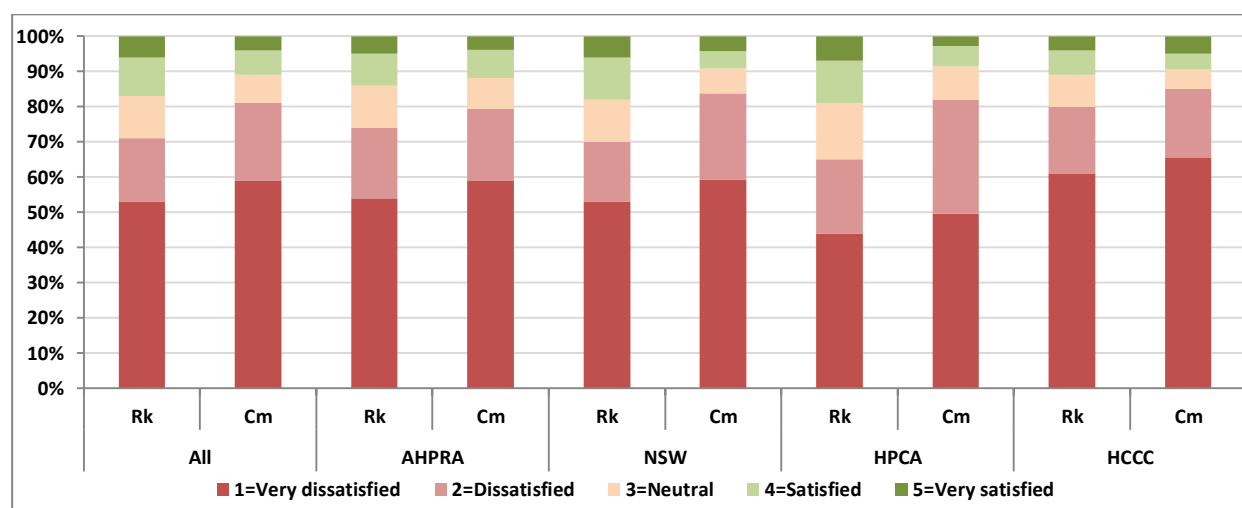


Figure 37: Survey 1: satisfaction with the outcome: comparing the proportion of ranked responses (Rk) and coded comment (Cm)

Outcome responses in Ranks 1 (*'very dissatisfied'*) and 2 (*'dissatisfied'*) are distinguished by references to the practitioner "*getting away*" with something and not being called to account. [A.6.5.10] Respondents comment about this being unjust; and being "*hauled over the coals*" or '*dismissed*' from their job if the same circumstances applied to them. Those with '*neutral*' responses reported mixed feelings, mentioning the limits of what can be achieved and being '*disheartened*' but also reporting some positive feelings on finding their complaint justified.

The most satisfied reported a '*fair*' or '*appropriate*' outcome. '*Satisfied*' and '*very satisfied*' respondents indicated their '*hope*' the practitioner would reconsider their practices in light of the complaint or that they had been made aware of what needs change; where-as those ranking lower are not convinced about this. An additional sub-theme from those '*satisfied*' - not seen in other responses - is their disappointment at not receiving an apology or acknowledgement directly from the practitioner. One comment (seen occasionally in other surveys) expressed concern that the HCCC based its decision on input from a Council, which was seen as having a vested interest in the outcome.

A sample of respondents was interviewed to better understand the reasons for rankings. Case 17 was selected as an example of dissatisfaction with allowing practitioners to relinquish registration. Voluntary relinquishment drew mixed responses - in some cases respondents were satisfied with the fact that the practitioner had ceased practice, particularly when the issue related to impairment. However, others felt more proactive interventions should be made. In this case, a practitioner reported another practitioner whom he observed to be unsafe. The respondent described it as a very serious complaint involving significant harms; some of which he believed could have been avoided had the regulator acted more promptly.

As with other practitioners interviewed, the respondent said they discussed the situation with colleagues before making the report. The respondent felt that those closer to the situation should have done this, but he did as they were not prepared to do so. During the interview he described being verbally abused and challenged on different occasions for taking the action that he did, but he '*stood his ground*' as it was his legal and moral obligation to act.

The interview focused on three elements: why they were of the view that allowing the practitioner to voluntarily withdraw their registration was not an adequate regulatory response; why their colleagues would not report; and what action the regulator could take about circumstances when professionals are not reporting. In part, he describes the reflection by practitioners that '*it could be me*' stays their hand in reporting; but is also critical of regulators who don't act on the '*non-reporters*'.

Box 16: Interview extract: dissatisfaction with voluntary relinquishment of registration as an outcome

Case 17

Respondent: AHPRA wrote a letter that said *'we believe your complaint has been resolved because he voluntarily withdrew his registration'*. But for me, voluntarily withdrawing his registration is completely and utterly inadequate ... because he could voluntarily get his registration reinstituted when all of this blows over.

Interviewer: *If I could play 'devils' advocate', one argument I would anticipate is that public safety is secured as the practitioner is not practising.*

Respondent: I accept that.

Interviewer: *And this person would have to come back and reapply to resume their registration, so they [the regulators] would have a look at it then - so from your perspective, what is the inadequacy?*

Respondent: Because the problem has not been resolved in that yes, I accept he isn't practising so that is a good thing. However, he could resume practice. But you don't know if it goes to a tribunal or whatever; and when he re-applies it's just *"oh well you have your CPD points, there's no reason why [you can't resume practice]; there's nothing on your record; you've withdrawn your registration, so we can just put you back on"*. To me, that is not safe; that is not an adequate response. This person was doing really doing very dangerous things and lying about what he was doing. And that to me is a very big red flag. I worry that he has a [other] problems, I worry that there are other issues involved; I don't know; there could be. So that response to me is inadequate. You have a dangerous practitioner; they [AHPRA] should be getting on to it and formally withdrawing his registration, as a formal act.

....

Interviewer: *This was someone; you said other practitioners knew about this. You had conversations with them about it, so why weren't they saying something?*

Respondent: Well, I think it is all about the feeling of *"there but for the grace of god go I"*. In each one of these things, the problem is complications always occur in isolation; and in isolation everyone has them, these things happen to us all. But not as an ongoing stream of complications and I think there-in lies the problem-*"well, we have all done that"*. But we haven't done it 6-7 times in a row. That's the essential different element here; and then we lie [he lied] about what we do [he did] as well. The first one, as I said, you can have a one off, but when I got the second one [with the same situation], it really prompted me. ... The legislation is clear. If you think someone is acting in a dangerous manner and threatening patients' lives, then under the law, you must do something, but morally you must as well ... *"you must report these doctors"*- the legislation says this. Now, none of the people involved in this case; none of them reported this to AHPRA. AHPRA should be looking at them and saying *"why didn't you report this doctor- that is the rule; that is the legislation"*. And that might just, maybe nothing will come of it, but maybe just the letter would be enough to get them to say *'well maybe I should be doing this better in the future'*. You know, the law is clear; and if you are not doing it, then you are not obeying the law. And all of these doctors who were involved with him, including the doctors that work with him all the time, why haven't they reported him? That letter should be going to them.

Interviewer: *Why it took someone externally to raise this?*

Respondent: Absolutely. And that has not been addressed by AHPRA whatsoever. Patient safety is paramount. And some [complications] are just bad luck; some are all the holes lining up- *'Swiss cheese'*. But some aren't - and in these cases you must act and I expect AHPRA to act. I should be taken seriously. I went out on a limb over this I felt so strongly about it and it cost me a little bit, but still.

Interviewer: *But that [pressure] would play on a more junior person?*

Respondent: Oh you would have no hope. You would just be knocked off. I have enough gravitas to withstand that kind of onslaught.

Interviewer: *That would be a worry I presume- the junior staff seeing these things are in a culture that says 'don't report'?*

Respondent: They would never report it. They wouldn't, they should.

Cases 18 and 19 were selected because of very low rankings for satisfaction with the outcome notwithstanding action had been taken by the regulator.

Case 18 appeared relatively unusual at the time the interview was conducted because many people who had made a complaint in the national system and completed a survey were reporting not being contacted or given information about the outcome. In this case however, the respondent had been interviewed at the start and had the opportunity to view and respond to the practitioner's response.

However, when she followed up many months later 'Simone' was told the practitioner had been cautioned; something she was unaware of. She was underwhelmed by the lack of notice about this part of the process; the outcome and most particularly the lack of reasons for the decision. She says she wanted acknowledgement by the doctor that they had *'done the wrong thing'* and to prevent events recurring; neither of which she feels has been achieved.

While the practitioner acknowledged some elements of the complaint; in her response she indicated she had taken certain actions, which Simone disputes. Simone was told the practitioner had taken steps to prevent a recurrence, but not what these steps were. She returns to this issue repeatedly during the interview; expressing doubts that anything had been done, especially as she herself cannot imagine what these steps were. During the interview Simone says she isn't sure what a 'caution' is, other than it is not a formal finding, and it doesn't appear on the practitioner's record. She refers to it variously as a '*slap on the wrist*', '*an empty threat*' and as '*a bit of nothing*'.

Box 17: Interview extract: dissatisfaction with lack of reasons for decisions and the outcome notwithstanding regulator action

Case 18

Respondent: The telephone interview was fantastic. The person I spoke to was very sympathetic ... Very understanding during the call I felt like he listened to me. He had clarified things that I said; he asked questions So I was very happy with that part of the process... I was given the doctor's response and given the opportunity I guess to rebut what she had had to say - so yes they did follow through that part of the process ... [but then] I got a letter from the Board saying they had made this decision - I didn't know that part of the thing was happening - it just all happened. I wasn't greatly impressed by the outcome and the decision that the board had come to. More so not the decision, but the explanation as to why they came to the decision because basically there was no explanation. The other thing that I found difficult was the length of time the process actually took. It was well over 12 months before I had an outcome.

Interviewer: You indicated in the survey that you definitely wouldn't recommend the process- can you tell me why?

Respondent Look I was pretty happy with the rest of the process, it was just the reasoning for the decision and look maybe at the time I was actually annoyed with the actual decision. I felt that she should have been dealt with in a different way; so it might have been partially why I answered the question that way but it was mostly I just didn't get that background as to why they came to that decision. I thought well, have they really addressed my concerns because, well they listened to me and whatnot and the phone call was great but then I felt that - did you really listen because you have come to this conclusion but you haven't really given me any explanation as to why; so then I was sort of like, maybe they didn't [listen]. ...

The letter said they had cautioned her and she had taken steps to occur that this did not occur again, but they didn't explain what those steps were ... well, what steps? What has she done? Like they didn't tell me any of that - I don't know, you know, I don't know what has happened. I honestly don't know what steps she could have taken to ensure it doesn't happen again. Like in my mind I don't think there is anything that would prevent it from happening again to someone else. ...

Interviewer: You said the Board cautioned her - do you know what it means to be cautioned?

Respondent Um, it's not recorded on her record I guess; so there is no formal, I guess finding against her. So I guess it's on her record, I assume so if anything ever happens again but no formal record- that's my understanding of it. Like I know you can search doctors on the website to see if they have had disciplinary action taken previously - and so I know the caution is not recorded on there. They told me that in a letter where they gave me the information that they had cautioned her and it's not a formal finding.

Interviewer: Did you know what you wanted from the process?

Respondent I didn't really want anything out of it - I wanted her to know that she had done the wrong thing and I wanted it, I wanted to make sure it didn't happen to anyone else. So for me that was really all I wanted out of it.

Interviewer: Do you think it [the process] delivered on those two things?

Respondent I can honestly say no because in terms of this ever happening to anyone else, apparently she has changed her processes and practices to make sure it doesn't, but they haven't told me what they are, so I don't think it has delivered on that point. And the other point, making sure she knows she has done the wrong thing, well - they cautioned her, so they gave her a slap on the wrist and said '*don't do it again*', but I'm not confident it's even met the point either.

Interviewer: So you don't - there's nothing she wrote -

Respondent She basically said '*I didn't do anything wrong - I did this and I did that*' and I'm telling you now she did not - the things that she said- she admitted to the phone call and telling me [diagnosis] over the telephone - but she said she did offer me [other treatment] - that's what she told the board, but she didn't. So it was basically my word against her word. And when I wrote back - I did point that out.

I don't even know if the Board would know if further complaints were made after mine. It would be nice to have that information - like, it's not formally recorded, but if something like this should happen again, this information would be provided to the Board - it would be good to know that - I think I would feel more comfortable with the decision knowing that if it happened again that my case would be relooked at or brought up again. So I think that would make a big difference to my satisfaction with the decision. I think a caution is - honestly, I feel like it's a bit of nothing. Either she has done the wrong thing or she hasn't - if she has done the wrong thing, then you discipline her - I don't see why there needs to be that middle ground - that grey area where they say to her '*Well, you have done the wrong thing, but this time we're going to let you off*' and that's how I feel it is - they are just letting her off - '*We're not going to do anything to you*'.

Interviewer: So you don't have the sense that there's much weight behind the idea of a caution?

Respondent No I think it's really an empty threat. I don't know- nothing will happen - the idea of a caution- like you said- there's no weight behind it.

Interviewer: Do you think if you had more information that they understood why you raised this - what you're concerned about- would that have made a difference?

Respondent: Yes- if they had said - "*Look, we came to this conclusion because of a, b and c*", I would have felt, "*Ok, fair enough*". That would have helped, but obviously I didn't get that.

In Case 19 a dental practitioner made a mandatory notification about a colleague after trying to first deal with it directly. 'Anthea' is concerned that the practitioner is deliberately over-servicing, falsifying records and causing harm to patients. Like others, she was not contacted for information as a witness; an issue for her as she had indicated she had other examples to support her concerns. She questions the expertise of those managing the case – "*they're not qualified*" and is worried that not only was insufficient action taken in this particular case (conditions applied; undertakings made) but the regulatory model itself is weak when dealing with practitioners that are consciously doing the wrong thing.

Anthea stresses the importance of ethical behaviour- for herself, for her family, for the profession as a whole and the patients who come to her and have a right to expect good treatment. She comments that she has '*stuck her neck out*' and would be willing to work with others to '*clean up*' the profession but is aware colleagues are worried about what will happen if they '*speak up*'; and is at a loss about how this can be achieved. She believes the lack of strong action by the regulator indicates disinterest in addressing the issue.

Box 18: Interview extract: dissatisfaction with the process and outcome notwithstanding regulator action

Case 19

Interviewer: *In your survey response, you gave a very low rating for both the outcome and the process, can you tell me why?*

Respondent: They should at least have been fined and suspended to show the severity of the misdemeanor, this is not something that was about a one-off mistake; this was consistent behaviour, a pattern of over-servicing, false notes and damage done to patient's teeth. I am still seeing patients that he treated, they come back with gross carries and had teeth lost. And there was no infection control. It was immoral and criminal.

Interviewer: *Is there anything on the public register to indicate or signal its importance?*

Respondent: I looked. Even though they wrote and said he had made undertakings and it was referred to another body, there is no indication about any conditions being placed on his registration. What's the point of telling me when no one else would know? I am pretty disappointed. On the one hand I make a mandatory report, but then they give them a slap on the wrist. I know he has been dismissed from other places.

Interviewer: *Were you contacted for further information or to discuss the case?*

Respondent: No they only acknowledged that they had received my report and that things would be done. There was no contact, they weren't the witnesses, they're not qualified, but they just relied on his statement. It's not a satisfactory way of dealing with it. I stuck my neck out for this- it was not an isolated case. After I made the report, I told AHPRA that I had other cases, other examples, but I got a nil response. I was hoping that they would be interested in clearing up cowboys from the profession. What is an undertaking? Who is there to monitor this? I have heard from other multi-practice dentists who are very alarmed about the behaviour of other practitioners who are doing similar things. I feel the others should report, but it's not something people want to do, it's something to be avoided. ... How you get treated for notifying? Management doesn't care – they take their money, their percentage. I tried to speak with him first. But all he said was "who are you to judge my work". Therefore I reported him [to AHPRA] because he wouldn't take constructive criticism.

Interviewer: *Are your other colleagues prepared to speak up?*

Respondent: They're terrified by what they hear from the Association. But I'm so concerned. Is there any effective mechanism to deal with the cowboys out there? What happens when I retire for me and my family? There are dentists out there who are manufacturing cavities. For example I saw one patient who was told that they had more than 10 cavities and when I examined them they had two, with another two teeth of concern.

Interviewer: *Do you know what steps they [AHPRA] took?*

Respondent: I have no idea how they looked into it. I don't know. Is there an effective way to deal with the cowboys? It's immoral to rip patients off. To do unnecessary work and to do low quality work. It's in the interests in the whole body of dental practitioners that something is done. I would readily join them, join with others. I called the ADA before I went to AHPRA. They advised me to try and speak directly with the practitioner. I tried to do that, but they just threw it back in my face.

I noticed that a lot of these cases, the practitioners appear to be from overseas. I suspect it's a cultural issue, that making money is all that counts. It isn't a question of training, and it's not a question of ignorance. Therefore all the guidelines in the world won't have an impact if you can bypass them at will. Guidelines are fine and work for good practitioners and good citizens. It's like the law, for good citizens it works, but what do you do about those who don't care, who don't have those standards and will bypass them if they can? I understand that they (the Board) don't want to adversely affect someone's ability to earn a living, but you can't be too sentimental about bad behaviour; about bad practice. And I'm also upset because I work in a blue-collar area - it costs a lot of money. It's important that the dental work is done properly

6.5.3 Preparedness to recommend the process to others

Notwithstanding the low overall satisfaction rates both with the process (6 percent '*very satisfied*' and 13 percent '*satisfied*') and outcome (5 percent '*very satisfied*' and 11 percent '*satisfied*'); nearly one-quarter of respondents indicated that they '*definitely would*' recommend the process to others and a further 17 percent indicated that they '*probably would*'. (Fig.38)

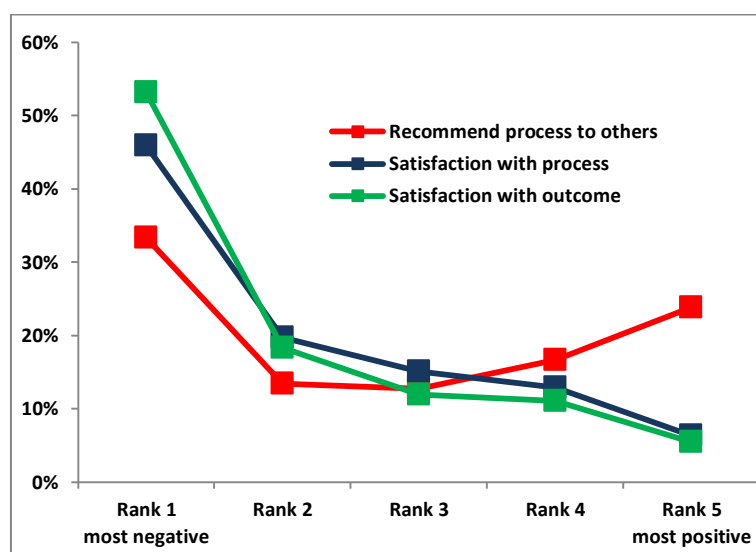


Figure 38: Survey 1: whether prepared to recommend the process to others compared with satisfaction with process and outcome

Responses for AHPRA and 'all NSW' were similar, although the HCCC attracted a higher proportion of '*definitely wouldn't*' recommend responses and a lower proportion of '*definitely would*'. (Table 69)

A similar pattern is seen when comparing the responses for medical practitioners with all other professions. [A6.5.12-6.5.13] Dental practitioners had a similar response profile to their medical counterparts, while a higher proportion of '*definitely would recommend*' responses occurred when pharmacy or nursing practitioners were the subject of complaint.

Table 69: Survey 1: preparedness to recommend the process to others

	Rank 1 Definitely wouldn't		Rank 2 Probably wouldn't		Rank 3 Neutral		Rank 4 Probably would		Rank 5 Definitely would	
	N	%	N	%	N	%	N	%	N	%
ALL	555	33	229	14	213	13	279	17	398	24
AHPRA	336	34	140	14	104	10	174	17	249	25
NSW	219	33	89	13	109	16	105	16	149	22
HPCA	75	27	36	13	43	16	48	17	76	27
HCCC	144	37	53	14	66	17	57	15	73	19
DR	362	36	154	15	147	15	147	15	201	20
All excl. DR ¹	193	29	75	12	66	10	132	20	197	30

[1] All professions excluding medical practitioners

Forty five percent (N=748) gave reasons, the majority (99%) relating to the agencies. The proportion of comments was consistent with ranked responses. Agency responses were similar; the HCCC attracting a slightly higher '*definitely*' or '*probably*' wouldn't recommend response compared with the others. (Fig.39) [A6.5.14]

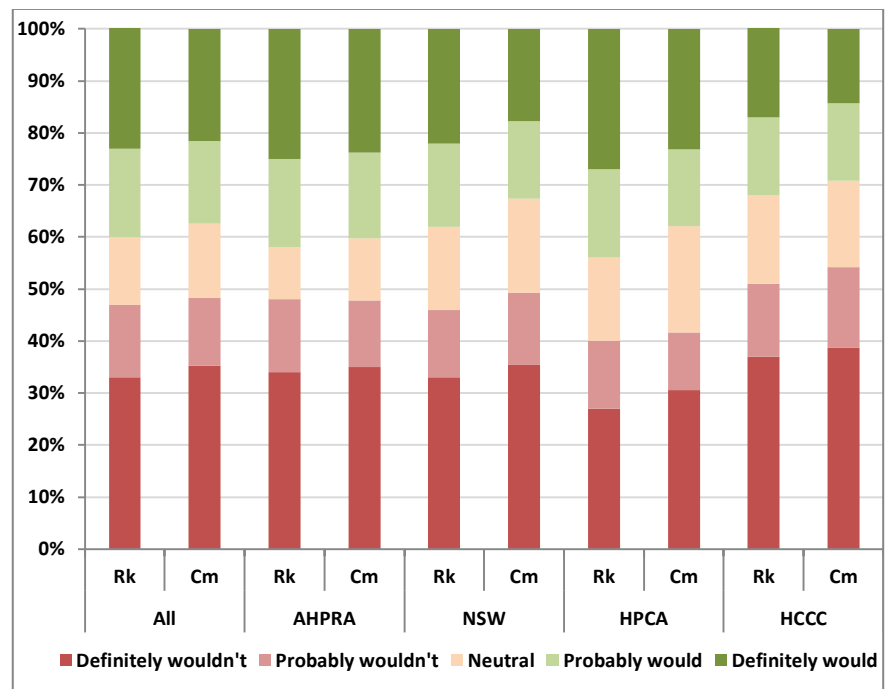


Figure 39: Survey 1: whether respondent would recommend the process: comparing ranked response (Rk) by comment (Cm)

Thematic analysis of comments was undertaken, and cross- checked with a second reviewer. Seven main themes were identified. (Table 66) Four of these focused on specific issues, relating to a preparedness to recommend the process:

1. On the basis of a legal obligation to report (mandatory reporting under National Law).
2. Out of a lack of alternate options or the cost of alternate options.
3. In order to place the matter on record; to facilitate or support future action should other complaints arise.
4. On the basis of principle: being the right thing to do; to ensure or contribute to improved accountability, practice improvement and public protection.

Themes 1 to 4 accounted for just under one-third of comments (31%), half relating to a legal obligation or lack of alternatives; the other half to improving practice or to place matters on the record even if they were not acted on in this instance. All responses were analysed for secondary themes and keywords assigned. Sub-themes identified in themes one to four included 'processes', 'outcome' and 'law'.

The remaining responses that did not contain any reference to these themes were initially allocated into one of three categories, being: overtly negative responses; responses that were equivocal, contained reservations or made other comment; and overtly positive responses.

Themes 5 to 7 accounted for over-two thirds (69%) of responses, negative comments accounting for three-quarters of these. (Table 70) Identified subthemes included 'process', 'impact', 'attitude', 'outcome' and 'other'.

Table 70: Survey 1: whether respondent would recommend the process to others: coded comment by ranked response

	Theme 1 Legal, required ²		Theme 2 Lack, cost options ³		Theme 3 On record for future ⁴		Theme 4 In principle, protect public ⁵		Theme 5 Negative ⁶		Theme 6 Equivocal ⁷		Theme 7 Positive ⁸		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
ALL¹	31	4	88	11	31	4	94	12	403	52	93	12	39	5	779	
AHPRA	24	5	65	13	20	4	61	12	249	50	57	12	19	4	495	
NSW	7	2	23	8	11	4	33	12	154	54	36	13	20	7	284	
HPCA	4	4	10	9	4	4	12	11	52	47	17	15	11	10	110	
HCCC	3	2	13	7	7	4	21	12	102	59	19	11	9	5	174	
Rank 1	2	1	7	3	2	1	4	2	246	94	1	0	0	0	262	34
Rank 2	1	1	7	7	4	4	2	2	88	86	0	0	0	0	102	13
Rank 3	6	5	16	14	0	0	10	9	40	35	41	36	0	0	113	15
Rank 4	5	4	33	25	13	10	25	19	10	8	29	22	15	12	130	17
Rank 5	17	10	25	15	12	7	53	31	19	11	22	13	24	14	172	22

[1] Ranked comments only included in analysis.

[2] Legal, required: as part of a legal obligation to report (mandatory reporting under National Law).

[3] Lack or cost of other options: due to a lack of alternate options or the cost of alternate options make them inaccessible.

[4] On record for future: on the record to facilitate or support future action should other complaints arise.

[5] In principle, protect public: being the right thing to do; to ensure accountability; improvement in practice; for public protection.

[6] Negative: negative comment about process underpins whether prepared to recommend the process.

[7] Equivocal: responses that were equivocal, contained reservations or made other comment.

[8] Positive: positive comment about process underpins whether prepared to recommend the process.

There appears little difference in comments about recommending the process on the basis of Theme 1 (*must do so on the basis of legal obligation*) irrespective of rank, with negative feedback scattered across the ranks (i.e. would not report otherwise; lack of confidence in the process or concern about harm to patient from the complaint process). [A6.5.15] The same holds for Theme 2 responses (*respondent would recommend due to the lack of alternatives or the cost of other options*); and Theme 3 responses (*so the matter was 'on the record, for the future'*). Theme 4 comments- recommending the process on principle (relating to doing the right thing, ensuring accountability, contributing to improvements and public safety) were similar. In this last theme however, there was a more explicit expression in the more positive rankings that the process would be recommended notwithstanding dissatisfaction with the process or outcome in the respondent's specific experience.

Comments in Themes 1 to 4 suggest the 'gap' between overall satisfaction levels and preparedness to recommend the process in the future is that respondents would recommend the process out of obligation; in 'hope' of future improvements; or in good conscience rather than confidence that the systems would necessarily be effective and/or act in the public interest.

Comments in themes 5 to 7 [A6.5.16] reflect views expressed in previous questions regarding the efficiency and management practices of the agencies including engagement and communication; perceptions of balance and attitude; perceived adequacy and impact of assessment, investigation and outcomes.

Lack or inadequate feedback significantly undermined confidence in the system; a view expressed by all respondent types. In Case 20 an employer is told that they cannot be given information by the regulator for '*privacy and confidentiality*' reasons, yet is expected to provide fulsome details about the practitioner. 'Zita' reports her peers do not report matters and sometimes question why she does when she '*gets nothing back*'. She contrasts her experience with the regulator with her own practice of both investigating concerns and providing feedback to those that have raised them. Zita observes that the lack of information results in a lack confidence that the regulator is performing its role fully and effectively – a view which may not be fair, but if so, is the regulator's fault for not effectively communicating.

Box 19: Interview extract: negative effects of not providing feedback on willingness to report and confidence in the regulator

Case 20

Respondent: And I find the frustration is that we are supposed to provide a very comprehensive form to them [AHPRA] about what the incident is, and who is involved and when and 'blah, blah, blah'; yet they will just send a notification to say e.g. "*This person can and can't do xyz*", and then when you ring up and say "*Can you give me some information about that*", you are completely blocked at that point.

Interviewer: Have you ever been given an explanation as to why you aren't allowed to have reasons for decisions or access to information?

Respondent: Privacy and confidentiality has been the explanation... we are required to be really open and transparent, and these are also issues of privacy and confidentiality for us, and we give that information willingly; but there doesn't seem to be any reciprocity back... I don't know what they have done. I don't know how seriously, what sort of person has investigated them. And I know; I have spoken to a lot of other managers that just don't bother putting in reports to AHPRA because just think nothing happens.

Interviewer: Your peers don't?

Respondent: They don't do it because they think nothing is going to happen and it takes months to get any feedback. ...

Interviewer: Your peers aren't reporting –

Respondent: Yes, and I have to confess sometimes it crosses my mind that I couldn't be bothered. Because I think what do I get out of it really? I get nothing out of it. It's not like I get some feedback telling me that "*look, we investigated this and we ...*" look, even myself, when I get written complaints about my staff, we follow the up and we send back to the person that sent the complaint "*Dear X, thank you, this is what we have done and what the staff person has done*". We feedback what actions we have taken so that they know, with confidence, what the problem was and that we have dealt with it. But I don't get that sense from AHPRA that they follow up properly... And we get lots of complaints, and they are of all kinds. And we have to investigate them all. And some are people being pig-headed but some are true and real issues. I want people to know that if they send me a complaint about a staff member that it will be investigated.

Interviewer: So, correct me if I am wrong, what you are saying is that it not only has to be done it has to be seen to be done for that confidence in the system to be there?

Respondent: Yes, and I expect that when I give feedback [like] "*Look I have spoken to x and these things have been put in place*" - I don't expect them to be telling the whole world about it. I'm not worried that they are going to betray my confidence in that. I have given that information so they know what action we have taken. And I think that is where AHPRA has fallen down. It seems to me they are worried that somehow there is going to be a liability there, and maybe there is, maybe they feel that they are liable to be sued, I don't know, that's not my area of expertise. But I don't have that sense. I just know I am dealing with a complaint and feeding back to the person so that they know what action has been taken and that they know now that the situation has been dealt with and that the issue won't happen again. ...

The only other thing I would say is that I feel very passionately about it because I am more exposed because of the size of my workforce... AHPRA is our national body and we should have confidence in them; that they are doing everything that they can. And on a personal level, I don't have that confidence. I have confidence in what I do, in my own practice and I have confidence that I am covering myself by making sure that the people that I think are unsafe are reported and if they go on to harm somebody in another organisation; I have done what I can to prevent it from happening here; and I have done as much as I can do; but I'm not sure that that is happening; and that it is being followed up with that same amount of vigilance at the other end. **And I might be doing them a dis-service, and if I am, that's because they don't give you the information back that would enable you to make a proper judgement.** ...

I think there are some things they can do easily to make it better. And I think they have to be working with us, [and] that's what I don't get a sense of. I get a sense that there is a real push-back. You know, "*thanks for telling us and move on- we'll deal with it from now on, you don't need to know anything more*". Whereas I think we need to be working together.

Summary of Sub-section 6.5: global experience measures

A significant proportion of respondents express substantial dissatisfaction with the overall complaint process (two-thirds) and the outcome (over three-quarters). Responses were similar for AHPRA and 'all NSW'; the most notable difference being a higher '*very dissatisfied*' response for the HCCC. Medical practitioners also attracted a higher '*very dissatisfied*' response compared with all other practitioners.

There is frustration with the lack of explanation for actions taken and reasons provided for decisions. Absence of this information undermines confidence in the process; and confidence that action, where taken, is appropriate and proportionate.

Respondents wanted a clear point of contact; an opportunity to discuss and clarify issues from the outset; confidence that issues were understood and a thorough but timely investigation. They mostly saw themselves as an active participant and expected an opportunity to review and respond to practitioner statements.

Lower rankings reflect the effort to make a complaint including gathering evidence; a belief that their evidence was not considered or used, or appropriate standards applied or whether issues were addressed. Influential factors in whether outcomes were perceived as appropriate included safety issues; whether action was taken; whether insights, improvements or oversight followed in relation to the specific practitioner or were applied more broadly. Negative responses include reference to the practitioner '*getting away*' with something and not being called to account. Concerns were expressed about the extent to which potential ongoing risks are monitored or managed.

Respondents were worried or believed that no ongoing oversight of practitioners of concern occurred; or patterns of practice monitored. Further perceptions were that authorities did not adequately triage matters and responded only to the most egregious circumstances, signalling a tolerance for 'lower' level but still-important poor or unacceptable practice or behaviours.

The proportion of people that would '*definitely recommend*' the process is larger than respondents '*very satisfied*' with the process or outcome. However, comments suggest this preparedness to recommend the process is often related to either a requirement to report or 'hope' for future improvements; rather than confidence in the system. The following section examines demographic or other factors associated with these views.

6.6 Most negative and positive responses

The most negative and most positive responses to experience questions were investigated using logistic regression to calculate Odds Ratios. Statistical analysis of the most negative responses appeared warranted given survey response trends towards negative rankings. It was also thought that understanding those ‘most negative’ would provide insights to not only that cohort but other respondents as well, given the presence of ‘adverse’ comment similar to the most negative responses appearing even in higher rankings. The most positive responses were also tested to identify whether the same factors were at play.

Demographic frequencies for individuals (consumers and practitioners combined) for all experience measures were established including age, gender and educational status. Two models were established, one comparing Rank 1 (most negative) with all other responses (Ranks 2-5); a second comparing Rank 5 (most positive) with all other responses (Ranks 1-4).

Regression analysis was undertaken for demographic factors associated with the most ‘*dissatisfied*’ and the most ‘*satisfied*’ respondents in relation to the three global experience measures (these being satisfaction with process; satisfaction with outcome and whether the process would be recommended to others). The model included age, gender, education and source of complaint; where source included consumers and practitioners. Organisation and ‘all individual’ responses were tested separately.

Other experience measures (e.g. perceived fairness) were then tested to identify their predictive value for the most negative global measure rankings.

Additional factors were also analysed to test their influence on the most negative responses. These factors included agency type; subject practitioner type; subject practitioner location of practice; outcomes; death and adverse events.

The smaller cohort meant more limited testing was undertaken with the most positive response model.

6.6.1 Most negative respondents

Table 71 shows the frequency and percentage of participants that gave the most negative responses. Across all experience indicators, age was associated with a ‘*most dissatisfied*’ response, older people being proportionately more dissatisfied. Gender differed in only select indicators. Education also appears to be an indicator, but it should be noted that practitioner complainants tended to have higher education levels compared with consumers.¹²⁹

¹²⁹ 89% of practitioner complainants had a university education compared with 38% of consumers. [A4.2]

Table 71: Survey 1: most negative ranking of experience measures by respondent demographic profile

	Very dissatisfied process [1]		Very dissatisfied outcome		Definitively would not recommend process		Process very unfair (not fair at all)		Very significant impact on health	
	N	%	N	%	N	%	N	%	N	%
Education level										
Nil-high school	153	51	186	62	111	37	140	47	92	31
Trade, diploma	227	55	253	63	166	41	199	49	134	33
University	337	46	382	53	245	34	274	39	121	17
Age										
<30 years old	22	31	26	37	13	18	18	25	6	9
30-49 years old	231	47	256	53	151	31	184	38	117	24
50-69 years old	393	52	450	61	295	40	346	47	182	25
70+ years	68	57	83	70	59	50	62	52	45	39
Gender										
Male	303	55	352	65	203	38	247	46	114	21
Female	431	47	486	54	321	36	378	42	245	27

Table 71 continued

	Issues not addressed at all		Role and powers not clear at all		Assessment criteria not clear at all		Poorly informed (no information provided)		Reasons poorly explained (no reasons given)		Not shown any respect	
	N	%	N	%	N	%	N	%	N	%	N	%
Education level												
Nil-high school	192	64	100	33	119	40	90	30	104	35	85	29
Trade, diploma	266	65	110	27	162	40	128	31	153	38	117	29
University	449	63	190	27	302	43	224	31	266	37	161	23
Age												
<30 years old	27	37	10	14	21	30	19	27	18	25	12	17
30-49 years old	312	64	139	29	190	40	125	26	154	32	122	25
50-69 years old	480	65	205	28	311	43	247	33	292	39	196	27
70+ years	80	67	43	37	58	49	47	39	51	43	28	24
Gender												
Male	363	68	173	32	235	44	183	34	212	39	151	28
Female	520	57	236	26	359	40	265	29	315	35	218	24

[1] Each experience measure is the most negative response (Rank 1) to the question in a 5 point Likert scale. Each measure includes the wording and descriptor (where given) in the survey e.g. 'very dissatisfied with process' includes Rank 1 'very dissatisfied' responses to the question 'Rate your overall satisfaction with the process'. The exception is 'Issues not addressed at all' which included four possible responses to the question "When the complaint process was closed (finished), were the issues that led to the complaint addressed?", possible responses being 'Not at all', 'Partly', 'Mostly' and 'In full'.

Key > 5% to 10% > 10% to 20% > 20%

Age, gender and source were statistically significant for respondents 'very dissatisfied' with the outcome. (Table 72) Adjusting for age, gender, highest level of education and source (consumer or practitioner), age is the most important predictor- people aged 70 years and over were over three times more likely to be 'very dissatisfied' with the outcome (odds ratio [OR] 3.30, 95% confidence interval [CI] 1.72-6.32) and those aged 50-69 years were nearly two and a half times more likely (OR 2.42, 95% CI 1.44-4.05) compared to those aged under 30. Women were less likely to be 'very dissatisfied' than men (OR 0.69, 95% CI 0.55-0.86) and organisations four times less likely than individuals (OR 0.24, 95% CI 0.18- 0.33). Among individuals, consumers were nearly twice as likely as practitioners to be 'very dissatisfied'.

The pattern was similar for those ‘*very dissatisfied*’ with the process, although the odds ratio for those aged 70 and over was lower (OR 2.5, 95% CI 1.32-4.77) and the gender differences smaller.

Only age and source were statistically significant for respondents who would ‘*definitely not recommend*’ the process to others; the odds ratio following a similar pattern to the outcome and process responses, although higher for those aged 70 and over (OR 4.2, 95% CI 2.05-8.64).

Table 72: Survey 1: association between respondent demographic profile and the most negative ranking for global experience measures (satisfaction outcome, satisfaction process, recommend process)

	Very dissatisfied with outcome				Very dissatisfied with process				Definitely wouldn't recommend			
	P-value	Odds Ratio	95% CI		P-value	Odds Ratio	95% CI		P-value	Odds Ratio	95% CI	
			Lower	Upper			Lower	Upper			Lower	Upper
Age [1]	<0.001				0.012				<0.001			
70+ years		3.30	1.72	6.32		2.51	1.32	4.77		4.21	2.05	8.64
50-69 years		2.42	1.44	4.05		2.23	1.31	3.79		2.92	1.56	5.45
30-49 years		1.79	1.06	3.03		1.85	1.08	3.18		1.98	1.05	3.73
<30 years [2]		1				1				1		
Gender	0.001				0.026				0.77			
Female		0.69	0.55	0.86		0.78	0.62	0.97		1.04	0.82	1.30
Male [2]		1				1				1		
Education	0.69				0.26				0.33			
University		1.05	0.77	1.44		1.19	0.88	1.61		1.24	0.91	1.71
Trade diploma		1.14	0.83	1.57		1.29	0.95	1.76		1.24	0.91	1.70
High school [2]		1				1				1		
Source [1]	<0.001				<0.001				<0.001			
Practitioner		0.51	0.39	0.68		0.52	0.39	0.68		0.55	0.41	0.74
Consumer [2]		1				1				1		
Source	<0.001				<0.001				<0.001			
Organisation		0.24	0.18	0.33		0.24	0.17	0.34		0.24	0.16	0.37
Individual [2]		1				1				1		

[1] Model included age, gender, education and source where source = individuals (consumers and practitioners) only.

Organisation and all individuals tested separately

[2] Comparator group for calculation of Odds Ratios

6.6.1.1 Association between experience measures and whether issues were addressed

The extent to which issues were addressed was statistically significant for global measures ranking. (Table 73) Where issues were not addressed ‘*at all*’, respondents were twelve times more likely to be ‘*very dissatisfied*’ with the outcome (OR 11.86, 95% CI 0.934-16.06) and the process (OR 12.17, 95% CI 9.45-15.69). These respondents were seven and a half times more likely to feel that they or their organisation ‘*definitely wouldn't*’ recommend the process (OR 7.51, 95% CI 5.70-9.91).

Adjusting for age, gender, highest level of education and source (consumer or practitioner), age and source are statistically significant. People over thirty were over two and a half times more likely to report their issues were not addressed *at all*; and organisations were three times less likely than individuals to have this view.

Table 73: Survey 1: association between whether issues were addressed and the most negative ranking for global experience measures (satisfaction outcome, satisfaction process, recommend process)

	Very dissatisfied with outcome			Very dissatisfied with process			Definitely would not recommend		
	P-value	Odds Ratio	95% CI	P-value	Odds Ratio	95% CI	P-value	Odds Ratio	95% CI
			Lower Upper			Lower Upper			Lower Upper
Not at all [1]	<0.001	11.86	9.34 15.06	<0.001	12.17	9.45 15.69	<0.001	7.51	5.70 9.91
Partly to in full [2]		1			1			1	

[1] Includes issues not addressed at all [N= 958] and unsure [N= 54]

[2] Includes issues 'partly' addressed, 'mostly' addressed and addressed 'in full'. Comparator group for calculation of Odds Ratios

Satisfaction with process and outcome were statistically significant for whether respondents would recommend the process to others (Table 74); negative process rankings having a greater impact for those who '*definitely would not*'.

Tested separately, those who were '*very dissatisfied*' with the process were 87 times more likely; and those with the outcome 38 times more likely than those who were '*very satisfied*' to indicate they '*definitely would not*' recommend the process (process OR 87.2 95% CI 21.4-355.8; outcome OR 38.9, 95% CI 12.2-124.0).

Those '*dissatisfied*' with the process were over eleven times, and with the outcome over four and a half times less likely; compared to those who were '*very satisfied*'.

Table 74: Survey 1: association between satisfaction with the outcome and satisfaction with the process and whether respondent would recommend the process to others

	Satisfaction with outcome			Satisfaction with process		
	P-value	OR	95% CI	P-value	OR	95% CI
			Lower Upper			Lower Upper
Definitely would not	<0.001	38.93	12.23 123.96	<0.001	87.16	21.35 355.80
Probably would not		4.66	1.40 15.42		11.37	2.73 47.37
Neutral		1.08	0.30 4.28		3.59	0.81 15.91
Probably would		0.32	0.05 1.98		1.50	0.30 7.56
Definitely would [1]		1	.		1	.

[1] The comparator group for calculation of Odds Ratios

6.6.1.2 The importance of fairness in negative responses

Adjusting for all other measures excluding impact on health¹³⁰; and comparing the most negative responses (Rank 1) with all other responses (Ranks 2-5), fairness was the most statistically significant factor for all global measures. (Table 75) Those ranking the process '*very unfair*' were sixteen times more likely to be '*very dissatisfied*' with the outcome (OR 15.9, 95% CI 10.9-23.22); thirteen times more likely to be '*very dissatisfied*' with the process (OR 13.3, 95% CI 9.43-18.72); and six and a half times more likely to indicate they '*definitely wouldn't*' recommend the process (OR 6.57, 95% CI 4.83-8.94).

¹³⁰ Health was excluded as it did not apply to all respondents and because it was ranked differently to other experience measures.

Table 75: Survey 1: association between the most negative ranking for global experience measures (satisfaction outcome, satisfaction process, recommend process) and the most negative ranking for other experience measures

	Very dissatisfied with outcome				Very dissatisfied with process				Definitely would not recommend			
	P- value	OR	95% CI		P- value	OR	95% CI		P-value	OR	95% CI	
			Lower	Upper			Lower	Upper			Lower	Upper
Role, powers Very unclear [1]	0.010	1.84	1.16	2.91	<0.001	2.33	1.47	3.68	0.17	1.29	0.90	1.84
Assessment Criteria Very unclear	0.001	1.82	1.27	2.61	<0.001	3.32	2.29	4.82	0.004	1.65	1.17	2.33
Informed No information	<0.001	2.02	1.38	2.98	<0.001	2.44	1.64	3.62	0.031	1.19	.85	1.66
Reasons Not given	0.20	1.26	0.89	1.80	0.60	1.11	.760	1.61	<0.001	1.81	1.33	2.47
Respect None shown	<0.001	2.93	1.70	5.06	<0.001	5.56	3.22	9.58	<0.001	1.89	1.33	2.68
Fairness Very unfair	<0.001	15.9	10.90	23.22	<0.001	13.3	9.43	18.72	<0.001	6.57	4.83	8.94

[1] The comparator group for all Odds Ratios except 'Health effect' was Ranks 2-5. E.g. for Role Powers were 'very unclear' (Rank1), the comparator group was 'unclear, neutral, clear and very clear' (Ranks 2-5) responses.

Age and source were again statistically significant for perceived unfairness. (Table 76)

Respondents aged 50 years and over were two and a half times more likely to believe the process was '*very unfair*' (for aged 70+ years OR 2.69, 95% CI 1.38-5.22; those 50-69 years OR 2.54, 95% CI 1.44-4.46).

Organisations were seven and a half times less likely than individuals to regard the process as '*very unfair*' (OR 0.13, 95% CI 0.69-0.85) and practitioners two times less likely than consumers (OR 0.49, 95% CI 0.36-0.65).

Age, gender, education and source (individual or practitioner) were all statistically significant for those reporting a '*very significant*' impact on health. (Table 76) Those aged 70 or over were over five times more likely to report this (OR 5.37 95% CI 2.11-13.7) and those aged 30-69 nearly four times compared to those aged less than 30 years. Women were one and a half times more likely than men (OR 1.51, 95% CI 1.16-1.97) to report this.

Those with a university education and practitioners were less likely (one and a half to two times respectively) to report this level of impact.

Table 76: Survey 1: association between respondent demographic profile and the most negative ranking (Rank 1) compared with all other rankings (Rank 2-5) for all experience measures and whether issues were addressed

	Understanding of system								Engagement & communication							
	Role power very unclear				Assess criteria very unclear				No information provided				Reasons not given			
	P-value	Odds Ratio	95% CI Lower	95% CI Upper	P-value	Odds Ratio	95% CI Lower	95% CI Upper	P-value	Odds Ratio	95% CI Lower	95% CI Upper	P-value	Odds Ratio	95% CI Lower	95% CI Upper
Age [1]	0.05				0.038				0.004				0.003			
70+		2.99	1.36	6.54		2.36	1.24	4.51		1.80	0.93	3.48		2.24	1.15	4.36
50-69		2.13	1.07	4.27		1.70	0.99	2.91		1.31	0.75	2.28		1.90	1.09	3.33
30-49		2.28	1.13	4.59		1.46	0.84	2.52		0.89	0.51	1.58		1.32	0.74	2.33
<30 years [2]		1				1				1				1		
Gender	0.05				0.43				0.28				0.49			
Female		0.78	0.61	1.0		0.91	0.73	1.14		0.88	0.69	1.11		0.92	0.73	1.15
Male [2]		1				1				1				1		
Education	0.27				0.031				0.13				0.21			
University		0.81	0.58	1.13		1.44	1.13	1.96		1.36	0.98	1.90		1.32	0.96	1.81
Trade diploma		0.76	0.55	1.07		1.06	0.78	1.46		1.09	0.78	1.52		1.13	0.82	1.56
High school [2]		1				1				1						
Source	0.50				0.007				0.004				0.05			
Practitioner		0.90	.65	1.23		0.68	0.51	0.90		0.64	0.47	0.87		0.74	0.56	0.99
Consumer [2]		1				1				1				1		
Source	<0.001				<0.001				0.002				0.011			
Organisation		0.40	0.26	0.58		0.57	0.42	0.76		0.61	0.44	0.85		0.68	0.45	0.92
Individual [2]		1				1				1				1		

[1] Model included age, gender, education and source where source = individuals (consumers and practitioners) only. Organisation and all individuals tested separately

[2] The comparator group for calculation of Odds Ratios

Table continued on next page

Table 76 continued

Parameters Ref values	Balance								Impact on health				Were issues addressed			
	Process very unfair				Shown no respect				Very significant impact				Not at all			
	P-value	Odds Ratio	95% CI Lower	Upper	P-value	Odds Ratio	95% CI Lower	Upper	P-value	Odds Ratio	95% CI Lower	Upper	P-value	Odds Ratio	95% CI Lower	Upper
Age [1]	<0.001				0.31				0.005				0.001			
70+		2.69	1.38	5.22		1.23	0.57	2.67		5.37	2.11	13.70		2.95	1.56	5.57
50-69		2.54	1.44	4.46		1.66	0.86	3.19		3.57	1.51	8.48		2.88	1.72	4.80
30-49		1.73	0.98	3.08		1.53	0.79	2.97		3.68	1.54	8.79		2.74	1.63	4.61
<30 years [2]		1	.	.		1	.	.		1	.	.		1	.	.
Gender	0.56				0.29				0.002				0.003			
Female		0.94	0.75	1.17		0.87	0.68	1.12		1.51	1.16	1.97		0.70	0.55	0.88
Male [2]		1	.	.		1	.	.		1	.	.				
Education	0.72				0.87				0.001				0.48			
University		1.02	0.75	1.38		0.94	0.67	1.37		0.64	0.45	0.91		1.21	0.88	1.68
Trade diploma		1.11	0.82	1.52		1.01	0.72	1.42		1.15	0.83	1.60		1.08	0.78	1.49
High school [2]		1	.	.		1	.	.		1	.	.		1	.	.
Source	<0.001				<0.001				<0.001				0.001			
Practitioner		0.49	0.36	0.65		0.38	0.26	0.55		0.51	0.35	0.74		0.61	0.46	0.81
Consumer [2]		1	.	.		1	.	.		1	.	.		1	.	.
Source	<0.001				<0.001				NA							
Organisation		0.13	0.08	0.20		0.24	0.15	0.40					<0.001	0.33	0.25	0.44
Individual [2]		1				1								1		

[1] Model included age, gender, education and source where source = individuals (consumers and practitioners) only. Organisation and all individuals tested separately

[2] The comparator group for calculation of Odds Ratios

6.6.1.3 Association between agency or practitioner type and negative responses

Regression analysis was undertaken for agency and practitioner type to identify any associations with the 'most negative' responses. The only statistically significant factor when comparing national and all-NSW responses is in '*reasons not given at all*'; which is moderately higher for the national scheme. (Table 77) This factor was tested for any differences between the HCCC and HPCA but was not significant (P-Value 0.60)

Table 77: Survey 1: association between the most negative ranking for experience measures and whether the complaint/notification was managed in the national or NSW scheme

	P- value	OR	95% CI	
			Lower	Upper
Outcome Very dissatisfied [1]	0.62	0.95	0.78	1.16
Process Very dissatisfied	0.21	1.132	0.93	1.38
Recommend process Definitely would not	0.71	1.04	0.85	1.28
Role, powers Very unclear	0.41	0.91	0.73	1.14
Assessment criteria Very unclear	0.16	1.16	0.95	1.41
Kept informed No information provided	0.49	1.08	0.87	1.34
Reasons Not given	0.03	1.25	1.02	1.53
Respect None shown	0.07	1.24	0.98	1.57
Fairness Very unfair	0.60	1.06	0.86	1.29

[1] The comparator group for all Odds Ratios was Ranks 2-5. For example, for outcome 'very dissatisfied r' (Rank1), the comparator group was 'dissatisfied, neutral, satisfied and very satisfied' responses (Ranks 2-5).

Practitioner type was statistically significant for only medical and nursing practitioners; showing a moderate effect when tested in relation to the most negative responses for global measures, perceived fairness and whether issues were addressed or not.

Complaints involving medical practitioners were one and a half times or more likely to be ranked negatively, particularly in relation to perceived fairness and outcomes ('*very unfair*' OR 1.74, 95% CI 1.41-2.14 and '*very dissatisfied with outcome*' OR 1.82, 95% CI 1.49-2.21). (Table 78) Conversely, matters involving nurses were less likely to respond in this way ('*very unfair*' OR 0.41, 95% CI 0.31-0.54 and '*very dissatisfied with outcome*' OR 0.41, 95% CI 0.32-0.53).

Table 78: Survey 1: most negative ranking for select experience measures where the subject practitioner was a medical or a nursing/midwifery practitioner

	Medical practitioner				Nursing/midwifery practitioner			
	P- value	OR	95% CI		P- value	OR	95% CI	
			Lower	Upper			Lower	Upper
Very dissatisfied outcome [1]	<0.001	1.82	1.49	2.21	<0.001	0.41	0.32	0.53
Very dissatisfied process	<0.001	1.67	1.37	2.03	<0.001	0.45	0.35	0.58
Definitely would not recommend the process	0.004	1.36	1.10	1.68	<0.001	0.51	0.38	0.68
Process very unfair	<0.001	1.74	1.41	2.14	<0.001	0.41	0.31	0.54
Issues not addressed at all	<0.001	1.50	1.23	1.83	<0.001	0.55	0.43	0.71

[1] The comparator group for all Odds Ratios was 'dissatisfied, neutral, satisfied and very satisfied' responses (Ranks 2-5).

6.6.1.4 Association between outcome types and negative responses

The impact of summary outcome type was assessed in relation to global measures, whether issues were addressed and fairness. (Table 79) For global measures, ‘no action’ outcomes are statistically significant: ‘very dissatisfied with outcome’ OR 5.46, 95% CI 3.80-7.84; ‘very dissatisfied with process’ OR 4.78, 95% CI 3.29-6.98; and ‘definitely wouldn’t recommend process’ OR 3.55, 95% CI 2.37-5.31. Respondents reporting other outcomes (excluding ‘referral’ and ‘don’t know’) were statistically less likely to respond in this way. A similar pattern was observed for perceived fairness and whether issues were addressed.

Table 79: Survey 1: association between summary outcome categories and the most negative ranking for global experience measures (satisfaction outcome, satisfaction process, recommend process) and whether issues were addressed

	Very dissatisfied with outcome				Very dissatisfied with process			
	P- value	OR	95% CI		P- value	OR	95% CI	
			Lower	Upper			Lower	Upper
Don't know [1]	0.27	1.26	0.84	1.90	0.082	1.44	0.96	2.17
No action	<0.001	5.46	3.80	7.84	<0.001	4.78	3.29	6.96
Apology, info, explain [2]	<0.001	0.42	0.32	0.57	<0.001	0.37	0.28	0.50
Refer	0.51	0.80	0.41	1.56	0.15	0.59	0.29	1.20
Relinquish [3]	<0.001	0.19	0.07	0.48	0.004	0.26	0.10	0.64
Action excl. suspend, cancel	0.001	0.48	0.31	0.73	0.012	0.57	0.37	0.88
Suspend, cancel	0.094	0.43	0.16	1.16	0.66	0.82	0.34	1.99

Table 79 continued

	Definitely would not recommend				Issues not addressed at all			
	P- value	OR	95% CI		P- value	OR	95% CI	
			Lower	Upper			Lower	Upper
Don't know	0.12	1.40	0.91	2.14	0.005	1.85	1.20	2.84
No action	<0.001	3.55	2.37	5.31	<0.001	3.75	2.61	5.37
Apology, info, explain	<0.001	0.44	0.32	0.61	<0.001	0.33	0.25	0.45
Refer	0.55	0.80	0.39	1.65	0.49	0.75	0.38	1.48
Relinquish	0.008	0.65	0.01	0.49	<0.000	0.14	0.06	0.33
Action excl. suspend, cancel	0.14	0.70	0.43	1.12	<0.001	0.28	0.18	0.42
Suspend, cancel	0.028	0.51	0.15	1.75	0.005	0.20	0.07	0.62

[1] The comparator group for all Odds Ratios was Ranks 2-5

[2] ‘Apology, info, explain’ includes apology, information, explanation, reimburse or waive fees or costs; compensation; Relinquish includes practitioner relinquished or did not renew registration; ‘Action excl. suspend, cancel’ includes all actions or requirements by regulator except suspension or cancellation of registration; ‘Suspend, cancel’ includes suspension or cancellation of registration by the regulator

Most dissatisfied responses for global measures were then tested with an expanded set of outcome measures to see if there was an association with specific action types. (Table 80) As previously, those ‘most dissatisfied’ were tested against all other responses (Ranks 2-5).

Receiving an apology and information were statistically significant for all global measures and of greater importance than explanations. Conciliation is statistically significant for outcomes. Action by regulators (e.g. conditions, cautions, or requiring a practitioner to undertake a health or education program) in comparison with undertakings by practitioners, were of greater significance unless a practitioner ceased practice altogether (relinquished or did not renew registration). Suspension and cancellation were of similar significance for satisfaction with outcomes, but only suspension was statistically significant for satisfaction with the process or whether the process would be recommended.

Table 80: Survey 1: association between major outcome types and the most negative ranking for global experience measures (satisfaction outcome, satisfaction process, recommend process)

	Very dissatisfied with outcome				Very dissatisfied with process				Definitely would not recommend			
	P- value	OR	95% CI		P- value	OR	95% CI		P-value	OR	95% CI	
			Lower	Upper			Lower	Upper			Lower	Upper
No action [1]	<0.001	5.41	4.16	7.02	<0.001	4.12	3.18	5.35	<0.001	3.11	2.33	4.16
Apology [2]	<0.001	0.38	0.22	0.64	0.002	.41	0.23	0.72	0.01	0.39	0.20	0.75
Explanation	0.12	0.75	0.52	1.08	0.004	.58	0.40	0.84	0.19	0.77	0.52	1.14
Information	<0.001	0.38	0.23	0.62	0.001	.40	0.24	0.67	0.001	0.35	0.19	0.63
Fees, costs	0.25	0.58	0.23	1.50	0.08	.40	0.14	1.10	0.12	0.38	0.11	1.30
Compensat'n	0.14	0.19	0.02	1.68	0.22	.26	0.03	2.21	0.97	0.97	0.19	5.00
Conciliation	0.014	4.81	1.38	16.8	0.89	.91	0.24	3.40	0.53	0.60	0.12	3.00
Relinquish	<0.001	0.18	0.07	0.46	<0.001	.24	0.10	0.60	0.006	0.06	0.01	0.45
Conditions	0.015	0.51	0.29	0.88	0.04	.55	0.32	0.96	0.02	0.45	0.23	0.88
Health, Ed.	0.13	0.61	0.31	1.17	0.16	.62	0.32	1.21	0.51	0.79	0.38	1.62
Undertaking	0.19	0.66	0.36	1.22	0.39	.77	0.42	1.41	0.85	0.94	0.49	1.81
Counsel	0.45	0.79	0.44	1.45	0.12	.59	0.30	1.15	0.47	0.78	0.39	1.55
Caution, rep.	0.15	0.67	0.39	1.15	0.33	.76	0.44	1.32	0.84	1.06	0.59	1.91
Reg suspend	0.26	0.52	0.17	1.60	1.00	1.00	0.38	2.63	0.24	0.41	0.09	1.83
Reg cancel	0.50	0.58	0.12	2.80	0.49	.58	0.12	2.76	0.80	1.24	0.25	6.19

[1] The comparator group for all Odds Ratios was Ranks 2-5 in a 5 point Likert scale where Rank 1= the most negative response.

[2] Outcomes include: No action was taken; Apology given; Explanation given; Information provided; Fees or costs waived or reduced; Received compensation; Referred to conciliation; Practitioner retired or surrendered registration; conditions placed on practice; Practitioner made undertakings; Practitioner required to do a health or education program; Practitioner counselled; Caution or reprimand issued; Registration suspended; Registration cancelled. Outcome types exclude Don't know; Referred to another agency; Fine imposed; Fine imposed; Prohibition order issued responses.

6.6.1.5 Association between adverse events or death and negative responses

The relationship between the most negative responses and complaints involving death or adverse outcomes (including a failure to respond or disclose an adverse outcome) identified in survey responses was tested separately.¹³¹ (Table 81)

Adverse events were not statistically significant for any experience indicators. However, of the 106 identified deaths, death was statistically significant; showing a moderate effect for the most negative responses for outcome ('*very dissatisfied*' OR 1.59, 95% CI 1.05-2.40); clarity of assessment criteria ('*very unclear*' OR 1.51, 95% CI 1.01-2.24) agency role and powers ('*very unclear*' OR 1.57, 95% CI 1.04-2.37); and reasons for decisions ('*not provided at all*' OR 1.54, 95% CI 1.04-2.30). These respondents were also one and a half times more likely to indicate their issues were '*not addressed at all*' (OR 1.56, 95% CI 1.01-2.40).

These factors are congruent with survey comments and interviews where respondents questioned the adequacy of agency powers to address the seriousness of events; and took issue with or could not understand reasons for decisions or outcomes when a death was involved where no action was taken or action perceived as only 'minor' was taken.

¹³¹ When asked to identify issues, "*adverse outcome*" and "*failed to respond or disclose adverse outcome*" were included as options in '*care or treatment*' responses; with '*adverse outcome*' indicated as "*unexpected complications, harm or death*". Sixteen percent (N=268) indicated their complaint involved an adverse outcome (N=249) or a failure to respond/disclose this (N=85). In addition, 108 specifically mentioned a death in their comments, of which 106 indicated the death was directly related to events subject of complaint. Of these 106 cases, 44 indicated their complaint involved an adverse outcome and of these, 12 also involved a failure to respond or disclose this.

Table 81: Survey 1: association between cases where a death or adverse event occurred and the most negative experience measure ranking

	Death				Adverse outcome			
	P- value	OR	95% CI		P- value	OR	95% CI	
			Lower	Upper			Lower	Upper
Very dissatisfied outcome [1]	0.03	1.59	1.05	2.40	0.59	1.08	0.82	1.40
Very dissatisfied process	0.97	1.40	0.94	2.09	0.81	0.97	0.75	1.26
Definitely not recommend	0.06	1.48	0.99	2.22	0.30	0.86	0.64	1.15
Role power very unclear	0.03	1.57	1.04	2.37	0.79	0.96	0.71	1.30
Assess. criteria very unclear	0.04	1.51	1.10	2.25	0.64	0.94	0.71	1.23
No information provided	0.62	1.11	0.73	1.71	0.72	0.95	0.71	1.27
Reasons not provided	0.03	1.54	1.04	2.30	0.83	0.97	0.74	1.28
No respect shown	0.70	1.10	0.69	1.73	0.49	0.89	0.65	1.23
Very unfair	0.07	1.44	0.97	2.15	0.66	0.94	0.72	1.24
Issues not addressed at all	0.04	1.56	1.01	2.40	0.66	1.06	0.81	1.40

[1] The comparator group for all Odds Ratios was Ranks 2-5 in a 5 point Likert scale where Rank 1= the most negative response.

6.6.1.6 Association between where events occurred and negative responses

Testing for all experience measures, location (where events occurred) was statistically significant for the most negative responses in relation to outcome, fairness, whether the process would be recommended and whether issues were addressed. (Table 82) Compared with public inpatient hospitals, moderate effects were seen in sole and group practice and private hospitals. This is more so in group practice; particularly responses '*definitely would not recommend*' (OR 2.05, 95% CI 1.46-2.87); and process '*very unfair*' (OR 1.72, 95% CI 1.25-2.38).

Table 82: Survey 1: most negative ranking for select experience measures where events occurred in a private hospital, in group practice and sole practice compared with public hospitals

	P- value	Private hospital			Group practice			Sole practice		
		OR	95% CI		OR	95% CI		OR	95% CI	
			Upper	Lower		Upper	Lower		Upper	Lower
Very dissatisfied outcome	0.049	1.44	0.98	2.10	1.55	1.14	2.12	1.46	1.04	2.04
Very unfair process	0.023	1.56	1.05	0.23	1.72	1.25	2.38	1.38	0.97	1.96
Definitely not recommend	0.011	1.56	1.03	2.36	2.05	1.46	2.87	1.34	0.92	1.95
Issues not addressed	0.026	1.38	0.93	2.04	1.30	0.94	1.78	1.26	0.89	1.78

The comparator group for Odds Ratios was 'Public hospital'

Private hospital N=181 (11%); Group practice N=453 (27%); Sole practice N=293 (18%). Statistically significant for public hospital outpatients (4%) and community health centres (2%); but not presented due to small numbers

6.6.2 Most positive respondents

In 108 cases the respondent was 'very satisfied' with the process; in 92 the outcome and in 67 (4% of returns) both. The proportion in each category was consistent with overall returns for the agencies. [A6.6.1]

Table 83 shows the frequency and percentage of participants that gave the most positive responses. In contrast with those 'most dissatisfied', demographic characteristics were far less notable, and where they occurred, of a more modest range for the 'most positive' respondents. Those aged less than 30 or with a university education reported more frequently that their health was 'not affected at all'; and the proportion of those aged less than 30 that would 'definitely recommend' the process was higher.

Table 83: Survey 1: most positive ranking of experience measures by respondent demographic profile

	Very satisfied with process		Very satisfied with outcome		Definitively would recommend process		Process very fair		Health not affected at all	
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Education level										
Nil-high school	21	7	10	3	69	23	17	6	59	20
Trade, diploma	26	6	16	4	84	21	17	4	81	20
University	38	5	37	5	140	20	52	7	255	36
Age										
<30 years old	6	9	4	6	20	28	5	7	30	42
30-49 years old	32	7	23	5	99	20	34	7	133	30
50-69 years old	45	6	35	5	154	21	45	6	207	28
70+ years	3	3	2	2	20	17	2	2	25	21
Gender excl. org										
Male	19	4	12	2	102	19	26	5	167	31
Female	67	7	51	6	195	22	61	7	230	26

Table 83 continued

	Issues addressed in full		Role and powers very clear		Assessment criteria very clear		Very well informed		Reasons very well explained		Treated very respectfully	
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Education level												
Nil-high school	20	7	42	14	39	13	29	10	25	8	52	18
Trade, diploma	31	8	52	13	42	10	45	11	32	8	83	20
University	61	9	93	13	52	7	43	6	32	5	137	19
Age												
<30 years old	8	11	8	11	5	7	7	10	7	10	15	21
30-49 years old	37	8	49	10	36	8	34	7	25	5	87	18
50-69 years old	64	9	117	16	79	11	66	9	54	7	150	20
70+ years	4	3	13	11	12	10	9	8	5	4	21	18
Gender excl. org												
Male	28	5	68	13	45	8	37	7	26	5	101	19
Female	84	9	121	13	88	10	82	9	65	7	173	19

All experience measures include the most positive response (Rank 5) in a 5 point Likert scale and include the wording and descriptor (where given) in the survey

Key > 5% to 10% > 10% to 20% > 20%

Only gender was statistically significant for those 'very satisfied' with the process or outcome (Table 84); women two and a half times more likely to report this (outcome OR 2.80, 95% CI

1.43-5.45; process OR 2.54, 95% CI 1.45-4.45). Source and level of education were statistically significant for respondents that would '*definitely recommend*' the process, with organisations three times more likely than consumers to report this (OR 3.05, 95% CI 2.28-4.08), and to a lesser extent, practitioners (OR 1.74, 95% CI 1.24-2.43). However, those with a higher education were less likely to report this view.

Source and agency type were not statistically significant for those '*very satisfied*' with the process: AHPRA p-Value 0.16 (OR 0.75 95% CI 0.51-1.11); HPCA p-Value 0.27 (OR 1.32 95% CI 0.81-2.15); and HCCC p-Value 0.51 (OR 1.16 95% CI 0.75-1.82).

Table 84: Survey 1: association between respondent demographic profile and the most positive ranking for global experience measures (satisfaction outcome, satisfaction process, recommend process)

	Very satisfied with outcome				Very satisfied with process				Definitely would recommend			
	P-value	Odds Ratio	95% CI		P-value	Odds Ratio	95% CI		P-value	Odds Ratio	95% CI	
			Lower	Upper			Lower	Upper			Lower	Upper
Age [1]	0.80				0.47				0.44			
70+ years		0.46	0.08	2.67		0.38	0.09	1.69		0.54	0.26	1.13
50-69 years		0.97	0.33	2.85		0.92	0.35	2.42		0.70	0.40	1.24
30-49 years		0.92	0.31	2.77		1.02	0.38	2.74		0.71	0.40	1.26
<30 years		1	.	.		1	.	.		1	.	.
Gender	0.003				0.001				0.31			
Female		2.80	1.43	5.45		2.54	1.45	4.45		1.15	0.88	1.52
Male		1	.	.		1	.	.		1	.	.
Education	0.90				0.34				0.05			
University		1.20	.54	2.66		0.63	0.34	1.20		0.64	0.44	0.93
Trade diploma		1.07	.47	2.43		0.86	0.47	1.59		0.86	0.59	1.25
High school		1	.	.		1	.	.		1	.	.
Source [2]	0.30				0.80				0.001			
Practitioner		1.38	0.75	2.54		1.08	0.60	1.95		1.74	1.24	2.43
Consumer		1	.	.		1	.	.		1	.	.
Source	<0.001				0.90				<0.001			
Organisation		3.01	1.88	4.80		1.57	0.95	2.58		3.05	2.28	4.08
Individual		1	.	.		1	.	.		1	.	.

[1] The model included age, gender, education and source where source = individuals (consumers and practitioners) only. [2] Organisation and all individuals tested separately

Those '*very satisfied*' reported significantly less 'don't know' and 'no action' results. (Table 85)

Table 85: Survey 1: most positive ranking for process and outcome by summary outcome categories

	Don't know		No action		Acknowledge comm., fees		Retire or surrender		Actions excl. suspend/cancel		Suspend, cancel	
	N	%	N	%	N	%	N	%	N	%	N	%
All	254	15	1032	60	335	20	47	3	322	19	38	2
Process	3	3	18	17	44	42	9	9	46	44	2	2
Outcome	3	3	9	10	33	37	12	14	46	52	2	2
Process & Outcome	1	-	4	6	28	44	6	9	35	55	7	11

Being given an 'apology' was significant for the process ('*very satisfied*' OR 2.21, 95% CI 1.11-4.39) and whether the process would '*definitely be recommended*' (OR 2.05, 95% CI 1.26-3.35); but not for outcome. (Table 86)

As with those '*very dissatisfied*', provision of information, imposition of conditions and relinquishment of registration are statistically significant for those '*very satisfied*' either with the

outcome or process. Unlike those ‘*very dissatisfied*’ with the outcome, a requirement to undergo a health or education program (OR 1.94, 95% CI 0.98-3.86) or undertakings by the practitioner (OR 2.03, 95% CI 1.01-4.08) were statistically significant for those ‘*very satisfied*’.

Table 86: Survey 1: global experience measures: most positive responses (Rank 5) compared with all other ranked responses (Ranks 1-4) by major outcome categories

	Very satisfied with outcome				Very satisfied with process				Definitely would recommend			
	P- value	OR	95% CI		P- value	OR	95% CI		P-value	OR	95% CI	
			Lower	Upper			Lower	Upper			Lower	Upper
No action [1]	<0.0001	0.10	0.05	0.20	<0.001	0.16	0.09	0.28	<0.001	0.34	.256	.442
Apology [2]	0.45	1.38	0.59	3.23	0.023	2.21	1.11	4.39	0.004	2.05	1.26	3.35
Explanation	0.85	1.07	0.53	2.18	0.12	1.61	0.89	2.94	0.38	0.83	0.56	1.25
Information	<0.000	3.45	1.76	6.73	0.003	2.55	1.38	4.71	<0.001	2.33	1.49	3.65
Conciliation	0.78	1.26	0.25	6.36	0.88	0.88	0.17	4.54	0.44	0.62	0.18	2.10
Relinquish	0.001	3.90	1.78	8.58	0.017	2.71	1.20	6.16	0.05	1.93	1.01	3.67
Conditions	0.042	1.84	1.02	3.32	0.024	1.91	1.09	3.37	0.001	2.02	1.32	3.08
Health, educ. program	0.06	1.94	0.98	3.86	0.12	1.70	0.87	3.33	0.81	1.07	0.64	1.78
Undertakings	0.047	2.03	1.01	4.08	0.89	1.05	0.50	2.21	0.02	1.80	1.09	2.98
Counsel	0.65	0.82	0.34	1.96	0.60	0.81	0.36	1.80	0.65	1.13	0.68	1.88
Caution, rep.	0.045	0.41	0.17	0.98	0.26	0.66	0.32	1.36	0.59	0.88	0.55	1.40
Reg suspend	0.86	1.12	0.33	3.78	0.87	1.10	0.34	3.62	0.15	1.85	0.81	4.24
Reg cancel	0.031	3.81	1.13	12.84	0.67	1.36	0.33	5.57	0.11	2.59	0.82	8.22

[1] The comparator group for all Odds Ratios was Ranks 1-4 (very dissatisfied, dissatisfied, neutral and satisfied)

[2] Outcomes include: No action was taken; Apology given; Explanation given; Information provided; Fees or costs waived or reduced; Received compensation; Referred to conciliation; Practitioner retired or surrendered registration; conditions placed on practice; Practitioner made undertakings; Practitioner required to do a health or education program; Practitioner counselled; Caution or reprimand issued; Registration suspended; Registration cancelled. Excludes don't know; Referred to another agency; Fine imposed; Fine imposed; Prohibition order issued

These findings make sense when looking at specific professions and what was sought from the process. Only medical and nursing matters were statistically significant for those ‘*very satisfied*’ with the process or the outcome; responses relating to nurses being over two and a half more time ‘*very satisfied*’ with the outcome. (Table 87)

Table 87: Survey 1: experience measures most positive responses (Rank 1) compared with all other responses (Ranks 2-5) where subject practitioner was a medical or nursing practitioner

	Medical practitioner				Nursing practitioner			
	P- value	OR	95% CI		P- value	OR	95% CI	
			Lower	Upper			Lower	Upper
Very satisfied outcome [1]	0.001	0.50	0.33	0.77	<0.001	2.89	1.86	4.49
Very satisfied process	0.002	0.54	0.37	0.80	0.014	1.73	1.12	2.69
Definitely would recommend	<0.001	1.70	1.36	2.14	<0.001	0.45	0.35	0.69
Very fair	<0.001	0.42	0.30	0.62	<0.001	2.45	1.67	3.70

[1] The comparator group for all Odds Ratios was ‘very dissatisfied, dissatisfied, neutral and satisfied’ responses (Ranks 1-4) for each profession.

Reflecting the association between nursing and organisational complainants, organisations were three times more likely to be ‘*very satisfied*’ with the outcome than individuals (p-value <0.001 OR 3.01 95% CI 1.88-4.80). This related to consumers, who were less likely to be ‘*very satisfied*’ (p-value <0.001 OR 0.42 95% CI 0.27-0.64); whereas this was not statistically significant for practitioner complainants.

Similar patterns were observed for whether the process would ‘*definitely be recommended*’ (organisation P-value <0.001 OR 3.10 95% CI 2.28-4.08) and to a lesser extent fairness (organisation P-value <0.001 OR 2.73 95% CI 1.79-4.17).

Those ‘*very satisfied*’ with the outcome were less likely to have wanted a practitioner ‘disciplined or punished’ and more likely to want the practitioner assessed, particularly when the practitioner was a nurse. (Table 88)

Table 88: Survey 1: what respondent wanted for the subject practitioner: ‘very satisfied’ respondents compared with all responses and responses where the subject was a medical or nursing practitioner

	Improve standards ²		Discipline punish ³		Assessed ⁴		Stopped ⁵	
	N	%	N	%	N	%	N	%
Process ¹	74	69	43	40	46	43	29	27
Outcome ¹	59	64	32	35	49	53	29	32
Process & Outcome ¹	43	64	24	36	32	48	18	27
All survey responses	1297	75	1092	63	686	40	612	35
DR only responses	803	77	679	65	377	36	336	32
NMW only responses	222	68	178	54	175	54	159	49
Source organisation	143	59	113	47	133	55	102	42

[1] Process= very satisfied with process; Outcome= very satisfied with outcome; Process & outcome= very satisfied with both the process and the outcome; All= all survey responses

[2] Improve standards= Wanted practitioner's standard of treatment or care improved

[3] Discipline punish= Wanted practitioner disciplined or punished

[4] Assessed= Wanted practitioner assessed (have health check or treatment)

[5] Stopped= Wanted practitioner stopped from practising

Another key difference is that 82% of those ‘*very satisfied*’ with both the process and outcome reported their issues were addressed ‘*in full*’ compared with 11% of all respondents. (Table 89) While numbers are small, the proportion reporting awareness of improvements ‘*planned*’ or ‘*made*’ was twice that of all respondents.

Whether issues were addressed (partly, mostly or in full) was also statistically significant ($P < 0.0001$); respondents 78 times more likely to be ‘*very satisfied*’ with the outcome (OR 78.11, 95% CI 19.16-318.43). Fairness was also statistically significant ($P < 0.0001$); particularly respondents ranking the process as ‘*very fair*’ (OR 726.26, 95% CI 98.96-5338.77) or ‘*fair*’ (OR 63.25, 95% CI 8.39-476.99).

Table 89: Survey 1: most positive responses (Rank 5) for process and outcome by whether issues were addressed and respondent awareness of improvements

	Whether issues were addressed ¹								Respondent awareness of improvements							
	Not at all		Partly		Mostly		In full		Planned		Made		No		Don't know	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Process [2]	5	5	7	7	24	23	70	66	15	14	19	18	55	51	18	17
Outcome	2	2	7	8	13	14	69	76	14	15	18	20	47	51	13	13
Process & outcome	2	3	1	-	9	14	54	82	10	15	14	21	32	48	11	16
All	959	57	304	18	180	11	177	11	94	6	95	6	1181	69	345	20

[1] Don't know not included

[2] Categories: Process= very satisfied with process; Outcome= very satisfied with outcome; Process & outcome= very satisfied with both the process and the outcome; All= all survey responses

Summary of Sub-section 6.6: most negative and most positive responses

Demographic characteristics were statistically significant for those ‘*most dissatisfied*’ with the process and outcome and whether the process would ‘*definitely not be*’ recommended to others. Older age is the most important factor, followed to a lesser extent by gender (men being less satisfied). Individuals, particularly consumers are the least satisfied; and practitioner complainants less than organisations.

The extent to which issues were addressed was statistically significant. Where issues were not addressed *at all*, respondents were twelve times more likely to be '*very dissatisfied*' with the outcome and seven and a half times more likely to feel that they or their organisation '*definitely would not*' recommend the process. Eighty-two percent of those '*very satisfied*' with both process and outcome reported issues were addressed '*in full*' compared with 11 percent of all respondents.

Tested separately, those who were '*very dissatisfied*' with the process were 87 times more likely; and those with the outcome 38 times more likely than those who were '*very satisfied*' to indicate they '*definitely would not*' recommend the process. In contrast, demographic characteristics were far less notable, and where they occurred, of a more modest range for the '*most positive*' respondents.

Fairness was the most statistically significant factor for all global measures; those ranking the process '*very unfair*' being sixteen times more likely to be '*very dissatisfied*' with the outcome thirteen times more likely to be '*very dissatisfied*' with the process and six and a half times more likely to indicate they '*definitely would not*' recommend it.

The only statistically significant factor when comparing national and all-NSW responses for experience measures is in '*reasons not given at all*'; which is moderately higher for the national scheme.

Experiencing some form of action was significant. Receiving an apology and information were statistically significant for all global measures and of greater importance than explanations for those '*very dissatisfied*'. Information was the same for those '*most satisfied*' but apology only for process but not outcome.

Action by regulators (e.g. conditions, cautions, or requiring a practitioner to undertake a health or education program) in comparison with undertakings by practitioners, were of greater significance unless a practitioner ceased practice altogether (relinquished or did not renew registration) for those '*most dissatisfied*'. Suspension and cancellation were of similar significance for outcomes for those '*most dissatisfied*'.

For those '*most satisfied*', relinquishment or cancellation of registration, imposition of conditions, making undertakings or undertaking a health or education program were significant. These outcomes were consistent with what was sought by the respondent, who were significantly more likely to have had action taken and their issues addressed. They were also less likely to have wanted a practitioner '*disciplined or punished*' and more likely to want them assessed, particularly when the practitioner was a nurse.

6.7 Survey 2: observations on the management of complaints and notifications

Over three-quarters of community and professional organisation¹³² respondents provided feedback on complaint trends and their management. The focus here is on the latter.

Community respondents described ‘*defensive*’ and ‘*bureaucratic*’ responses; and perceived pressure to ‘*soften*’ responses; resulting in consumer frustration; issues going unaddressed and lack of change. Impediments to raising or sustaining a complaint faced by vulnerable populations featured, including older people, people from non-English speaking backgrounds, refugees and people with a mental illness.¹³³ One commented on the challenges of achieving system reform to recognise consumers and their views, noting:

“While [we] have worked hard to embed the consumer feedback standards and create a culture in health services that values feedback I do not think we have achieved what we have set out to achieve.” (Ref 40)

In contrast, professional organisations noted an increasing trend in consumers exercising their rights; one commenting this was at “*an alarming rate*” (Ref 80); and concern that some complaints are trivial or unfair. Timeliness and the stress of the process were raised by professional organisations, including comment that practitioners are asked to provide detailed responses in short timeframes but then experience protracted processes without updates; another felt complaint management had become so complex as to impede the process. These respondents also commented on employers escalating matters to agencies before internal investigations were undertaken or that would be more appropriately handled at the service level through performance management strategies. The use of different complaint management pathways (health, performance and conduct) was noted positively, as “*beneficial to the public and the practitioner.*” (Ref 58)

There were mixed views on the overall performance of both the national and NSW schemes—ranging from “*process with pharmacists working effectively, no change needed*” (Ref 68) to “*appalling, a huge failure since inception, hated by patients and doctors alike.*” (Ref 37)

The reasons varied, as did the comment, which ranged from specific operational practices to system wide issues. Some focused on process issues previously flagged in Survey 1 - such as timeliness, communication, procedural fairness or perceived systems imbalance - all talking about similar issues but from opposite perspectives. For one, the current system is “*too one-*

¹³² Community respondents include ‘Population’ organisations, which are community organisations representing specific demographic groups (e.g. Aboriginal and Torres Strait Islander peoples; older or younger people; people living in rural or remote areas); and ‘Consumer’ organisations which are community organisations representing public health or specific health consumer interests. ‘Professional’ organisations include professional associations or insurers (indemnity and defence organisations) representing health practitioner interests.

¹³³ Expressed concerns for people with mental illness included rough handling; objections to the (forced) use of medication; and problems with a lack of evidence when seeking to make complaints.

sided, consumers can lodge complaints about the smallest of matters” (Ref 80); the system causing adverse personal or financial impacts on practitioners. For others *“the practitioner’s rights appear to outweigh any patient’s complaint”* (Ref 37), the system failing patients by not taking them seriously or engaging respectfully to understand their substantive concerns.

Both community and professional organisations expressed concern about lack of consistency of personnel and approach as well as knowledge and systems capacity. These related to adequacy of triage processes; skill of staff undertaking assessments or investigations; the qualifications of ‘expert reviewers’; and knowledge of decision-makers. One questioned whether the regulators scope was too broad, with some matters better managed through other means (e.g. leaving deaths for Coronial inquiries). Another (professional organisation) noted that while generally good, matters on occasion were dealt with in a punitive, arbitrary or disciplinary manner – inconsistent in their view with a rehabilitative approach and the intended aim of public protection; commenting there should be a *“realistic and collaboratively enhanced complaint model.”* (Ref 43)

Another systemic concern was that the regulatory system did not adequately support individual practitioners to understand and meet their responsibilities, it is *“all care, no responsibility”* and greater support is needed. (Ref 45) Whether the national changes had delivered as intended was also raised by professionals:

“this system (under National Law) has become bureaucratic and more fragmented than before the scheme was centralised...Because health professional bodies were at different stages of development the minimum standard for the national agency is now too low. This means some professions have gone backwards in their capacity to self-regulate in the public interest.” (Ref 46)

Another (consumer) organisation observed that the regulatory system, practitioners and their representative organisations are being overtaken by public expectations and initiatives to make themselves heard through other channels:

“Whilst necessary, the formal processes of complaints/notification process are becoming less important for the public and, in some cases, totally irrelevant. The public are now turning to social media to have a voice. The problem for health services and practitioners is that they find it difficult to engage with this newfound voice. We need mechanisms that bring these two worlds together so that there are constructive conversations, rather than what appears to be things 'done behind closed doors'. Citizens favour transparency when it comes to these matters, and tend to be more concerned that it doesn't happen to others. They want their experience (good or bad) to be helpful in shaping the quality of health services.” (Ref 35)

Sixty percent of respondents commented on how we might judge whether the system is working well or not. Many stressed the importance of engaging with peak organisations to both develop performance measures and reflect on their implications for future practice and improvements.

Suggestions included indicators of accessibility; content; and process and outcome factors. Examples included number and type of complaints; efficiency of handling; categories of management and outcomes. Others identified perceived fairness and satisfaction from both a complainant and profession perspective. Whether the content of concerns was understood and responded to; consistency of approach; and whether experience translated to preventative strategies were also proposed.

Some emphasised the importance of ensuring that whatever data are collected is used; and establishing the infrastructure to support this. This included a national approach to complaint data gathering, management and reporting. Aligning complaints data with data arising from other sources also featured.

Finally, views differed on the implications of complaint trends, particularly whether an increase or decrease in complaint numbers should be regarded positively or negatively. For some, a decrease demonstrates a system working well. For others, an increase is positive, signalling a confidence to come forward and raise concerns.

Summary of Chapter 6

Survey 1 respondents' understanding about the role and powers of agencies varied and few appeared familiar with statutory requirements in either scheme. '*Public protection*' featured in Survey 2 responses; however '*representing consumer rights*' was highly ranked by community organisations and there were mixed responses in relation to other statutory roles. In Survey 2 twice as many professional compared to community organisations thought agency powers were '*adequate*' for investigations and interventions; but only one-third of all respondents thought the ability to monitor and enforce compliance was '*adequate*'.

A lack of clarity about assessment criteria and dissatisfaction with the assessment process featured in Survey 1 responses for both systems. Over half ranked information received as '*very poor*' or '*poor*'; with two-thirds receiving '*no reasons*' or only '*minimal information*' about why a decision was made. This was higher for medical compared with all other professions. Differences between AHPRA and NSW were small, mainly relating to a higher rate of minimal contact by AHPRA. The HCCC had a lower rate of '*no reasons provided*'; but a higher proportion of perceived unfairness associated with information provided. Absence of explanation for actions taken and reasons for decisions undermined confidence in the process; and confidence that action, where taken, is appropriate and proportionate.

Sixty percent of Survey 1 respondents rated the process as '*unfair*' or '*very unfair*'. AHPRA and NSW responses were similar although more marked for the HCCC; and complaints about medical practitioners compared with all other professions. Fairness was the most statistically

significant factor for 'global measures' of satisfaction - those ranking the process '*very unfair*' were sixteen times more likely to be '*very dissatisfied*' with the outcome and thirteen times with the process; and six and a half times more likely to indicate they '*definitely would not*' recommend it.

Perceptions of fairness were influenced by whether parties were treated equally; assumption of practitioner credibility; and the level of seriousness demonstrated by providing information and reasons for decisions; accepting inaccurate or false information from practitioners without challenge; and complainant ability to review and respond. Rankings for the level of respect shown are more positive, with over 40 percent indicating they were treated '*reasonably*' or '*very*' respectfully. However, respondents distinguished between courtesy shown to individuals and (lack of) respectfulness of the process.

Overall, respondents told us that making a complaint was an onerous, time consuming, difficult and stressful experience; whether they were a consumer, practitioner or employer. Both physical and psychological effects of the process as well as original events were significant. Many were concerned both for themselves and the practitioner; and Survey 2 responses indicate subject practitioners find the process equally difficult. Fear of repercussions and retribution was substantial and an identified barrier to raising concerns. Survey 2 suggests population groups particularly disadvantaged include people who are not literate, people with mental illness and older people.

A significant proportion of respondents expressed substantial dissatisfaction with the overall complaint process and outcome. The proportion of people who would '*definitely recommend*' the process was larger than respondents '*very satisfied*' with the process or outcome. However, comments suggest this preparedness to recommend the process was often related to a requirement or 'hope' for future improvements rather than confidence in the system.

Older age followed to a lesser extent by male gender is statistically significant for those '*most dissatisfied*' with the process and outcome and '*definitely not*' recommending the process. Individuals, particularly consumers were the least satisfied; and practitioner complainants less than organisations. Demographic characteristics were less notable for the '*most positive*' respondents.

Where issues were not addressed *at all*, respondents were twelve times more likely to be '*very dissatisfied*' with the outcome; while the '*most satisfied*', were significantly more likely to have had their issues addressed and action taken. They were less likely to have wanted a practitioner '*disciplined or punished*' and more likely to want them '*assessed*'. Receiving an apology and information were statistically significant for those '*very dissatisfied*'. Action by regulators was significant for those '*most*' and '*least*' satisfied with outcomes.

Chapter 7. Discussion

This study was designed to gain an understanding of the motivations, expectations and experiences of complainants; to compare and contrast points of similarity and difference between the national and NSW systems and professions; and to report on implications of respondent perceptions to inform future practice; having regard to developments in 'best practice' regulation and complaint management. This chapter discusses key findings in relation to each of the study objectives.

7.1 Developments in regulation and complaint management and the NSW and national schemes

Conceptual and practice advances away from 'top down' and 'rules-based' regulation have been adopted and implemented in Australia - 'responsive' and 'risk based' regulation principles and approaches both cornerstones of health practitioner regulatory practice.(20, 65, 77, 271, 275, 291, 293) However, the historical model of practitioner self-regulation has not been entirely displaced.(8, 12, 14) Health professionals retain a central role in registration, education, standard-setting, and the assessment, management and adjudication of complaints.(423, 424) NSW (followed by Queensland) departed most from traditional models by the possession of investigative and prosecutorial powers exercised independently of, although in consultation with, professional boards.(187-191)

Australian health complaint commissions were established in response to evidence of the scale and cost of healthcare errors and harms and unacceptable standards of care and behaviour; combined with regulatory failure to respond to patient and practitioner complaints drawing attention to these problems.(94, 98, 159, 160, 170-172) Complaint mechanisms offer the potential to serve multiple interests, principally by signalling risks to safety and quality of care; providing an accessible path for issue resolution; and providing information that may contribute to education, standards and practice improvements.(44, 52, 79, 128, 280, 289) This study found that the extent to which these potential roles are realised or effectively communicated to complainants is variable.

Receipt and management of complaints remains a core responsibility for regulators in both the NSW and national schemes, although resolution is not part of the national model. In NSW this is a recognised role. However, study responses indicate tensions identified early in the HCCC's establishment remain regarding the extent to which individual versus the public interest can or is intended to be served by the process.(190)

Other tensions identified in previous reviews and studies of regulatory practice and complaint management remain also. These include how to resolve competing principles, particularly access to information and confidentiality (12); the relative value and appropriate use of learning and 'sanction' responses (137, 142); and appropriate allocation of individual and system-wide accountability for errors and harms.(138, 145-147, 425) These are discussed further in sub-sections 7.3 - 7.4 below. How to most effectively utilise complaints data is subject of ongoing discussion and work.(272, 278, 282, 426)

Good complaint management and regulatory practice principles include transparency and stakeholder engagement to engender acceptance and confidence in system design, process and outcomes.(17, 22, 26, 28) These were subject of significant criticism in this study. Notably, while experience rankings varied, all sources (consumers, practitioner complainants, organisations and employers) raised common issues regarding the model and operations of both schemes; with comments thematically consistent whether positive or negative.

A significant source of respondent dissatisfaction with the statutory design of the national scheme was lack of formal recognition of the role of those making complaints.(225-227, 229, 243) Asymmetries of knowledge, influence and power between complainants and subjects of complaint in the process were raised in relation to both schemes.(78, 139, 307, 313, 318) Reported experience was at odds with changing social attitudes towards authority and patient autonomy (16); expectations given impetus through alignment with a quality and safety movement that identified patient participation with improved outcomes.(15, 100, 103, 105, 121, 124, 126, 427) These expectations were reinforced by formal recognition given to consumers being informed, taking an active role in their care, and rights to express concerns and have them addressed.(53, 428) Dissatisfaction with the national scheme's opacity centred particularly on absence of information about process and outcomes and review rights available through existing jurisdictional commission processes.(225-230, 243, 248, 256-259) Employers too expressed concern about the lack of engagement and information in light of their obligations and responsibilities for both staff and patients; and other potential employers likely to be unaware of issues and risks due to limited information being publicly available.

Respondents wanted to know they could contribute with information, insights or suggested improvements; and confidence that their role was as meaningful, no more and no less, than the subject of complaint.(313) They sought a clear and justifiable rationale for limits to what might be achieved with a specific matter or the extent of their involvement; the response on par with how professionals subject of complaint are treated and informed.

7.2 Respondent profile: who is and isn't using the complaint and notification systems

Characteristics of Survey 1 respondents (age, gender, language, urban dwelling) were consistent with previous literature on the profile of complainants.(311, 314, 326, 328, 330, 331, 429) For one-quarter, high school was the highest level of educational attainment; one-third a trade certificate or diploma. These figures contrast with some literature indicating complainants are more likely to have higher qualifications and socio-economic status.(139, 325, 329, 430) A significant proportion acted for others, consistent with previous studies.(287, 328, 431)

Under-represented relative to their population profile were Aboriginal and Torres Strait Islander peoples and people from culturally and linguistically diverse communities. Few responses were from people with a mental illness, and reported disability (where specified) appeared predominantly physical rather than intellectual. This profile reflects barriers reported in Survey 2 and available literature.(311, 321, 326, 331) This persistent under-representation suggests further targeted strategies are needed to encourage and support specific groups to raise concerns; consistent with recommendations and government policy directions to make health services for these populations more accessible and appropriate.(432-438) Consistent with other studies, older people (70 years or more) are also under-represented, or indirectly represented through complaints made on their behalf by others.(325, 328)

Information about how to contact the HCCC is available in 20 community (non-Indigenous) languages and NSW Councils in 19 languages; appearing on each agency's '*Contact*' webpage; as is information about services for people who are deaf or hearing impaired.(439, 440) AHPRA includes contact details for national translating and interpreting services for community languages and people with hearing impairment, but the information is not as readily apparent and in English only.(441) In 2016 the HCCC reported undertaking specific outreach programs with Aboriginal health services and complaints involving mental health issues; work that is continuing in 2017.(442) The HCCC also undertook a review of its consumer consultative committee in 2015-16 to inform changes for better engaging with consumers.(442)

The importance of attending to complaints lodged follows literature indicating rates of complaint are low relative to preventable adverse events (94, 95, 98, 280, 288) and lower than those identified as having cause for grievance.(290, 307, 314, 317, 325, 326) Further, a proportion of those who do complain use informal processes rather than the mechanisms established for this purpose.(326, 330)

Both surveys confirm making a complaint was not undertaken lightly and was highly stressful; respondents fearing repercussions; particularly retribution. This reflects literature and reviews reporting significant physical, mental, social and professional impacts for those raising concerns.(156, 157, 159, 164, 170, 173, 180, 314, 324) Survey and interview responses indicate practitioner complainants find the process as stressful and challenging as consumers; and fear or experience adverse reactions no less. Other identified barriers in the two surveys (not knowing where or how to complain; requirements to put concerns in writing and be identified; levels of evidence needed; time and effort involved; and perceived or actual power imbalances and bias) reinforce available literature.(290, 307, 314, 322, 324-326, 330, 430)

Health practitioner respondents in Survey 1 were mostly a peer or senior to the practitioner the complaint or concern was about; reflecting the hierarchical nature of health services and historical cultural norms against reporting colleagues, particularly professional seniors.(102, 106, 180, 443) This appears congruent with more recent Australian inquiries into bullying, particularly in the medical profession.(444-447) It is notable that in a regime promoting open disclosure and requiring mandatory reporting, Survey 2 responses suggest professional and defence organisation engagement was predominantly with practitioners' subject of complaint; compared to assisting those reporting.

7.3 Motivations: issues and outcomes sought

Common issues leading to complaints in Survey 1 were care, conduct, competence and communication; consistent with issues contained in agency annual reports.(268, 388, 426, 442, 448) Analysis of comments identified a high correlation and 'compounding' of issues, particularly clinical issues associated with poor communication and/or insensitive or defensive responses to issues raised; also identified in the literature.(216, 287, 302, 306, 307, 328, 431, 449)

Poor communication has been found to affect health outcomes; can lead to loss of confidence in care and may 'mask' other substantive clinical issues (450-453); with positive experiences identified as engendering trust.(290) Research also shows consumers are concerned with more than traditional concepts of 'technical' competency. They regard the quality of patient-professional interactions, information and communication as a core part of expected professional behaviours; and deficiencies or failings are a significant source of complaint.(100, 134, 149, 153, 216, 407, 431, 450, 452, 454-459) This study reinforces the importance with which these are regarded and the impact on patient wellbeing and outcomes.(451, 452, 460)

While part of professional codes of practice (54, 132, 133, 461-466), this study suggests these skills and behaviours have yet to receive the same serious regulatory attention as traditionally

recognised 'technical' skills in the complaints process.(149, 150, 153, 154) Further, the central importance placed by consumers on communication skills and adherence to 'open disclosure' frameworks appears problematic still, notwithstanding significant effort to embed these in practice; lack of fulsome explanations and apologies underpinning many complaints in this study.(54, 132, 133, 135, 136, 139, 149-152, 288, 315, 467-469)

Motivations and outcomes sought were consistent with the literature. The main reasons for complaint in this study were to prevent events from happening again and to report that what occurred was wrong, unfair, unjust or unsafe.(83, 287, 301, 306, 307, 309-311, 318)

Respondents referred to both the effort and risk involved in raising concerns; their duty or obligation to do so; and the importance of issues raised.(83, 301) Many indicated 'complaining' was not something they usually or ever did.(453)

The majority wanted an improvement in standards; an assurance that change would be implemented; and action taken to achieve these ends.(301, 310, 313, 317) Over two-thirds advised no improvements occurred as a result of raising their concerns, in stark contrast with their stated interest and intentions.(83, 310, 313, 317) Most improvements planned or made occurred in public hospitals or group practice.

Being acknowledged, receiving an apology experienced as direct and genuine and being provided with information were significant for satisfaction with both process and outcome; yet complainants commonly report being dis-believed; 'fobbed-off', not taken seriously; receiving 'defensive' or 'self-serving' responses; or no response at all.(139, 287, 306, 307, 309, 311, 401, 429, 470)

Unlike many studies, Daniel et al. found complainants wanted 'stern action'.(308) Many in this study, including when a death was involved, questioned the adequacy of agency powers to address serious events and took issue with or could not understand outcomes perceived as 'minor'. However, this study found that while '*disciplinary action*' was significant in terms of outcomes sought, feedback in surveys and interviews indicates this was interpreted in different ways; encompassing a range of actions the practitioner should do or be required to do; or actions by the regulator, similar to findings about expectations of the Dutch regulator.(83)

7.4 Expectations of the process

While a minority indicated they felt 'flagging' issues was sufficient, most saw themselves as a stakeholder and active participant in the process, consistent with other studies.(83, 320) Some consumers expressed interest in being engaged beyond their specific complaint. Employers too were seeking a 'partnership' approach. These views suggest legislative reforms proposed

for the national scheme (264-266) should contemplate more than provision of information to complainants as passive recipients.

Respondents expected those managing their complaints to engage with them; listen to and address their concerns; be transparent; to act in a timely and fair manner; and provide information about the process, reasons for decisions and changes made. These expectations are consistent with regulatory and complaint management standards and 'best practice' guides (17, 19, 26, 36, 38-40, 42, 49); priorities identified by consumer organisations when the NSW and national schemes were established (1, 190, 225-230, 243) and relevant literature.(83, 139, 301, 307, 310, 313, 317-320) This study found a significant proportion of complainants did not experience a process congruent with these expectations or standards.

A lack of engagement at the outset, particularly to clarify issues, was the focus of criticism of many respondents. Some expressed concern that the focus of complaint changed from their central concerns, reflecting a potential disjunct between individual interests and 'public protection' concerns of regulators. It may also reflect a lack of understanding of the available powers of agencies to adjust complaint particulars, and reasons for doing this.(152, 423, 424)

Other engagement criticisms related to dependence on what was referred to as the 'post box' ('he said-she said') model of inquiry; perceived as limiting opportunity for resolution or to have issues addressed; and conversely, enabling practitioners subject of complaint to avoid accountability and answering direct questions. This criticism also applied to some respondents' experience of how 'resolution' processes were conducted. Mediation and conciliation were not relevant or appropriate to all, but many that experienced lengthy processes conducted at 'arms-length' and resulting in '*no action*' and/or '*no explanation*' outcomes expressed a strong preference for the opportunity to meet directly; some involving a mediator, and in cases, conciliator.(198, 200, 314)

The extent to which issues are addressed and fairness experienced in terms of communication, process and outcome have been identified as significant factors in complainant perceptions and satisfaction.(139, 313, 317, 318, 324) Fairness in this study was the most significant determinant of satisfaction with process, outcome and willingness to recommend the process to others. A core component – perceived bias (favouring professionals) - was identified by respondents across the complaint activity chain; from point of assessment to closure. This was experienced variously as a lack of transparency, poor communication, assumptions of practitioner veracity and perceived lack of 'distance' between the subject practitioner and those reviewing or judging their actions, as well as from the profession more generally.(306, 309, 310, 314, 324) Quoting practitioner responses for

reasons provided in NSW cases contributed to a perception of bias and lack of independent assessment, particularly where the quoted 'evidence' was untested.

Relevant also to perceived fairness were lack of opportunity for complainants to view and respond to practitioner statements and lack of access to reasoning for decisions when practitioners accessed these in full. This created or reinforced low expectations and perceptions of inadequate regulatory responses and outcomes.(290, 307, 313, 318, 401) A disjunct between agency reasons and adequate communication so these are fully understood may be relevant.(313) Other deficiencies identified by respondents that were provided with decision reasons included lack of congruence with existing standards or the evidence; or lack of thorough investigation. The latter was prominent in cases where respondents had undertaken significant research; investigated standards; provided detailed statements, records and contact details for other witnesses or sources of information that were not pursued. The impression of many respondents was that if they did not undertake and submit detailed evidence, the regulator would not do so. However, they often perceived the material supplied was not pursued or did not inform decisions.

Expectations about what regulators should focus on varied. Some expressed concern that major threats to health and safety were not adequately triaged and prioritised (176, 471); others that failure to respond to matters involving less immediate harms to physical welfare allowed more subtle harms go unaddressed and sent a poor signal to professions regarding tolerance for 'lower-level' poor performance.(320) Some commented positively on the skill with which their matter was handled; others questioned the adequacy of clinical and investigative skills and knowledge of resolution and investigation staff as well as expert reviewers.(199) Some requested but were refused information about these. Some respondents, particularly employers with experience in multiple complaints commented on inconsistency of process and outcomes in similar types of matters. Consumers expressed interest in whether lay people were involved in decision-making; often assuming decision-makers were all professionals, or 'lay involvement' insufficient to have impact.

While the focus of study was regulators, some practitioners, especially dental and medical practitioners pointed to deficiencies in the profession that hampered regulators. Examples included 'defensive' responses; failure to focus on the merits of issues raised; or 'rallying' to support or represent the subject of complaint but not providing expert assistance to regulators in specific cases.(324, 401)

Both surveys indicate significant variance in understanding of regulators' roles.(83, 253, 318-320) Most respondents did not know about the agencies or what to expect prior to

approaching them. The high rate of referral identified in this study may also explain respondents' confusion about roles and responsibilities.

7.5 Comparing the NSW and national schemes

Overall there appears little difference in responses about the national and NSW schemes, suggesting they are administered in a similar manner notwithstanding their legislative differences.

One might expect that the maturity of the system; continuity of complaint arrangements; opportunities for resolution; greater availability of information and review rights in the NSW model would result in a more substantial contrast. At the same time, the national scheme, now in its seventh year, had the opportunity to learn from national and international experiences at the time it commenced in 2010. While adopting developments in regulatory practice (12, 62, 65, 77, 82, 271, 291) the national model did not reflect key developments in complaint management (26); nor translate to regulatory practice charters and codes articulating expectations and rights of consumers as active partners in health care.(15, 16, 52, 53, 120, 121, 124, 126, 427, 428) Reviews consistently identified consumer dissatisfaction with the opacity of the model; perceived bias; lack of accessibility and timeliness of processes; and lack of rationale for decisions made and actions taken or not taken.(248, 250, 253, 472)

There was a high level of '*no action*' outcomes (60%) overall; highest in complaints handled by the HCCC and about medical, psychology and dental practitioners. This study found many respondents concluded that '*no action*' meant their complaint was viewed as invalid or lacking merit. Well over half (57%) indicated their issues were not addressed '*at all*', and 69 percent were unaware of any service or practice improvements planned or implemented as a result of their complaint. The level of '*don't know*' responses was also high. These factors and the 'gap' between outcomes sought and achieved have been identified in previous studies as contributing to dissatisfaction; and perceptions that 'justice' has not been achieved or that complaining is 'futile'.(290, 301, 307, 310, 313, 314, 317, 324) However, Survey 2 indicated that professional bodies were more aware of improvements following complaints than community organisations; and agency annual reports indicate '*no action*' may be a result of actions already taken or in train, with further intervention deemed unnecessary.(426, 473) These factors suggest greater action or impact may result than complainants are aware of. If so, it reinforces issues of engagement and communication previously identified.

The national scheme had a higher rate of outcomes involving conditions, undertakings and health or education programs than NSW as a whole; but these differences are less apparent when compared only with the HPCA. NSW had a lower rate of referral for both investigation

and disciplinary action than in the national scheme. This primarily relates to the HCCC; consistent with the high proportion of '*no action*' outcomes and lower rate of organisational responses. The proportion of cases reported as being investigated or having disciplinary action taken is lower for medical practitioners when compared with all other practitioners; as reported elsewhere (250, 324); although dental practitioner rates were also low.

The HCCC attracted a greater proportion of negative rankings, but it also had a higher proportion of surveys involving doctors, lodged by consumers and '*no action*' outcomes, all associated with more negative responses. Annual reports indicate some variation in '*no action*' outcomes since the study period; increasing in the national scheme from 2013-14 (57%) to 2015-16 (66%).(426) In NSW, the HCCC reported these declined in the assessment phase in the same period (52% to 40%); the figure for the investigation phase remaining constant (14%); while resolution rates increased (5% to 12%); as did referral to investigation.(442) The HPCA reported a small increase in the year to 2015-16 (27% to 33%).(473, 474)

The HCCC profile in this study contrasts sharply with feedback it receives through surveys it regularly provides to both the complainant and provider at the completion of assessment. The 2015-16 annual report stated 88 percent of complainants indicated satisfaction with the service (9% response rate); 74 percent in 2013-14 (13% response rate).(442, 448) One possible explanation is that those dissatisfied were less likely to respond directly to the HCCC if they did not believe it would have an effect. This would be consistent with people who contacted the researcher to advise they received the study survey but would not participate because they believed it would have no effect.

Timeliness of assessments and investigations is a recurring theme in reviews and annual reports of both the NSW and national schemes.(176, 247, 248, 253, 255, 268, 388, 426, 442, 448, 472, 475) Respondents were concerned about lack of timeliness on both the complainant and professional involved. Employers also indicated that lack of timeliness meant outcomes if communicated lacked immediacy and the window of opportunity for learning had closed. While no firm conclusions can be drawn, reported delays in this study appear related to the following. Two-thirds first took other steps to address their issues and over one-third reported their matter was referred. This may simultaneously heighten expectations of regulators, while lowering tolerance for perceived impediments or deficiencies of process. Relevant is that three-quarters of those reporting delays also indicated communication during the process was '*poor*' or '*very poor*' and a similar proportion that they were either given '*no reasons*' or only '*minimal*' information. Annual reports indicate agencies continue to be challenged by the volume of complaints; increasing for both schemes since the study period. Notifications to AHPRA increased by nearly 20 percent in 2015-16 (426). In NSW, inquiries (7%) and complaints (15%) to the HCCC and to the HPCA (13%) also rose.(442, 473)

7.6 What this study adds

Previous reviews and studies have highlighted the value and importance of establishing efficient and responsive complaint processes, and engaging with those raising concerns.(26, 44, 52, 54, 79, 102, 103, 128, 289, 476) Transparency is important in the context of increasing demands for public accountability and engendering confidence in the system.(19, 22, 57, 58, 477) This study confirms the central importance of sound operational processes, including ease of access, efficiency, good communication regarding process and outcome and in the context of a federated political system, well-integrated structures and roles. Positive survey responses confirm this but overall the study suggests more work remains to be done.

The results of this study point to more fundamental issues and a need to address other facets of regulatory practice: what 'protecting the public' means in operational terms; evidence of efficacy for regulatory interventions; better communicating complaint management in the context of networked governance; and practitioner responsibilities and skills in responding to complaints. These issues reflect respondents' perceptions and reported experience of the systems, centering on power and transparency. (Fig.40)

Respondents approached agencies as a moral stakeholder articulating issues they believed to be of importance and value. However, in its most negative manifestation of the process, respondents experienced roles of unpowered and diminished actors; alienated from the detail and resolution of events both deeply personal and painful. While this is most acutely expressed by patients and relatives, professional and organisational respondents report similar effects.

The conceptual absence of the complainant is reflected in both language and infrastructure. There is no concept for the complainant that is equivalent to the assumed 'good practitioner', and in the process of raising a complaint many complainants experience a transition from raising a problem to being perceived as one. Structurally, there is no-one who 'speaks' - represents or provides expert advice to the complainant. In the process, complained about practitioners typically have a professional representative. Regulatory agencies may call on 'clinical' expertise with no input from any 'consumer' perspective to interpret or comment on the suitability, appropriateness or professionalism of practice or behaviour from this perspective.

The mode of complaint operations also challenges the emotional and temporal dimensions of complainants' overall experience, this particularly, although not exclusively pertinent for consumers. In survey comments and interviews, people typically narrate a sequence of events that may include the individual practitioner, the employer, significant others and the agency. Each exchange has its own dynamic and builds on others, generating and tempering a

complex array of emotions and perceptions. In contrast, the assessment process of particularising issues and allocating accountabilities and responsibilities fragments and segments the narrative of the experience. The depersonalised nature and focus of the process does not address the deeply emotional and psychological impacts of either the original events or the complaint process itself.

Categories	Power	Transparency	Implications
Complainant	Value: recognition of issues; ability and willingness to address Identity: morality, value, rights Standing: possession and exercise of authority in process*	Explanatory completeness and resonance Conceptual assumptions: protecting the public; error, professionalism; accountability	Confidence in regulator Willingness to raise issues in future
<i>Negative manifestation</i>	<i>Unpowered and diminished actor Raising a problem - becoming the problem – no complainant equivalent to ‘good doctor’</i>	<i>Opacity of reasoning Lack/fail to exercise authority</i>	<i>Perception biased; act on most egregious only; tolerate poor performance; harms to others</i>
Model infrastructure and process	Professional not complainant expert advisors Capacity: regulatory skills, clinical skills; risk management ‘Post box’ methods Knowledge access – activities, outcomes	Independence from profession Principles e.g. privacy, disclosure Assessment, investigation, decision criteria Evidence of appropriateness and efficacy of process	Understanding and support for regulatory model, focus, methods
Outcome	Learning, prevention - individual practitioners; translation to systems: monitoring, standards, quality, education, policy	Evidence of appropriateness of efficacy of regulatory choices Impact on professionals, patients, employers	Signals to professions and consumers Measures of success

Figure 40: Most significant factors moderating respondents’ perceptions

* ‘Standing’ refers to the sociological concepts of individual and personal agency

7.6.1 What ‘protecting the public’ means and measuring success

Good regulatory practice tells us that clear governance arrangements and rationale are key components of effective regulation.(19) Both schemes describe regulatory tools used, activities undertaken and possible outcomes.(478-480) However, while both the national and NSW schemes are designed to ‘protect the public’, this study found there remains a lack of clarity and understanding about what ‘protecting the public’ means operationally; notwithstanding this is the core mandate of health professional regulation. This includes the focus of regulatory effort and the underlying concepts and/or assumptions that inform regulatory practice.(318-320) It may go some way towards explaining both the ‘expectation gap’ identified in other studies as well as perceptions regarding impartiality and fairness.(139, 313)

For many respondents, the regulators did not appear to recognise or share their view of the significance or seriousness of issues raised.(150, 151) How matters are triaged; what

'investigating' means or entails; how and why some matters are or are not investigated; how or why some evidence is pursued or used or not; the basis of assessment and how evidence is weighed; and whether regulators are concerned with what is accurate rather than plausible are not clear.(138, 143, 401) So too how regulators think what 'serious', 'risk' and 'error' encompass; or accountability is appropriately interpreted, apportioned and responded to.(106, 136, 142, 144-146, 149, 152, 425, 481) At interview people consistently agreed that they thought '*individual*' and '*public*' interests may not align, but were uncertain about how this difference is or should be resolved.(248) Most typically this was done by reference to what is '*serious*'; but many also commented they anticipated views on what this meant would no doubt vary.

These are complex matters; and there is no absolute 'agreed' or 'correct' answer to definitions or choices. What is important is that regulatory actors provide a narrative beyond the lens of process and operational outputs and refocus on a framework and narrative that includes communicating their understanding, interpretation and application of these concepts and how assessment, investigation and outcome decisions are made, including tensions and uncertainties in the process.

Bringing some clarity to these concepts might also help articulate what success looks like. Current metrics appear predominantly action or output oriented.(268, 388, 426, 442, 448, 473-475) From 2016, AHPRA established quarterly (online) public performance reporting; including data at a jurisdictional and profession level.(426) Reported activities include notifications opened and closed; investigations completed and timeframes; performance assessments undertaken by outcome; and cases monitored. These are important measures of accountability but don't go to the heart of how we know the system is operating optimally. As noted in Survey 2 responses, complaint numbers, while important to track, may be a poor measure of efficacy as an increase may simply reflect greater confidence in the systems' performance.

7.6.2 Accountability for and efficacy of regulatory decisions and interventions

This study identified the importance of providing reasons for decisions in terms of respondent perceptions of fairness and justice; understanding and confidence in the process and achieving public protection. This includes addressing a gap between respondents' interpretation of '*no further action*' outcomes and regulators.(426, 473) As noted, the former frequently construed this as demonstrating disinterest, disbelief or bias; whereas the latter report this may result from an assessment that action has or will be taken that does not require further involvement of the regulator.

Absent explanatory context or information, actions taken by the regulator, including directions or conditions on a practitioner often appeared 'light on' and easily disregarded; contrary to practitioner reported experience.(61, 482)

Importantly, this study indicates regulators need to communicate the body of evidence that informs their decisions and actions; demonstrate that consistent with this evidence, these choices are commensurate and efficacious; and a framework for monitoring and reporting these.(483) The variability in outcomes found in this study relative to the profession involved and source of complaint need also to be addressed and explained.(250, 484)

7.6.3 Managing complaints and notifications in a networked governance framework

This study identifies a need to communicate how complaints 'fit' within a broader regulatory frame. Some complainants sought action or resolution on their particular issue. However, many were concerned with broader implications their matter raised for improvements in practice, policy, standards, education or law.(83, 301, 310, 311)

Yet described complaint pathways appear mainly confined to process steps and potential outcomes within the agencies' direct complaint process and remit.(478-480) Articulating how the agencies 'fit' with other institutions would assist complainant's understanding of what the agencies are responsible for and what is managed through or with regulatory partners. This includes government, profession and consumer bodies with safety, quality, education, standard-setting, policy and adjudication roles. Such an approach might also contribute to more flexible, creative and effective responses to the different types of issues raised. While not suitable for all complainants or issues, this study indicates some matters may be better served by dialogue with experts rather than a traditional 'complaint' pathway.

This study also points to a need to better inform and support complainants through the complaint process and the interface between health practitioner complaints and other systems and processes.(256) These include coronial; aged care; family court; statutory workforce health and safety; and 'fair trade' (compensatory) agencies and processes. A source of significant respondent frustration, issues included lack of clarity about roles and powers; having to work through multiple agencies and processes (e.g. coronial, complaint, compensation) and reasons for suspending complaint action pending completion of other processes. Some respondents also struggled to understand how different processes (e.g. legal, coronial, complaint) could result in different conclusions, suggesting a need to better communicate the focus of different bodies.

7.6.4 Practitioner responsibilities and skills in responding to complaints and notifications

This study indicates a need to more clearly articulate in the regulatory context the expectations of practitioners in receiving and responding to complaints.(153, 154) The majority of respondents sought to first address their issues through alternatives to the regulator; least commonly when the practitioner was a psychologist or doctor. A significant proportion took direct action, raising their issues with the practitioner, their employer, or other internal inquiry.

Seeking resolution at the lowest 'level' possible is consistent with complaint standards; a '*responsive regulation*' approach; and as articulated in codes of conduct and open disclosure frameworks in the case of error or harm.(26, 54, 132, 133, 461-466) At issue is the question of how matters are being managed in the first instance in everyday practice.(130, 135, 136, 141, 150-152, 169, 467, 468) Literature and submissions to inquiries points to a perception that complainants are unreasonable and disproportionate in the outcomes they seek.(472, 485) This study, contrary to that perception, identifies the contribution of practitioners and the services in which they work in creating or at least substantially contributing to problems and 'hardening' of positions through their response to complaints or failure to proactively seek patient and carer views before matters escalate to a complaint.(139, 154, 307, 315, 324)

Dissatisfaction is compounded further with regulatory responses that appeared to unquestioningly accept practitioner statements at variance with complainant statements or understanding of events; or without affording complainants an opportunity to respond to practitioner statements and submissions.(83, 139, 401) Also relevant is lack of information, or refusal to provide information about the skills and experience of expert reviewers; and concerns about conflicts of interest between expert reviewers and practitioners' subject of complaint.

A question for the professions is the extent to which practitioners are adequately supported and skilled to manage well when complaints are received. National data on the proportion of practitioners undertaking professional development in communication skills; providing and responding to feedback and managing complaints would be useful. So too evidence of efficacy and impact about strategies and modes of delivery. Stronger regulatory signals may be required. Consultations being undertaken by the Medical Board of Australia on revalidation present a further opportunity for consumers and complaints to be incorporated into ongoing professional development.(486)

Chapter 8. Conclusions and recommendations

Australia has an enviable record in establishing and refining health complaint mechanisms. Given the substantial investment and experience in these processes to date, the low levels of expressed satisfaction and understanding of the systems are surprising. If a core function of a regulator is to engender confidence in the system, then the outcome of this study is of significance.

Striking is the extent to which survey responses were consistent with studies undertaken over the last three decades and the extent to which concerns expressed regarding the management of individual complaints echo submissions made by consumer organisations in the establishment of the National Scheme. This study shows that complaint processes matter and have a direct bearing on complainants' respect for and confidence in both regulators and the regulated professions. Regulators were approached to 'bring to account', raise the standards of or stop practitioners regarded as unsafe, not competent or not responsive to concerns raised directly. Study respondents were also looking to regulators to account for themselves; with the same detail and rigour applied to those regulated.

Literature and public inquiries point to notable costs when processes are inadequate or unresponsive, including individual harms and public resources expended in dealing with the impacts. It may drive demand for more prescriptive regulatory approaches that may prove more costly and less effective.

This mixed methods study found respondent expectations of quality complaint processes were congruent with the literature on best practice regulation and complaint management. The most significant factors moderating respondents' perceptions and experience were power and transparency. These factors were relevant in accounting for reported views both of operational processes and underlying assumptions of the regulatory model.

Contrary to their expectations, respondents experienced roles of unpowered actors; alienated from the detail and resolution of events both deeply personal and painful; concerning issues of significance for future patients and practise. The majority reported issues were either not or only poorly addressed; and few were aware of any resultant changes. There is a lack of understanding about what '*protecting the public*' – the core mandate of health professional regulators - means operationally; including the rationale for and focus of regulatory effort and underlying concepts and assumptions.

Regulation, like healthcare itself, is a complex undertaking, requiring a mix of capabilities to address recurring and emerging problems, minimise perverse impacts, effectively communicate intent and manage interests and expectations. The very flexibility offered by

'responsive' regulation no doubt increases challenges of communication. This study suggests many complainants recognise these complexities. Even when dissatisfied with their experience, they value the complaint process, and want to contribute to and see improvements. There are opportunities to leverage better insights to deliver a more efficient and effective regulatory system. A more informed public may facilitate a more nuanced dialogue on expectations of regulatory practice and unresolved challenges.

8.1 Conclusions

8.1.1 Conclusions about the respondent profile

The respondent profile was broadly consistent with previous studies. An exception is a higher proportion of people with high school, trade and diploma certification. Under-represented are key population groups, including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse communities, people with mental illness and older people; indicating further work is required to improve access.

8.1.2 Conclusions about issues and professions giving rise to complaints and notifications

Common issues leading to complaints were care, conduct, competence and communication; with a high correlation and 'compounding' of issues, particularly clinical issues associated with poor communication and/or insensitive responses to issues raised. The central importance placed by consumers on communication skills and adherence to 'open disclosure' frameworks appears problematic still, notwithstanding significant effort to embed these in practice; lack of fulsome explanations and apologies underpinning many complaints in this study.

Medical practitioners accounted for the majority of complaints and more negative responses when compared with all other professions. Medical, dental and psychology practitioners had the highest proportion of issues '*not addressed at all*' and '*no action*' outcomes; with a higher proportion of regulatory action taken in relation to nurses and pharmacists.

8.1.3 Conclusions about motivations and expectations

Consistent with good regulatory and complaint practice and available literature, respondents expected those managing complaints to engage with them, carefully investigate issues, act in a timely and fair manner, provide information about the process, reasons for decisions and changes made; and afford them opportunities to respond. While a minority indicated 'flagging' issues was sufficient, most saw themselves as a stakeholder in the process

Respondents reported a sense of obligation to raise concerns and the effort and risk involved. They wanted an explanation, an apology, improvement in standards and action by the practitioner or regulator to ensure events would not recur. While many sought 'stern action' what this entailed varied significantly. Contrary to expectations, the majority reported issues

were either not or only poorly addressed; few were aware of any resultant changes; and a significant proportion found their expectations of the process were not met. Professional organisations were more aware than community organisations of resultant changes.

Survey 1 indicates the calculus for those bringing concerns and complaints for regulatory attention is complex; whether they are a consumer, fellow practitioner or employer. These include consideration of personal, familial and professional impacts for both the complainant and practitioner; which may be emotional, social, technical and financial. Respondents reported the process to be complex, stressful and feared negative repercussions. Survey 2 confirms these, and also highlights equivalent challenges for practitioners responding to complaints.

8.1.4 Conclusions about the NSW and national schemes relative to advances in 'best practice' regulation and complaint management

Overall there appears little difference in responses about the national and NSW schemes, suggesting they are administered in a similar manner notwithstanding their legislative differences.

Receiving and managing complaints is a core function of both the NSW and national schemes; which implemented '*responsive*' and '*risk-based*' regulation principles and practices. These approaches are consistent with international developments in regulatory thinking following experience with the limits of 'top down' and prescriptive approaches and government concerns to balance accountability with regulatory efficiency. However, these regulatory frameworks do not address the issue of consumer standing and participation in the process, at the core of many respondents' dissatisfaction. Lack of consistency with key principles of good complaint management underpinned respondent dissatisfaction.

The statutory framework for the national scheme is not consistent with 'best practice' principles of transparency and responsiveness as they would be interpreted and understood by most respondents based on their survey comments and interviews. The intent to introduce legislative amendments to enable more information to be provided to complainants should assist. However, responses about the NSW scheme suggest that 'passive' information provision without opportunity to engage and respond will result in continued dissatisfaction.

8.1.5 Conclusions about reported experience and implications for future practice

This study confirms the central importance of sound operational processes, including efficiency, good communication and well-integrated structures and roles - identified in this study as requiring improvement.

Respondents demonstrated a mixed understanding about the purpose of complaint processes and the role of regulators; with most not knowing what to expect prior to approaching them.

The results of this study indicate the need to more clearly articulate regulatory objectives, priorities and assumptions. This includes what '*protecting the public*' means operationally; regulators understanding of and approach to error and harms; and how accountabilities and regulatory choices are determined. Absence of this information undermined respondent's understanding or acceptance of decisions made and their confidence in the system. There is a need to communicate evidence for the appropriateness and efficacy of regulatory choices, and complaint management in the context of networked governance arrangements.

Fairness was the most significant indicator for overall satisfaction with the process, the outcome and whether or not the process would be recommended to others. Respondents reported asymmetries of knowledge and influence; and perceived bias relative to the standing and treatment of practitioners' subject of complaint was significant. Tensions in the role and standing of complainants; regulatory principles between transparency and confidentiality; and the extent to which public or individual interests are served remain.

Communication and quality of interactions, identified as core professional skills by patients do not appear to attract the same regulatory attention as 'technical' skills. The majority attempted to first address their concerns through other means, subsequent escalation bringing into question the skill of practitioners in responding to complaints.

8.2 Recommendations

8.2.1 Regulatory objectives and operations

1. Agencies provide information on their websites that explains in plain English their regulatory objectives and operations that addresses issues identified in this study. This includes but is not limited to:
 - a. Definitions of key terms and concepts; management of competing principles; collection and management of evidence; assessment criteria and decision frameworks; evidence for efficacy of regulatory choices and interventions and how these are monitored over time.
 - b. Communicating how complaints 'fit' within a broader regulatory framework and institutions, including bodies with safety, quality, education, standard-setting, policy and adjudication roles; and pathways for information exchange and referral of issues arising from complaint processes relevant to these agencies.
 - c. Communicating the role, focus and interface with other complaint and regulatory systems including coronial, aged care, family court, statutory workforce health and safety, and 'fair trade' (compensatory) processes. Further work should be undertaken into strategies to support complainants to navigate these; and opportunities to better integrate and streamline processes.

2. Metrics of regulatory system effectiveness are developed.
3. Further work is undertaken into the reasons for the variability in outcomes identified in this study including variations between professions and source of complaint.
4. Further work is undertaken to address and report on factors identified in this study that contributed to substantial perceptions of unfairness. This includes but is not limited to:
 - a. Differences in the role and rights of complainants in the process relative to subjects of complaint.
 - b. Assumptions about the veracity of practitioner statements relative to complainant statements.
 - c. Engagement and communication, including reasons for decisions, evidence drawn on and how these are communicated.
 - d. More consistent and more frequent communication on the status of complaints. Consideration should be given to on-line status reporting that would enable complainants and subject of complaints to 'track' progress of their matter.
 - e. Better explanation of '*no action*' outcomes.
 - f. Better communication of any changes or improvements made as a result of a complaint.
5. Criteria are established for determining when information about decisions or reasons for decisions will not be provided to a complainant. The number and proportion of decisions according to these criteria are reviewed regularly and publicly reported.
6. Agencies give consideration to establishing criteria for, and providing complainants and subjects of complaint the opportunity to provide closing comment ('right of reply') to be included in their complaint files when a decision to close a matter is made.
7. Further work is undertaken on the use of more flexible 'complaint' pathways; including greater use of direct resolution and improvement strategies.

8.2.2 Capacity and expertise

8. Agencies note and utilise issues arising from this study for staff and Board or Council information and education; and review factors that may be contributing to variation in communication and management processes.
9. Agencies provide information on their websites about the process and criteria for the selection of expert advisors/reviewers; including how perceived, potential or actual conflicts of interests are identified and addressed.
10. Agencies provide de-identified information about the skills and experience of expert reviewers in individual cases when requested.

8.2.3 Access

11. Data on the demographic profile of complainants are regularly collected and reported on by agencies.
12. Work is undertaken to identify and assess the efficacy of strategies (jurisdictional, national, international) to improve the knowledge and understanding of and access to complaint processes by specific population groups identified as under-represented in complaint processes.
13. The deployment and impact of strategies designed to improve access to complaint processes are regularly and publicly reported.
14. Information resources are provided to community organisations on the roles and responsibilities of agencies; and the interface with other complaint processes to help them better support and inform their service users and members.
15. Further work is undertaken with community and professional organisations on assisting consumers and practitioners to report concerns and complaints; and to develop strategies to address barriers including concerns about retaliation or retribution. Progress should be regularly reviewed and reported on. A review is undertaken of agency powers to sanction individuals or organisations that impede complaints or engage in abuse of process; and the extent to which these are exercised.

8.2.4 Practitioner responsibilities and skills in responding to complaints and notifications

16. Work is undertaken on the evidence for the efficacy of strategies to improve practitioner skills (by registered profession type) in providing and responding to feedback, criticism and complaints.
17. National data is collected and publicly reported on the number and proportion of practitioners participating in initiatives to improve skills in providing feedback; management of and response to complaints; data collected including the number and proportion participating in initiatives with an identified evidence base.
18. Specific strategies and regulatory responses are developed in relation to practitioners attracting 'repeat' complaints about communication and professional-patient interactions.

References

1. Thomas D. *Medicine Called to Account: Health Complaints Mechanisms in Australasia*. Sydney: School of Public Health and Community Medicine, Faculty of Medicine, University of New South Wales; 2002.
2. Irvine D. *The Doctors' Tale: Professionalism and Public Trust*. United Kingdom: Radcliffe Medical Press; 2003.
3. Moran M. *Creating Club Regulation. The British Regulatory State: High Modernism and Hyper-Innovation*. UK: Oxford Scholarship Online; 2003.
4. Mulcahy L. *Disputing Doctors: The socio-legal dynamics of complaints about medical care*. Maidenhead: Open University Press; 2003.
5. Parker C, Braithwaite J. Regulation. In: Cane P, Tushnet M, editors. *The Oxford Handbook of Legal Studies*. Oxford: Oxford University Press; 2003.
6. Moran M. *Governing Doctors in the British Regulatory State*. In: Gray A, Harrison S, editors. *Governing Medicine: Theory And Practice*. Berkshire, England: Open University Press; 2004.
7. Freckelton I. *Regulating Health Practitioner Professionalism*. In: Freckelton I, editor. *Regulating Health Practitioners*. The Federation Press: NSW; 2005.
8. Chamberlain JM. *Regulating the Medical Profession: From Club Governance to Stakeholder Regulation*. *Sociology Compass*. 2010;4(12):1035-42.
9. Porter-O'Grady T. *Confronting the Realities of Regulation in a New Age of Practice*. *Journal of Nursing Regulation*. 2010;1(2):1-7.
10. Waring J, Dixon-Woods M, Yeung K. *Modernising medical regulation: where are we now?* *Journal of Health Organization and Management*. 2010;24(6):540-55.
11. Dixon-Woods M, Yeung K, Bosk CL. *Why is UK medicine no longer a self-regulating profession? The role of scandals involving "bad apple" doctors*. *Social Science & Medicine*. 2011:1-8.
12. Healy J. *Improving health care safety and quality: reluctant regulators*. Samford C, editor. Surrey, England: Ashgate; 2011.
13. McDonald F. *Challenging the Regulatory Trinity: Global Trends in Health Profession Regulation*. In: Short SD, McDonald F, editors. *Health Workforce Governance: Improved Access, Good Regulatory Practice, Safer Patients*. Surrey, England: Ashgate; 2012.
14. Chamberlain JM. *Medical Regulation, Fitness to Practise and Revalidation: A Critical Introduction*. Bristol, UK: Policy Press; 2015.
15. Epstein RM, Street RL. *The Values and Value of Patient-Centered Care*. *Ann Fam Med*. 2011;9:100-3.
16. Millenson ML. *Spock, Feminists, and the Fight for Participatory Medicine: A History*. *Journal of Participatory Medicine Reviews* Vol 3. 2011.
17. Organisation for Economic Co-operation and Development. *OECD Guiding Principles for Regulatory Quality and Performance*. 2005.
18. Organisation for Economic Co-operation and Development. *Recommendations of the Council on Regulatory Policy and Governance*. 2012.
19. Organisation for Economic Co-operation and Development. *OECD Best Practice Principles for Regulatory Policy: The Governance of Regulators* 2014.

20. Organisation for Economic Co-operation and Development. Risk and Regulatory Policy: Improving the Governance of Risk. 2010.
21. Organisation for Economic Co-operation and Development. 2015 Indicators of Regulatory Policy and Governance. 2015.
22. Australian National Audit Office. Administering Regulation - Achieving the Right Balance: Better Practice Guide. Barton, ACT: Commonwealth of Australia; 2014.
23. Norton DP, Kaplan RS. The Balanced Scorecard: Translating Strategy into Action: Harvard Business Press; 1996.
24. SAI Global. The Australian Business Excellence Framework Australia 2011.
25. Ombudsman. C. Better Practice Guide to Complaint Handling. 2009.
26. Standards Australia and Standards New Zealand. Australian/New Zealand Guidelines for complaint management in organizations. 2014.
27. Australian Treasury. Benchmarks for Industry-based Customer Dispute Resolution: Principles and Purposes. In: Treasury T, editor. ACT: Commonwealth of Australia; 2015.
28. Schweppenstedde D, Hinrichs S, Ogbu UC, Schneider EC, Krongos DS, Klazinga NS, et al. Regulating quality and safety of health and social care: International experiences. Cambridge, UK: RAND Europe, prepared for the Department of Health (England); 2014.
29. Australian and New Zealand Ombudsman Association. Ombudsman: a particular model of alternative dispute resolution 2015 [Available from: <http://www.anzoa.com.au/about-ombudsmen.html>].
30. Ombudsman Western Australia. The history of the Ombudsman 2016 [Available from: http://www.ombudsman.wa.gov.au/About_Us/History.htm].
31. International Ombudsman Institute. About the IOI [Available from: <http://www.theioi.org/the-i-o-i>].
32. Queensland Ombudsman. Effective Complaints Management. 2006.
33. British and Irish Ombudsman Association. Guide to principles of good complaint handling. 2007.
34. Commonwealth Ombudsman. Better Practice Guide to Complaint Handling. 2009.
35. Parliamentary and Health Service Ombudsman. Principles of Good Complaint Handling. 2009.
36. Ombudsman Western Australia. Guidelines: The principles of effective complaint handling. 2010.
37. Ombudsman Western Australia. Complaint handling systems: Checklist. 2011.
38. Scottish Public Services Ombudsman. SPSO Statement of Complaints Handling Principles. 2011.
39. Office of the Ombudsman New Zealand. Effective complaint handling 2012.
40. NHS England. Guide to good handling of complaints for CCGs. 2013.
41. Health Professionals Councils Authority and Health Care Complaints Commission. Dealing with complaints: A guide for health service providers. 2014.
42. New South Wales Ombudsman. Complaint Management Framework. 2015.
43. Health Services Review Council. Guide to Complaint Handling in Health Care Services. Victoria: Health Services Commissioner Victoria; 2011.

44. Australian Council for Safety and Quality in Health Care. Complaints Management Handbook for Health Care Services. 2005.
45. Ombudsman Western Australia. Guidelines on Complaint Handling. 2010.
46. New South Wales Ombudsman. Effective complaint handling guidelines 2nd edition. 2010.
47. Toronto Office of the Ombudsman. Complaint Handling Guide. 2010.
48. Scottish Public Services Ombudsman. Guidance on a Model Complaints Handling Procedure. 2011.
49. New South Wales Ombudsman. Complaint handling - research, resources and training. 2013.
50. Pires J, Trkulja C. An introduction to AS/NZS 10002:2014 Standard 2014.
51. Australia S, Zealand SN. Guidelines for complaint management in organizations. 2014.
52. Australian Commission on Safety and Quality in Health Care. Australian Safety and Quality Framework for Health Care 2010.
53. Australian Commission on Safety and Quality in Health Care. Australian Charter of Healthcare Rights. 2008.
54. Australian Commission on Safety and Quality in Health Care. Australian Open Disclosure Framework: Better communication, a better way to care. Sydney: ACSQHC; 2013.
55. Carlton AL. National models for regulation of the health professions. Law in Context. 2006;23(2):21-51.
56. House of Lords Select Committee on Regulators. UK Economic Regulators Volume 1: Report. The Stationary Office; 2007.
57. Organisation for Economic Co-operation and Development. Reducing the Risk of Policy Failure: Challenges for Regulatory Compliance. 2000.
58. Organisation for Economic Co-operation and Development. Regulatory Policies in OECD Countries: From Interventionism to Regulatory Governance. 2002.
59. Florini A. Introduction: The Battle Over Transparency. In: Florini A, editor. The Right to Know: Transparency for an Open World. New York: Colombia University Press; 2007.
60. McGivern G, Fisher M. Medical regulation, spectacular transparency and the blame business. Journal of Health Organization and Management. 2010;24(6):597-610.
61. Nash L, Walton M, Daly M, Johnson M. GPs' concerns about medicolegal issues: How it affects their practice. Australian Family Physician. 2009;38(1/2).
62. Professional Standards Authority for Health and Social Care. Rethinking regulation. London; 2015.
63. Quick O. A scoping study on the effects of health professional regulation on those regulated: Final report submitted to the Council for Healthcare Regulatory Excellence. 2011.
64. Black J. Critical Reflections on Regulation 2002.
65. Black J. Principles based regulation: risks, challenges and opportunities. Principles Based Regulation; 28 March 2007; Sydney 2007.
66. Organisation for Economic Co-operation and Development. Regulatory Policies in OECD Countries: From Interventionism to Regulatory Governance - Annex II Regulatory Alternatives. 2002.
67. Organisation for Economic Co-operation and Development. Glossary of Statistical Terms 2016 [Available from: <https://stats.oecd.org/glossary/detail.asp?ID=3295>].

68. Dixon J. Regulating Health Care: The way forward. UK; 2005.
69. Better Regulation Taskforce. Imaginative thinking for better regulation: regulatory intervention as a last resort: alternative approaches. UK; 2003.
70. Osborne D, Gaebler G. Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector 1992.
71. Hilmer G, Rayner MR, Taperell GQ. National Competition Policy Review Report. Canberra: Australian Government Publishing Service 1993.
72. Regulation Taskforce. Rethinking Regulation: Report of the Taskforce on Reducing Regulatory Burdens on Business. Canberra; 2006.
73. Douglas J. Deregulation in Australia. 2016.
74. Commission. P. From industry assistance to productivity: 30 years of 'the Commission'. Canberra: Productivity Commission; 2003.
75. Borland J. Microeconomic reform in Australia- An introduction 2001. Available from: <http://cf.fbe.unimelb.edu.au/staff/jib/documents/micref.pdf>.
76. Banks G. Structural reform Australian-style: lessons for others? Presentation to the IMF, World Bank and OECD 2005. Available from: <http://www.pc.gov.au/news-media/speeches/cs20050601/cs20050601.pdf>.
77. Ayres I, Braithwaite J. Responsive Regulation: Transcending the Deregulation Debate. New York: Oxford University Press 1995.
78. Braithwaite J, Ayres I. Tripartism: Regulatory Capture and Empowerment. Law & Social Inquiry. 1991;16(3):435-96.
79. Braithwaite J, Healy J, Dwan K. The Governance of Health Safety and Quality. The Australian Council for Safety and Quality in Health Care; 2005.
80. Allsop J. Regulation and the Medical Profession. In: Allsop J, Saks M, editors. Regulating the Health Professions. London: SAGE; 2002.
81. Parker C. The three strategies of 'permability' in the open corporation In: Parker C, editor. The Open Corporation: Effective Self-Regulation and Democracy. Cambridge, UK: Cambridge University Press; 2002.
82. Healy J, Braithwaite J. Designing safer health care through responsive regulation. MJA. 2006;184:556-9.
83. Bouwman R, Bomhoff M, Robben P, Friele R. Patients' perspectives on the role of their complaints in the regulatory process. Health Expectations. 2015.
84. Jacobson PD. Regulating Health Care: From Self-Regulation to Self-Regulation? Journal of Health Politics, Policy and Law. 2001;26(5).
85. Thomas D. The co-regulation of medical discipline: Challenging medical peer review. JLM. 2004;11:382-9.
86. Lewis MJ. Medicine in Colonial Australia, 1788-1900. MJA. 2014;201(1):S5-S10.
87. Geffen L. A brief history of medical education and training in Australia. MJA. 2014;201(1):S19-S22.
88. Raach JH. English Medical Licensing in the Early Seventeenth Century. Yale Journal of Biology and Medicine. 1944;16(4):267-88.
89. Baggott B. Regulatory Politics, Health Professionals, and the Public Interest. In: Allsop J, Saks M, editors. Regulating the Health professions. London: Sage; 2002.
90. Southon G, Braithwaite J. The End of Professionalism? Soc Sci Med. 1998;46(1):23-8.

91. Commonwealth Department of Health and Ageing and the Nuffield Trust. Centenary of Federation Seminar on Sustainable Health Financing Seminar Papers. Canberra: Commonwealth of Australia; 2001.
92. Coulter A, Cleary PD. Patients' experiences with hospital care in five countries. *Health Affairs*. 2001;20(3):244-52.
93. Blendon RJ, Schoen C, DesRoches CM, Osborn R, Scoles KL, Zapert K. Inequities In Health Care: A Five-Country Survey. *Health Affairs*. 2002;21(3):182-91.
94. Brennan TA, Leape LL, Laird N, Hebert L, Localio R, Lawthers AG, et al. Incidence of Adverse Events and Negligence in Hospitalized Patients - Results of the Harvard Medical Practice Study I. *N Engl J Med*. 1991;6(324):370-6.
95. Leape LL, Brennan TA, Laird N, Lawthers AG, Localio R, Barnes BA, et al. The Nature of Adverse Events in Hospitalized Patients - Results of the Harvard Medical Practice Study II. *N Engl J Med*. 1991;324(6):377-84.
96. Localio R, Lawthers AG, Brennan TA, Laird NM, Hebert LE, Peterson LM, et al. Relation between Malpractice Claims and Adverse Events Due to Negligence - Results of the Harvard Medical Practice Study III. *N Engl J Med*. 1991;325(4):245-51.
97. Studdert DM, Mello MM, Brennan TA. Medical Malpractice. *N Engl J Med*. 2004;350(3):283-92.
98. Wilson RM, Runciman WB, Gibberd RW, Harrison BT, Newby L, Hamilton JD. The Quality in Australian Health Care Study. *Medical Journal of Australia*. 1995;163(9):458-71.
99. Hamilton JD, Gibberd RW, Harrison BT. After the Quality in Australian Health Care Study, what happened? *MJA*. 2014;201(1):23.
100. National Expert Advisory Group on Safety and Quality in Australian Health Care. Implementing safety and quality enhancement in health care: National actions to support quality and safety improvement in Australian health care. 1999.
101. National Expert Advisory Group on Safety and Quality in Australian Health Care. Commitment to Quality Enhancement: the interim report. Canberra; 1998.
102. Institute of Medicine. To Err Is Human: Building a Safer Health System. Washinton: National Academies Press; 2000.
103. Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. Washinton D.C.; 2001.
104. Schuster MA, McGlynn EA, Brook RH. How Good is the Quality of Health Care in the United States? *Milbank Quarterly*. 1998;76(4):515-794.
105. Advisory Commission on Consumer Protection and Quality in the Health Care Industry. Quality First: Better Health Care for all Americans. 1998.
106. Department of Health. An organisation with a memory: Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer. London; 2000.
107. Baker GR, Norton P. Patient Safety and Healthcare Error in the Canadian Healthcare System: A Systematic Review and Analysis of Leading Practices in Canada with Reference to Key Initiatives Elsewhere. Ottawa: Health Canada; 2001.
108. Alexander Henderson and Associates. A Report on the Special Medical Seminar Lessons for Health Care: Applied Human Factors Research 22 November 2000 Prepared for the Australian Council for Safety and Quality in Health Care & NSW Ministerial Council for Quality in Health Care 2001.
109. Reason J. Human error: models and management. *BMJ*. 2000;320:768-70.
110. Reason J. Human Error. Cambridge: Cambridge Universirt Press; 1990.

111. Toft B, Reynolds S. Learning from disasters. UK: Perpetuity Press; 1997.
112. Fletcher M. The Quality of Australian Health Care: Current Issues and Future Directions. Commonwealth Department of Health and Aged Care; 2000.
113. Runciman WB, Merry AF, Titto F. Error, Blame, and the Law in Health Care-An Antipodean Perspective. *Ann Intern Med.* 2003;138:974-9.
114. Grober ED, Bohnen MD. Defining medical error. *Can J Surg.* 2005;48(1):39-44.
115. Vincent C, Taylor-Adams S, Stanhope N. Framework for analysing risk and safety in clinical medicine. *BMJ.* 1998;316:1154-7.
116. Cleary PD, Edgman-Levitan S, Roberts M, Moloney TW, McMullen W, Walker JD, et al. Patients evaluate their hospital care: a national survey. *Health Affairs.* 1991;10(4):254-67.
117. Cahill J. Patient participation: a concept analysis. *Journal of Advanced Nursing.* 1996;24:561-71.
118. Edgman-Levitan S, Cleary PD. What information do consumers want and need? *Health Affairs.* 1996;15(4):42-56.
119. Donaldson L. Expert patients usher in a new era of opportunity for the NHS. *BMJ.* 2003;326.
120. Bate P, Robert G. Experience-based design: from redesigning the system around the patient to co-designing services with the patient. *Qual Saf Health Care.* 2006;15:307-10.
121. Frosch DL, Kaplan RM. Shared Decision Making in Clinical Medicine: Past Research and Future Directions. *Am J Prev Med* 1999;17(4):285-94.
122. Coulter A, Ellins J. Patient-focused interventions: A review of the Evidence. 2006.
123. Queensland Health. Consumer and Community Participation Toolkit for Queensland Health staff. 2002.
124. Consumer Focus Collaboration. The evidence supporting consumer participation in health. Victoria; 2001.
125. Global Learning Services Pty Ltd for the Consumer Focus Collaboration. Education and Training for Consumer Participation in Health Care: Final Report of Project. 2000.
126. The National Resource Centre for Consumer Participation in Health. Feedback, Participation and Consumer Diversity: A Literature Review. 2000.
127. Romios P, Newby L, Wohlers M, Spink J, Gleeson D, Goldstein D. Turning wrongs into rights: learning from consumer reported incidents. 2003.
128. Australian Council for Safety And Quality in Health Care. Better Practice Guidelines on Complaints Management for Health Care Services. Commonwealth of Australia; 2004.
129. Australian Council for Safety and Quality in Health Care. Open disclosure standard: A national standard for open communication in public and private hospitals, following an adverse event in health care. Canberra. 2003.
130. Iedema R, Mallock N, Sorensen R, Manias E, Tuckett A, Williams A, et al. Final report: Evaluation of the National Open Disclosure pilot program. Sydney: University of Technology, Sydney; 2007.
131. Studdert DM, Piper D, Iedema R. Legal aspects of open disclosure II: attitudes of health professionals — findings from a national survey. *MJA.* 2010;193:351-5.
132. Australian Commission on Safety and Quality in Health Care. Open Disclosure Standard Review Report. Sydney; 2012.

133. Australian Commission on Safety and Quality in Health Care. Saying sorry: A guide to apologising and expressing regret during open disclosure. Sydney; 2013.
134. Gallagher TH, Studdert D, Levinson W. Disclosing Harmful Medical Errors to Patients. *N Engl J Med*. 2007;356:2713-9.
135. Duclos CW, Eichler M, Taylor L, Quintela J, Main DS, Pace W, et al. Patient perspectives of patient-provider communication after adverse events. *International Journal for Quality in Health Care*. 2005;17(6):479-86.
136. Iedema R, Allen S, Britton K, Piper D, Baker A, Grbich C, et al. Patients' and family members' views on how clinicians enact and how they should enact incident disclosure: the "100 patient stories" qualitative study. *BMJ*. 2011;343:d4423.
137. Marx D. Patient Safety and the "Just Culture": A Primer for Health Care Executives 2001. Available from: http://www.mha-apps.com/media/maps/Marx_Primer.pdf.
138. Rivard P. Accountability for Patient Safety: A Review of Cases, Concepts, and Practices. Boston; 2003.
139. Friele R, Reitsma PM, de Jong JD. Complaint handling in healthcare: expectation gaps between physicians and the public; results of a survey study. *BMC Res Notes*. 2015;8(529).
140. Iedema R, Allen S, Britton K, Gallagher TH. What do patients and relatives know about problems and failures in care? *BMJ Qual Saf*. 2011.
141. Langer T, Martinez W, Browning DM, Varrin P, Lee BS, Bell SK. Patients and families as teachers: a mixed methods assessment of a collaborative learning model for medical error disclosure and prevention. *BMJ Qual Saf*. 2016;25:615-25.
142. Reason J. Error Models International Federation of Airworthiness; 2016.
143. Russell KA, Radtke BK. An Evidence-Based Tool for Regulatory Decision Making: The Regulatory Decision Pathway. *Journal of Nursing Regulation*. 2014;5(2):5-9.
144. Bell SK, Delbanco T, Anderson-Shaw L, McDonald TB, Gallagher TH. Accountability for medical error: moving beyond blame to advocacy. *CHEST*. 2011;140(2):519-26.
145. Wachter RM. Personal accountability in healthcare: searching for the right balance. *BMJ Quality and Safety*. 2013;22(2):176-80.
146. Aveling EL, Parker M, Dixon-Woods M. What is the role of individual accountability in patient safety? A multi-site ethnographic study. *Sociol Health Illn*. 2016;38(2):216-32.
147. Faunce TA, Bolsin SN. Three Australian whistleblowing sagas: lessons for internal and external regulation. *MJA*. 2004;181(1):44-7.
148. Studdert D, Brennan TA. No Fault Compensation for Medical Injuries. *Health Law and Ethics*. 2001;286(2):217-23.
149. Ocloo JE. Harmed patients gaining voice: Challenging dominant perspectives in the construction of medical harm and patient safety reforms. *Soc Sci Med*. 2010;71:510-6.
150. Harrison R, Walton M, Manias E, Smith-Merry J, Kelly P, Iedema R, et al. The missing evidence: a systematic review of patients' experiences of adverse events in health care. *International Journal for Quality in Health Care*. 2016.
151. Lang S, Garrido MV, Heintze C. Patients' views of adverse events in primary and ambulatory care: a systematic review to assess methods and the content of what patients consider to be adverse events. *BMC Family Practice*. 2016;17(6).
152. Kooienga S, Stewart VT. Putting a Face on medical Errors: A Patient Perspective. *Journal for Healthcare Quality*. 2010;1(1):1-5.

153. Levinson W, Pizzo PA. Patient-Physician Communication: It's About Time. *JAMA*, 2011;305(17):1802-3.
154. Gallagher TH, Mazor KM. Taking complaints seriously: using the patient safety lens. *BMJ Qual Saf*. 2015;24:352-5.
155. Paterson R. The Patients' Complaints System In New Zealand. *Health Affairs*. 2002;21(3):70-9.
156. Fleming N. The Kerr/Haslam Inquiry. London 2005.
157. Smith DJ. The Shipman Inquiry Fifth Report: Safeguarding patients: lessons from the past - proposals for the future. London: Stationery Office; 2004.
158. Department of Health. The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol. London; 2001.
159. New South Wales & Walker Bret. Final report of the Special Commission of Inquiry into Campbelltown and Camden Hospitals. Sydney: NSW Government, Special Commission of Inquiry; 2004.
160. New South Wales. Report of the Royal Commission into Deep Sleep Therapy & Slattery, The Honourable Mr Acting Justice J.P.
. Sydney: The Commission; 1990.
161. Matthews HHJS. To Investigate how the NHS handled allegations about the performance and conduct of Richard Neale. London: The Stationery Office; 2004.
162. NSW Legislative Council General Purpose Standing Committee No. 2. Complaints handling within NSW Health. Sydney 2004.
163. Clwyd A, Hart T. A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture. 2013.
164. Francis R. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry London; 2013.
165. Walshe K, Shortell SM. When Things Go Wrong: How Health Care Organizations Deal With Major Failures. *Health Affairs* 2004;23(3):103-11.
166. Walshe K, Higgins J. The use and impact of inquiries in the NHS. *BMJ*. 2002;325(895-900).
167. Dunbar JA, Reddy P, Beresford B, Ramsey WP, Lord RSA. In the wake of hospital inquiries: impact on staff and safety. *MJA*. 2007;186(80-83).
168. Macrae C. Early warnings, weak signals and learning from healthcare disasters. *BMJ Qual Saf*. 2014:1-6.
169. Hindle D, Braithwaite J, Travaglia J, Iedemma R. Patient Safety: a comparative analysis of eight Inquiries in six countries. Centre for Clinical Governance Research, University of New South Wales and the Clinical Excellence Commission 2006.
170. Fahy K, Robinson J, Douglas NF, Women. KEMHf. Inquiry into obstetric and gynaecological services at King Edward Memorial Hospital 1990-2000. Perth; 2001.
171. Health Services Commissioner. Royal Melbourne Hospital Inquiry Report. 2002.
172. Community & Health Services Complaints Commissioner. Report of the Investigation into Adverse Patient Outcomes of Neurosurgical Services Provided by the Canberra Hospital. 2003.
173. Queensland Public Hospitals Commission of Inquiry & Davies G. Queensland Public Hospitals Commission of Inquiry Report. Brisbane; 2005.

174. New South Wales Parliament Joint Select Committee on the Royal North Shore Hospital. Report on inquiry into the Royal North Shore Hospital. 2007.
175. Garling P. and New South Wales. Final Report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals Sydney. 2008.
176. New South Wales Parliament Joint Committee on the Health Care Complaints Commission. Report on the investigations by the Health Care Complaints Commission into the complaints made against Mr Graeme Reeves, Report No. 3/54. 2008.
177. O'Connor D. Review of the appointment, management and termination of Dr Graeme Reeves as a visiting medical officer in the NSW public health system. 2008.
178. Pauffley DA. Independent investigation into how the NHS handled allegations about the conduct of Clifford Ayling. London: The Stationery Office; 2004.
179. New South Wales Parliament Committee on the Health Care Complaints Commission. Inquiry into health care complaints and complaint handling in NSW, Report No. 2/55. 2013.
180. Francis R. Freedom to Speak Up- An independent review into creating an open and honest reporting culture in the NHS. 2015.
181. Kingdom JW. Agendas, Alternatives, and Public Policies. 2nd Edition ed. Boston: Longman; 2011.
182. Pacey F, Harley K, Veitch C, Short SD. A national scheme for health practitioner registration and accreditation: the case of Australia. In: Short SD, McDonald F, editors. Health Workforce Governance: Improved Access, Good Regulatory Practice, Safer Patients. Surrey, UK: Ashgate; 2012. p. 163-81.
183. New South Wales & Walker Bret. Interim report of the Special Commission of Inquiry into Campbelltown and Camden Hospitals. Sydney 2004.
184. New South Wales & Walker Bret. Second interim report of the Special Commission of Inquiry into Campbelltown and Camden Hospitals. Sydney 2004.
185. Australian Council for Safety And Quality in Health Care. Lessons from the Inquiry into Obstetrics and Gynaecological Services at King Edward Memorial Hospital 1990-2000. 2002.
186. Medicare Agreements Act (No. 226) 1992 (Cth), (1992).
187. Barraclough S. Victoria: The Office of the Health Services Commissioner. In: Thomas D, editor. Medicine Called To Account: Health Complaints Mechanisms in Australia. Sydney: School of Public Health and Community Medicine, Faculty of Medicine, University of New South Wales; 2002.
188. Hovenga EJS. Queensland: The Health Rights Commission. In: Thomas D, editor. Medicine Called To Account: Health Complaints Mechanisms in Australia. Sydney: School of Public Health and Community Medicine, Faculty of Medicine, University of New South Wales; 2002.
189. Grenade L, Boldy D. Western Australia: The Office of Health Review. In: Thomas D, editor. Medicine Called To Account: Health Complaints Mechanisms in Australia. Sydney: School of Public Health and Community Medicine, Faculty of Medicine, University of New South Wales; 2002.
190. Thomas D. New South Wales: The Complaints Unit/ Health Care Complaints Commission. In: Thomas D, editor. Medicine Called To Account: Health Complaints Mechanisms in Australia. Sydney: School of Public Health and Community Medicine, Faculty of Medicine, University of New South Wales; 2002.
191. Titto F, Hess M, Leonard K. The Australian Capital Territory: The Health Complaints Unit. In: Thomas D, editor. Medicine Called To Account: Health Complaints Mechanisms in

Australia. Sydney: School of Public Health and Community Medicine, Faculty of Medicine, University of New South Wales; 2002.

192. Daniel AE. Medicine and the State. North Sydney, NSW: Allen & Unwin Australia; 1990.

193. Thomas D. Introductory Overview. In: Thomas D, editor. Medicine Called To Account: Health Complaints Mechanisms in Australia. Sydney: School of Public Health and Community Medicine, Faculty of Medicine, University of New South Wales; 2002.

194. Newby L. Concluding Commentary. In: Thomas D, editor. Medicine Called to Account: Health Complaints Mechanisms in Australasia. Sydney: School of Public Health and Community Medicine, Faculty of Medicine, University of New South Wales; 2002.

195. Parliament of New South Wales. Hansard, Legislative Assembly, Health Care Complaints Bill Second Reading 16 November 1993. New South Wales 1993.

196. NSW Parliamentary Services. Medical Practice Bill 1992 Explanatory Note. 1992.

197. New South Wales Parliament Joint Committee on the Health Care Complaints Commission. Report on Mandatory Reporting of Medical Negligence. 2000.

198. New South Wales Parliament Joint Committee on the Health Care Complaints Commission. Seeking Closure: improving conciliation of health care complaints in New South Wales. 2002.

199. New South Wales Parliament Joint Committee on the Health Care Complaints Commission. Report of the Inquiry into Procedures Followed During Investigations and Prosecutions Undertaken by The Health Care Complaints Commission, Report No. 2. 2003.

200. New South Wales Parliament Joint Committee on the Health Care Complaints Commission. Report into alternative dispute resolution of health care complaints in New South Wales, Report No. 5/53. 2004.

201. New South Wales Parliament Joint Committee on the Health Care Complaints Commission. Study of complaints handling and practitioner regulation in other jurisdictions, Report No. 14/53. 2006.

202. New South Wales Parliament Joint Committee on the Health Care Complaints Commission. Inquiry into Internal Complaint Handling in Private Health Practices, Report No. 15/53. 2006.

203. New South Wales Parliament Joint Committee on the Health Care Complaints Commission. Report on the 8th Meeting on the Annual Report of the Health Care Complaints Commission, Report No. 1. 2003.

204. Reid A. To Discipline or Not to Discipline? Managing Poorly Performing Doctors. In: Freckelton I, editor. Regulating Health Professionals. Annandale, NSW: The Federation Press; 2005.

205. New South Wales Health Care Complaints Commission. Campbelltown and Camden hospitals Macarthur Health Service: investigation report. NSW; 2003.

206. AAP. Health watchdog chief sacked after probe into 17 deaths. Sydney Morning Herald. 2003 11 December 2003.

207. Eager K. The weakest link? Australian Health Review. 2004;28(1):7-12.

208. Frankum B, Attree D, Gatenby A, Eager S, Aouad. Be very afraid. MJA. 2004;180:362.

209. Hugh TB. Back to punishment in New South Wales. BMJ. 2004;329:1111.

210. The Cabinet Office New South Wales. Review of the Health Care Complaints Act 1993 Consultation Report. 2004.

211. O'Connor D. Review of Medical Practice Amendment Bill 2008. 2008 28 March 2008.
212. Sharpe P. Second Reading Speech: Medical Practice Amendment Bill 2008. Hansard: NSW Parliament; 2008.
213. Sharpe PTH. Second Reading Speech: Health Practitioner Regulation Amendment Bill 2010. NSW Australia: Parliament of New South Wales; 2010.
214. Satchell CS, Walton M, Kelly PJ, Chiarella EM, Pierce SM, Nagy MT, et al. Approaches to management of complaints and notifications about health practitioners in Australia. Australian Health Review. 2015.
215. Cartwright SR. The Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and Into Other Related Matters. Auckland, New Zealand 1988.
216. Walton M, Smith-Merry J, Healy J, McDonald F. Health complaint commissions in Australia: Time for a national approach to data collection. Australian Review of Public Affairs. 2012;11(1):1-18.
217. Health Quality and Complaints Commission Act (No. 25) 2006 (Qld).
218. Department of Health and Ageing. Productivity Commission Health Workforce Study: Initial Scoping Paper from the Australian Government Department of Health and Ageing. Canberra, ACT2005.
219. Boyce RA. The health workforce: innovation, substitution and reform. In: Barraclough S, Gardner H, editors. Analysing Health Policy: A Problem-Oriented Approach. NSW: Elsevier Australia; 2008.
220. Brooks PM, Lapsley HM, NButt DB. Medical workforce issues in Australia: "tomorrow's doctors - too few, too far". MJA. 2003;179:206-8.
221. Productivity Commission. Australia's Health Workforce Canberra2005 [
222. Senate Standing Committees on Community Affairs. Report on the Inquiry into Nursing- The patient profession: Time for action. 2002.
223. Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professionals, (2008).
224. Australian Health Ministers' Advisory Council. National Registration and Accreditation Scheme for the Health Professions Consultation Paper: Proposed arrangements for handling complaints, and dealing with performance, health and conduct matters. 2008.
225. Consumers Health Forum of Australia. Submission on the proposed arrangements for handling complaints and dealing with performance, health and conduct matters. 2008.
226. CHOICE. Submission: National Registration and Accreditation Scheme for the Health Professions- Proposed arrangements for handling complaints, and dealing with performance, health and conduct matters. 2008.
227. Public Interest Advocacy Centre. Maintaining consumer focus in health complaints: the key to national best practice. Response to the Consultation Paper on national health complaints handling. 2008.
228. Health Consumers' Council WA. Submission: National Registration and Accreditation Scheme for the Health Professions - Consultation on Proposed arrangements for handling complaints, and dealing with performance, health and conduct matters. 2008.
229. Council of Social Service of New South Wales. Submission: Proposed Arrangements for handling complaints, and dealing with performance, health and conduct matters. 2008.
230. Health Care Consumers' Association ACT. Submission: Proposed arrangements for handling complaints, and dealing with performance, health and conduct matters. 2008.

231. Mental Health Coordinating Council. Complaints Arrangements Submission: National Registration and Accreditation Scheme for Health Practitioners. 2008.
232. Health Consumers Queensland. Submission: National Registration and Accreditation Scheme For the Health Professions: Proposed arrangements for handling complaints, and dealing with performance, health and conduct matters. 2009.
233. Durkin M. Health Services Commissioner ACT: Submission. 2008.
234. Allston S. Health Complaints Commissioner Tasmania: Complaints Arrangements Submission. 2008.
235. Donaldson L. Office of Health Review Western Australia: Complaints Arrangements Submission. 2008.
236. Health and Community Services Complaints Commissioner South Australia. HCSCC SA submission: National Registration & Accreditation Scheme for the Health Professions Consultation paper: Proposed arrangements for handling complaints and dealing with performance, health and conduct matters. 2008.
237. NSW Health Care Complaints Commission. NSW Health Care Complaints Commission Response to the consultation paper titled "Proposed arrangements for handling complaints, and dealing with performance health and conduct matters". 2008.
238. Richards C. Health and Community Services Complaints Commissioner and Ombudsman Northern Territory: Complaints Arrangement Submission. 2008.
239. Health Services Commissioner Victoria. Health Services Commissioner, Victoria response to Consultation Paper Proposed arrangements for handling complaints, and dealing with performance, health and conduct matters. 2008.
240. New South Wales Medical Board. Response to NRAIP Consultation Paper – Proposed arrangements for handling complaints, and dealing with performance, health and conduct matters. 2008.
241. Nursing and Midwives Board NSW. Complaints Arrangements Submission. 2008.
242. NSW Psychologists Registration Board. Submission: Consultation Paper on Proposed arrangements for handling complaints, and dealing with performance, health and conduct matters. 2008.
243. Physical Disability Council of New South Wales. Submission: National Registration and Accreditation Scheme for the Health Professions- Proposed arrangements for handling complaints, and dealing with performance, health and conduct matters. 2008.
244. Australian Health Ministers' Advisory Council. Consultation Paper: Proposed arrangements for handling complaints, and dealing with performance, health and conduct matters 2008 [Available from: <http://www.ahwo.gov.au/natreg-calls.asp>].
245. Community Members COAG Reference Group. Complaints Arrangements Submission: Proposed arrangements for handling complaints and dealing with performance, health and conduct matters. 2008.
246. Australian Health Ministers' Advisory Council. Regulatory Impact Statement for the Decision to Implement the Health Practitioner Regulation National Law. 2009.
247. The Senate Finances and Public Administration References Committee. The administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA). Canberra, Australia; 2011.
248. Parliament of Victoria Legislative Council Legal and Social Issues Legislation Committee. Inquiry into the Performance of the Australian Health Practitioner Regulation Agency. 2014. Contract No.: Report No. 2.

249. Legislative Assembly of Queensland Parliamentary Crime and Conduct Committee. A report on the Crime and Misconduct Commission's assessment of a public interest disclosure. 2012. Contract No.: Report N0. 87.
250. Forrester K, Davies E, Houston J. Final Report - Chesterman Report Recommendation 2 Review Panel. 2013.
251. Setting things right: Action plan to improve our customer service [press release]. 23 September 2014.
252. Setting things right: 10 steps to improve our customer service [press release]. 16 June 2015.
253. Health Issues Centre. Setting things right: Improving the consumer experience of AHPRA including the joint notification process between AHPRA and OHSC. Melbourne; 2014.
254. Regulatory principles endorsed for National Scheme [press release]. 1 July 2014 2014.
255. Snowball K. Review of the National Registration and Accreditation Scheme for health professions Consultation Paper. 2014.
256. Consumers Health Forum of Australia. Submission to the Independent Review of the National Registration and Accreditation Scheme for Health Professionals. 2014.
257. Health Care Consumers Association ACT. HCCA Submission for the Review of the National Registration and Accreditation Scheme for Health Professionals. 2014.
258. Health Consumers Alliance South Australia. Review of National Registration and Accreditation Scheme for Health Professions. 2014.
259. Health Issues Centre. Health Issues Centre submission to the Review of the National Registration and Accreditation Scheme for Health Professionals. 2014.
260. Snowball K. Independent Review of the National Registration and Accreditation Scheme for health professions Final report. 2014.
261. COAG Health Council meeting as the Australian Health Workforce Ministerial Council. Communique 15 August 2015: The Independent Review of the National Registration and Accreditation Scheme for Health Professions. 2015.
262. Australian Health Practitioner Regulation Agency. Briefing: Review of notification systems and processes in Victoria 2016.
263. Australian Health Practitioner Regulation Agency. Briefing: Review of notification systems and processes in Victoria 2016 [Available from: <http://www.ahpra.gov.au/News/2016-03-22-Summary-of-independent-review.aspx>].
264. COAG Health Council. Summary of the draft Health Practitioner Regulation National Law Amendment Law 2017. 2017.
265. COAG Health Council. Stage 1 reforms to the Health Practitioner Regulation National Law 2017 [Available from: <http://coag.adelaidecloud.net/Projects/Health-Practitioner-Regulation-National-Law>].
266. COAG Health Council. Communique 24 March 2017. 2017.
267. Australian Health Practitioner Regulation Agency. Regulatory principles for the National Scheme. 2014.
268. Australian Health Practitioner Regulation Agency. Annual Report 2014/15. 2015.
269. enHealth. Environmental Health Risk Assessment: Guidelines for assessing human health risks from environmental hazards. Commonwealth of Australia; 2012.
270. US EPA. Human Health Risk Assessment 2016 [Available from: <https://www.epa.gov/risk/human-health-risk-assessment#self>].

271. Black J. Risk Based Regulation. Presentation to OECD2008.
272. Lloyd-Bostock SM, Hutter BM. Reforming regulation of the medical profession: The risks of risk-based approaches. *Health, Risk & Society*. 2008;10(1):69-83.
273. Hampton P. Reducing administrative burdens: effective inspection and enforcement. Norwich: HM Treasury; 2005.
274. Hood C. A Public Management for all Seasons? *Public Administration*. 1991;69(1):3-19.
275. Hutter BM. The Attractions of Risk-based Regulation: accounting for the emergence of risk ideas in regulation London: The London School of Economics and Political Science; 2005.
276. Black J, Baldwin R. Really Responsive Risk-Based Regulation. *Law & Policy*. 2010;32(2):181-213.
277. Chief Medical Officer. Good doctors, safer patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients London; 2006.
278. Lloyd-Bostock SM. The creation of risk-related information. *Journal of Health Organization and Management*. 2010;24(6):584-96.
279. Karson AS, Bates DW. Screening for adverse events. *Journal of Evaluation in Clinical Practice*. 1999;5(1):23-32.
280. Murff HJ, France DJ, Blackford J, Grogan EL, Yu C, Speroff T, et al. Relationship between patient complaints and surgical complications. *Qual Saf Health Care*. 2006;15:13-6.
281. Anderson JE, Kodate N, Walters R, Dodds A. Can incident reporting improve safety? Healthcare practitioners' views of the effectiveness of incident reporting. *International Journal for Quality in Health Care*. 2013;25(2):141-50.
282. Bismark MM, Fletcher M, Spittal MJ, Studdert DM. A step towards evidence-based regulation of health practitioners. *Australian Health Review*. 2015;39:483-5.
283. Reader TW, Gillespie A, Roberts J. Patient complaints in healthcare systems: a systematic review and coding taxonomy. *BMJ Qual Saf*. 2014;23:678-89.
284. Carroll AE. To Be Sued Less, Doctors Should Consider Talking to Patients More. *The New York Times*. 2015 1 June 2015.
285. Hultman CS, Gwyther R, Saou MA, Pichert JW, Cooper WO, Hickson GB. Stuck In a Moment: An Ex Ante Analysis of Patient Complaints in Plastic Surgery, Used to Predict Malpractice Risk Profiles, From a Large Cohort of Physicians in the Patient Advocacy Reporting System. *Ann Plast Surg*. 2015;74:S241-S6.
286. Kohanim S, Sternberg P, Karrass J, Cooper WO, Pichert JW. Unsolicited Patient Complaints in Ophthalmology: An Empirical Analysis from a Large National Database. *Ophthalmology*. 2016;123:234-41.
287. Lloyd-Bostock S, Mulcahy L. The Social Psychology of Making and Responding to Hospital Complaints: An account Model of Complaint Processes. *Law & Policy*. 1994;16(2):123-47.
288. Christiaans-Dingelhoff I, Smits M, Zwaan L, Lubberdin S, van der Wal G. To what extent are adverse events found in patient records reported by patients and healthcare professionals via complaints, claims and incident reports? *BMC Health Services Research*. 2011;11(49).
289. Kroening HL, Kerr B, Bruce J, Yardley I. Patient complaints as predictors of patient safety incidents. *Patient Experience Journal*. 2015;2(1):94-101.

290. Wessel M, Lynøe N, Juth N, Helgesson G. The tip of an iceberg? A cross-sectional study of the general public's experiences of reporting healthcare complaints in Stockholm, Sweden. *BMJ Open*. 2012;2(e000489).
291. Sparrow M. *The Regulatory Craft: Controlling Risks, Solving Problems & Managing Compliance*. Washington DC: Brookings Press; 2000.
292. Sparrow M. *The Character of Harms: Operational Challenges in Control*: Cambridge University Press; 2008.
293. Sparrow M. *What does it mean to be a Risk-Based Regulator?* Institute of Public Administration Australia; Victoria2014.
294. Sparrow M. *Effective Regulation*. 25th IOSCO Annual Conference; Sydney2000.
295. Sparrow M. *Joining the Regulatory Fold*. *Criminology & Public Policy*. 2012;11(2):345-59.
296. Sparrow M. *Measuring Performance in a Modern Police Organization*. Washington, D.C.: US Department of Justice, National Institute of Justice; 2015.
297. Professional Standards Authority for Health and Social Care. *Right-touch regulation revised*. London; 2015.
298. Professional Standards Authority. *Right-touch assurance: a methodology for assessing and assuring occupational risk of harm*. London, UK; 2016.
299. Secretary of State for Health. *Trust, Assurance and Safety-The Regulation of Health Professionals in the 21st Century*. London: The Stationery Office; 2007.
300. Berwick D. *A promise to learn– a commitment to act: Improving the safety of patients in England*. The National Advisory Group on the Safety of Patients in England; 2013.
301. Friele RD, Sluijs EM. Patient expectations of fair complaint handling in hospitals: empirical data. *BMC Health Services Research*. 2006;6.
302. Nettleton S, Harding G. *Protesting patients: a study of complaints submitted to a Family Health Service Authority*. *Sociology of Health & Illness*. 1994;16(1).
303. Allsop J, Jones K. *Withering the Citizen, Managing the Consumer: Complaints in Healthcare Settings*. *Social Policy and Society*. 2008;7(2):233-43.
304. Fallberg L, Mackenney S. *Patient Ombudsmen in Seven European Countries: an Effective Way to Implement Patients' Rights?* . *European Journal of Health Law*. 2013;10:343-57.
305. Dew K, Roorda M. *Institutional innovation and the handling of health complaints in New Zealand: an assessment*. *Health Policy*. 2001;57:27-44.
306. Bark P, Vincent C, Jones A, Savory J. *Clinical complaints: a means of improving quality of care*. *Quality in Health Care*. 1994;3:123-32.
307. Howard M, Fleming ML. *Patients Do Not Always Complain When They Are Dissatisfied: Implications for Service Quality and Patient Safety*. *Journal of Patient Safety*. 2013;9(4):224-31.
308. Daniel AE, Burn RJ, Horarik S. *Patients' complaints about medical practice*. *Medical Journal of Australia*. 1999;170(12):598-602.
309. Vincent C, Young M, Phillips A. *Why do people sue doctors? A study of patients and relatives taking legal action*. *The Lancet*. 1994;343:1609-13.
310. Friele RD, Sluijs EM, Legemaate J. *Complaints handling in hospitals: an empirical study of discrepancies between patients' expectations and their experiences*. *BMC Health Services Research*. 2008;8.

311. Bismark M, Dauer E, Paterson R, Studdert D. Accountability sought by patients following adverse events from medical care: the New Zealand experience. *CMAJ*. 2006;175(8):889-94.
312. Bismark MM, Spittal MJ, Gogos AJ, Gruen RL, Studdert DM. Remedies sought and obtained in healthcare complaints. *BMJ Qual Saf* 2011;20:806-10.
313. Department of Health & Human Services. Study of people lodging complaints with the Victorian Health Services Commissioner: Final Report. 2013.
314. Jones JA, Meehan-Andrews TA, Smith KB, Humphreys JS, Griffin L, Wilson B. There's no point in complaining, nothing changes: rural disaffection with complaints as an improvement method. *Aust Health Rev*. 2006;30(3):322-32.
315. Mazor KM, Greene SM, Roblin D, Lemay CA, Fineno CL, Calvi J, et al. More Than Words: Patients' Views on Apology and Disclosure When Things Go Wrong in Cancer Care. *Patient Educ Couns*. 2013;90(3):341-6.
316. Tyler TR. Social Justice: Outcome and Procedure. *International Journal of Psychology*. 2000;35(2):117-25.
317. Bismark M, Spittal M, Gogos AJ, Gruen RL, Studdert DM. Remedies sought and obtained in healthcare complaints. *BMJ Qual Saf* 2011;20:806-10.
318. communityresearch. Exploring the experience of public and patient complainants who have been through the GMC's Fitness to Practise procedures.pdf>. 2014.
319. Hewell Taylor Freed & Associates. Evaluation of the Pilot of Meetings with Complainants. UK; 2014.
320. Research Works. Research with patients and service users on assuring the quality of health and care professionals through Right-touch regulation. London; 2015.
321. Beaupert F, Carney T, Chiarella M, Satchell C, Walton M, Bennett B, et al. Regulating healthcare complaints: a literature review. *International Journal of Health Care Quality Assurance*. 2014;27(6):505-18.
322. Hsieh SY, Thomas D, Rotem A. The organisational response to patient complaints: a case study in Taiwan. *International Journal of Health Care Quality Assurance*. 2005;18(4):308-20.
323. Jiang Y, Xiaohua Y, Qian Z, Sirui RT, Sumit K, Maitrayee M, et al. Managing patient complaints in China: a qualitative study in Shanghai. *BMJ Open*. 2014;4:e005131.
324. Kent A. Dismissing the disgruntled: Swedish patient complaints management. *International Journal of Health Care Quality Assurance*. 2007;21(5):487-94.
325. Doron I, Gal I, Shavit M, Weisberg-Yosub P. Unheard voices: complaint patterns of older persons in the health care system. *Eur J Ageing*. 2011;8:63-71.
326. Gal I, Doron I. Informal complaints on health services: hidden patterns, hidden potentials. *International Journal for Quality in Health Care*. 2007;19(3):158-63.
327. Davis RE, Koutantji M, Vincent CA. How willing are patients to question healthcare staff on issues related to the quality and safety of their healthcare? An exploratory study. *Qual Saf Health Care*. 2008;17(90-96).
328. Anderson K, Allan D, Finucane P. Complaints concerning the hospital care of elderly patients: a 12-month study of one hospital's experience. *Ageing*. 2000;29(5):409-12.
329. Wu CY, Lai HJ, Chen RC. Patient Characteristics Predict Occurrence and Outcome of Complaints Against Physicians: A Study From a Medical Center in Central Taiwan. *J Formos Med Assoc*. 2009;108(2):126-34.

330. Gal I, Weisberg-Yosub P, Shavit M, Doron I. Complaints on Health Services: A Survey of Persons With Disabilities. *Journal of Disability Policy Studies*. 2010;21(3):181-8.
331. Välimäki M, Kuosmanen L, Kärkkäinen J, Kjervik DK. Patients' rights to complain in Finnish psychiatric care: An overview. *International Journal of Law and Psychiatry*. 2009;32:184-8.
332. Carter S. Justifying Knowledge, Justifying Method, Taking Action: Epistemologies, Methodologies, and Methods in Qualitative Research. *Qualitative Health Research*. 2007;17(10):1316-28.
333. Mason J. *Qualitative Researching* 2nd edition. London: SAGE; 2002.
334. Creswell JW. *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches* 3rd edition. Thousand Oaks, California: SAGE Publications; 2009.
335. Bryman A. *Social Research Methods* 4th Edition. United Kingdom: Oxford University Press; 2012.
336. Ormston R, Spencer L, Barnard M, Snape D. *The Foundations of Qualitative Research*. 2013. In: *Qualitative Research Practice: A Guide for Social Science Students and Researchers* [Internet]. London: SAGE.
337. Tashakkori A, Teddlie C. Overview of Contemporary Issues in Mixed Methods Research. In: Tashakkori A, Teddlie C, editors. *Handbook of Mixed Methods in Social & Behavioral Research*. Thousand Oaks, California: Sage; 2010.
338. Bazeley P. Teaching mixed methods. *Qualitative Research Journal*. 2003;3:117-26.
339. Bazeley P. Integrating Data Analyses in Mixed Methods Research. *Journal of Mixed Methods Research*. 2009;3(3):202-7.
340. Denscombe M. *The Good Research Guide for small scale research projects*. Fourth edition ed. Berkshire: Open University Press; 2010.
341. Willis JW. *Foundations of Qualitative Research: Interpretive and Critical Approaches*. Thousand Oaks, California: Sage Publications; 2007.
342. Smith JA, Flowers P, Larkin M. *Interpretive Phenomenological Analysis: Theory, Method and Research*. London: SAGE; 2009.
343. Shaw R, Burton A, Xuereb CB, Gibson J, Lane D. *Interpretative Phenomenological Analysis in Applied Health Research*. SAGE Research Methods Cases [Internet]. 2014.
344. van Manen M. *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy* 2nd edition. Canada: The Athlouse Press; 1997.
345. Mayoh J, Onwuegbuzie AJ. Toward a Conceptualization of Mixed Methods Phenomenological Research. *Journal of Mixed Methods Research*. 2015;9(1):91-107.
346. Birks M, Mills J. *Grounded Theory: A Practical Guide*. California: SAGE; 2012.
347. Bryant A. Grounded Theory and Pragmatism: The Curious Case of Anselm Strauss. *Forum Qualitative Social Research*. 2009;10(3).
348. Coffey A, Atkinson P. Narratives and Stories. In: Coffey A, Atkinson P, editors. *Making sense of qualitative data: Complementary research strategies*. California: SAGE; 1996.
349. Corbin J, Strauss A. Grounded Theory Research: Procedures, Canons, and Evaluative Criteria *Qualitative Sociology*,. 1990;13(1).
350. Corbin J, Strauss AL. *Basics of Qualitative Research (3rd edition): Techniques and Procedures for Developing Grounded Theory*. Los Angeles: Sage; 2008.
351. Glaser BG. *Theoretical sensitivity: advances in the methodology of grounded theory*. California: Sociology Press; 1978.

352. Glaser BG. The Future of Grounded Theory. *Qual Health Res.* 1999;9(6):836-45.
353. Glaser BG. Remodeling Grounded Theory. *Forum: Qualitative Social Research.* 2004;5(2).
354. Hood JC. Orthodoxy vs. Power: The Defining Traits of Grounded Theory. In: Bryant A, Charmaz K, editors. *The SAGE Handbook of Grounded Theory.* London: SAGE; 2007. p. 151-64.
355. Snow DA. Extending and Broadening Blumer's Conceptualization of Symbolic Interactionism. *Symbolic Interaction.* 2001;24(3).
356. Charmaz K. *Constructing Grounded Theory - A Practical Guide Through Qualitative Analysis.* Silverman D, editor. London: Sage; 2006.
357. Charmaz K. *Constructing Grounded Theory 2nd Edition.* London: Sage; 2014.
358. Glaser BG. Naturalist Inquiry and Grounded Theory. *Historical Social Research.* 2007;19:114-32.
359. Glaser BG, Strauss AL. *The Discovery of Grounded Theory: Strategies for Qualitative Research.* New Brunswick: AldineTransaction; 1967.
360. Strauss A. *Qualitative analysis for social scientists.* Cambridge: Cambridge University Press; 1987.
361. Bryman A. *Social Research Methods, third edition.* Oxford: Oxford University Press; 2008.
362. Rose S, Spinks N, Canhoto AI. *Management Research: Applying the Principles.* 2015.
363. Bryant A, Charmaz K. *The SAGE Handbook of Grounded Theory.* London: SAGE; 2007.
364. Bryant A, Charmaz K. Grounded Theory in Historical Perspective: An Epistemological Account. In: Bryant A, Charmaz K, editors. *The SAGE Handbook of Grounded Theory.* London: SAGE; 2007. p. 31-57.
365. Blumer H. *Symbolic interactionism; perspective and method.* New Jersey: Prentice-Hall; 1969.
366. Losekoot E, Wright N. Interpretive research paradigms: points of difference. 11th European Conference on Research Methods in Business and Management Bolton Academic Publishing International Limited; 2012.
367. Ritzer G, Stepnisky J. *Contemporary sociological theory and its classical roots : the basics: Fourth Edition.* California: McGraw Hill Higher Education; 2012.
368. Clarke AE. *Situational Analysis: Grounded Theory After the Postmodern Turn.* California: SAGE; 2005.
369. Clarke AE, Friese C, Washburn R. *Situational Analysis in Practice: Mapping Research with Grounded Theory.* California: Left Coast Press 2015.
370. Denzin KD, Lincoln YS. *The Qualitative Inquiry Reader.* California: Sage Publications; 2002.
371. Corbin J, Strauss AL. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory.* Los Angeles: Sage; 2015.
372. Kenny M, Fourie R. Contrasting Classic, Straussian, and Constructivist Grounded Theory: Methodological and Philosophical Conflicts. *The Qualitative Report.* 2015;20(8):1270-89.
373. Corbin J, Strauss A. *Basics of qualitative research : techniques and procedures for developing grounded theory: Fourth Edition.* California: SAGE; 2015.

374. Jupp V. The SAGE dictionary of social research methods London: Sage; 2006.
375. Bowen GA. Naturalistic inquiry and the saturation concept: a research note. *Qualitative Research Journal*. 2008;8(1):137 - 52.
376. Fusch PI, Ness R. Are We There Yet? Data Saturation in Qualitative Research. *Are We There Yet? Data Saturation in Qualitative Research*. 2015;20(9):1408-16.
377. O'Reilly M, Parker N. "Unsatisfactory Saturation": a critical exploration of the notion of saturated sample sizes in qualitative research. *Qualitative Research*. 2012;13(2):190-7.
378. Bulmer M. Concepts in the Analysis of Qualitative Data. *Sociological Review*. 1979;27(4):651-77.
379. Bazeley P. The Contribution of Computer Software to Integrating Qualitative and Quantitative Data and Analyses. *Research in the Schools*. 2006;13(1):64-74.
380. Greene J. Toward a methodology of mixed methods social inquiry. *Research in the Schools*. 2006;13(1):93-8.
381. Cresswell J. *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. California: SAGE; 2009.
382. Leech NL, Onwuegbuzie AJ. A typology of mixed methods research designs. *Quality & Quantity*. 2007;43(2):265-75.
383. Johnson B, Onwuegbuzie AJ, Turner LA. Towards a definition of mixed methods research. *Journal of Mixed Methods Research*. 2007;1(2):112-33.
384. Blaikie N. *Approaches to Social Inquiry*, 2nd edition. Cambridge, UK: Blackwell; 2007.
385. Cresswell JW, Klassen AC, Plano-Clark VL, Clegg-Smith K. *Best Practices for Mixed Methods Research in the Health Sciences*. Bethesda, MD; 2011.
386. Shneerson CL, Gale NK. Using mixed methods to identify and answer clinically relevant research questions. *Qual Health Res*. 2015;25(6):845-56.
387. Maggs-Rapport F. 'Best research practice': in pursuit of methodological rigour. *Journal of Advanced Nursing*. 2001;35(3):373-83.
388. Australian Health Practitioner Regulation Agency. *Annual Report 2013/14*. 2014.
389. Denscombe M. *The Good Research Guide for small-scale social research projects*. Fourth Edition ed. Berkshire England: Open University Press; 2010.
390. Kerr C, Taylor R, Heard G. *Handbook of Public Health Methods*. Sydney: McGrawHill; 1998.
391. Silverman D, Marvasti A. *Doing Qualitative Research: A Comprehensive Guide*. Thousand Oaks, California: SAGE Publications; 2008.
392. Hudon C, Fortin M, Haggerty JL, Lambert M, M. P. Measuring Patients' Perceptions of Patient-Centered Care: A Systematic Review of Tools for Family Medicine. *Ann Fam Med*. 2011;9(2):155-64.
393. Beaulieu M, Haggerty JL, Beaulieu C, Bouharaoui F, Levesque J, Pineault R. Interpersonal Communication from the Patient Perspective: Comparison of Primary Healthcare Evaluation Instruments. *Healthcare Policy*. 2011;7:108-23.
394. Hammersley M, Traianou A. *Ethics in Qualitative Research: Controversies and Contexts*. California: SAGE; 2012.
395. Sanjari M, Bahramnezhad F, Fomani FK, Shoghi M, Cheraghi MA. Ethical challenges of researchers in qualitative studies: the necessity to develop a specific guideline. *Journal of Medical Ethics and History of Medicine*. 2014;7(14).

396. Roller M. Interviewer Bias & Reflexivity in Qualitative Research 2012 [Available from: <https://researchdesignreview.com/2012/11/14/interviewer-bias-reflexivity-in-qualitative-research/>].
397. Charmaz K, editor Emergent Ethics in Qualitative Research. NCRM Research Methods Festival; 2008.
398. Rajendran NS. Dealing With Biases in Qualitative Research: A Balancing Act for Researchers. Qualitative Research Convention 2001: Navigating Challenges; Kuala Lumpur 2001.
399. Norris N. Error, bias and validity in qualitative research. Educational Action Research. 1997;5(1):172-6.
400. Vincent C, Phillips A, Young M. Why do people sue doctors? A study of patients and relatives taking legal action. The Lancet. 1994;343(8913):1609-13.
401. Skalen C, Nordgren L, Annerback E-A. Patient complaints about health care in a Swedish County: characteristics and satisfaction after handling. Nursing Open. 2016:201-11.
402. Friele R, Kruikemeier S, Rademakers JD, Coppens R. Comparing the outcome of two different procedures to handle complaints from a patient's perspective. Journal of Forensic and Legal Medicine. 2013;20:290-5.
403. Giugliani C, Gault N, Fares V, Jegu J, Eleni dit Trolli S, Biga J, et al. Evolution of patients' complaints in a French university hospital: is there a contribution of a law regarding patients' rights? BMC Health Services Research. 2009 9(141).
404. Halperin EC. Grievances against physicians: 11 years' experience of a medical society grievance committee. West J Med 2000;173:235-8.
405. Perse J. Review of patient satisfaction and experience surveys conducted for public hospitals in Australia. Health Policy Analysis Pty Ltd.; 2005.
406. Australian Council for Safety And Quality in Health Care. Complaints Management Handbook for Health Care Services: Commonwealth of Australia; 2005.
407. Walton M. Review of the Aged Care Complaints Investigation Scheme. 2009.
408. Haggerty JL, Baeaulieu C, Lawson B, Santor DA, Fournier M, Burge F. What Patients Tell Us About Primary Healthcare Evaluation Instruments: Response Formats, Bad Questions and Missing Pieces. Healthcare Policy. 2011;7 Special Issue(66-78).
409. Anderson K, Allan D, Finucane P. Complaints concerning the hospital care of elderly patients: a 12-month study of one hospital's experience. Age and Ageing. 2000;29:409-12.
410. Daniel AE, Burn RJ, Horarik S. Patients' Complaints about Medical Practice. MJA. 1999;170:598-602.
411. Karlsson S, Edberg AK, Westergren A, Hallberg IR. Functional ability and health complaints among older people with a combination of public and informal care vs. public care only. Scandinavian Journal of Caring Sciences. 2008;22:136-48.
412. Griffin LH, J.S.; Jones, J.A.; Smith, K.B.; Meehan-Andrews, T.A. and Wilson, B. . There's no point in complaining, nothing changes: rural disaffection with complaints as an improvement method. Australian Health Review. 2006;30(3):322-32.
413. The Senate Community Affairs Legislation Committee. National registration and accreditation scheme for doctors and other health workers. Canberra: Commonwealth of Australia; 2009.
414. Queensland Parliament Health and Community Services Committee. Health Ombudsman Bill 2013: Report No. 27. 2013.

415. Australian Bureau of Statistics. Australian Demographic Statistics (cat. no. 3101.0). 2016.
416. Australian Bureau of Statistics. Estimates of Aboriginal and Torres Strait Islander Australians, June 2011 (cat. no. 3238.0.55.001). 2013.
417. Australian Bureau of Statistics. Reflecting a Nation: Stories from the 2011 Census, 2012–2013 (cat. no. 2071.0). 2012.
418. Australian Institute of Health and Welfare. Australia's Welfare 2015. 2015.
419. Australian Bureau of Statistics. Disability, Ageing and Carers, Australia: Summary of Findings, 2015 (cat. no. 4430.0). 2016.
420. Department of Health and Ageing. The Mental Health of Australians 2: Report on the 2007 National Survey of Mental Health and Wellbeing. 2009.
421. Australian Institute of Health and Welfare. Australia's health 2014 (cat. no. AUS 178). 2014.
422. Australian Bureau of Statistics. Population by Age and Sex, Regions of Australia, 2015 (cat. no. 3235.0). 2016.
423. Health Practitioner Regulation National Law Act 2009, QLD [statute on the internet] 2009 [Available from: http://www.austlii.edu.au/au/legis/qld/consol_act/hprnla2009428/].
424. Health Practitioner Regulation National Law (No. 86a) 2010 (NSW). (2010).
425. Shojania KG, Dixon-Woods M. 'Bad apples': time to redefine as a type of systems problem? *BMJ Qual Saf*. 2013;22:528-31.
426. Australian Health Practitioner Regulation Agency. Annual Report 2015/16. 2016.
427. Batalden M, Batalden P, Margolis P, Seid M, Armstrong G, Opiari-Arrigan L, et al. Coproduction of healthcare service. *BMJ Quality and Safety*. 2015;1-9.
428. Luxford K. What does the patient know about quality? *International Journal for Quality in Health Care*. 2012;24(5):439-40.
429. Jones JA, Humphreys JS, Wilson B. Do health and medical workforce shortages explain the lower rate of rural consumers' complaints to Victoria's Health Services Commissioner? *Aust J Rural Health*. 2005;13:353-8.
430. Davis RE, Koutantji M, Vincent C. How willing are patients to question healthcare staff on issues related to the quality and safety of their healthcare? An exploratory study. *Qual Saf Health Care*. 2007;17:90-6.
431. Anderson K, Allan D, Finucane P. A 30-month study of patient complaints at a major Australian hospital. *J Qual Clin Practice*. 2001;21:109-11.
432. Ware VA. Improving the accessibility of health services in urban and regional settings for Indigenous people.pdf>. 2013.
433. Australian Health Ministers' Advisory Council. Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report. Canberra; 2015.
434. Bainbridge R, McCalman J, Clifford A, Tsey K. Cultural competency in the delivery of health services for Indigenous people. 2015.
435. Sawrikar P, Katz I. Enhancing family and relationship service accessibility and delivery to culturally and linguistically diverse families in Australia. 2008.
436. Gill GK, Babcan H. Developing a cultural responsiveness framework in healthcare systems: an Australian example. *Diversity and Equality in Health and Care*. 2012;9:45-55.

437. Department of Health and Ageing. Evaluation of the Better Access Initiative Final Report. Canberra; 2010.
438. Department of Developmental Disability Neuropsychiatry. Accessible Mental Health Services for People with an Intellectual Disability: A Guide for Providers. Sydney; 2014.
439. Health Care Complaints Commission. Contact us 2017 [Available from: <http://www.hccc.nsw.gov.au/Contact-Us/default.aspx>]
440. Health Professional Councils Authority. How to contact the Health Professional Councils Authority 2017 [Available from: <http://www.hpca.nsw.gov.au/Contact-Us/default.aspx>].
441. Australian Health Practitioner Regulation Agency. General support services 2017 [Available from: <http://www.ahpra.gov.au/Notifications/Further-information/General-support-services.aspx>]
442. Health Care Complaints Commission. Health Care Complaints Commission Annual Report 2015-16. 2016.
443. Hooper P, Kocman D, Carr S, Tarrant C. Junior doctors' views on reporting concerns about patient safety: a qualitative study. *Postgraduate Medical Journal*. 2015;91(1075):252-6.
444. beyondblue. beyondblue Submission: Senate Standing Committee on Community Affairs: Medical complaints process in Australia. Victoria; 2016.
445. Knowles THR, Szoke H, Campbell G, Ferguson C, Flynn J, Lay K, et al. Expert Advisory Group Report to the Royal Australasian College of Surgeons on discrimination, bullying and sexual harassment. 2015.
446. Ivory K. Listen, hear, act: challenging medicine's culture of bad behaviour. *MJA*. 2015;11.
447. Royal Australasian College of Surgeons. Building Respect, Improving Patient Safety: RACS Action Plan on Discrimination, Bullying and Sexual Harassment in the Practice of Surgery. 2015.
448. Health Care Complaints Commission. Health Care Complaints Commission Annual Report 2013-14. 2014.
449. Hsieh SY. The use of patient complaints to drive quality improvement: an exploratory study in Taiwan. *Health Services Management Research*. 2010;23:5-11.
450. Jangland E, Larsson J, Carlsson M, Gunningberg L. Patients' complaints about negative interactions with health professionals. *International Journal of Patient Centred Medicine*. 2011;4(1).
451. Street RL, Jr., Makoul G, Arora NK, Epstein RM. How does communication heal? Pathways linking clinician-patient communication to health outcomes. *Patient Educ Couns*. 2009;74(3):295-301.
452. Jangland E, Gunningberg L, Carlsson M. Patients' and relatives' complaints about encounters and communication in health care: Evidence for quality improvement. *Patient Education and Counseling*. 2009;75:199-204.
453. Lloyd-Bostock S, Mulcahy L. Calling doctors and hospitals to account: complaining and claiming as social processes. In: Rosenthal MM, Mulcahy L, Lloyd-Bostok S, editors. *Medical Mishaps: Pieces of the Puzzle*. Buckingham: Open University Press; 1999.
454. Hunt MT, Glucksman ME. A review of 7 years of complaints in an inner-city Accident and Emergency Department. *Archives of Emergency Medicine*. 1991;8:17-23.
455. Wong LL, Ooi SBS, Goh LG. Patients' complaints in a hospital emergency department in Singapore. *Singapore Medical Journal*. 2007;48(11):990-5.

456. Parry J, Hewage U. Investigating complaints to improve practice and develop policy. *Int J Health Care Qual Assur*. 2009;22(7):663-9.
457. Grenyer FS, Lewis KL. Prevalence, Prediction, and Prevention of Psychologist Misconduct. *Australian Psychologist*. 2012;47:68-76.
458. Kmietowicz Z. Half of complaints about hospitals concern poor communication and attitude. *BMJ*. 2015;351:h5036.
459. Srivastava R. Reflections on the Makings of a Good Doctor [Internet]: University of Queensland; 2016. Podcast. Available from: <https://www.youtube.com/watch?v=b1Yq53Ub-30>
460. Ha JF, Longnecker N. Doctor-Patient Communication: A Review. *The Ochsner Journal*. 2010;10(1):38-43.
461. Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia. 2014.
462. Nursing and Midwifery Board of Australia. Code of professional conduct for midwives in Australia. 2013.
463. Nursing and Midwifery Board of Australia. Registered nurse standards for practice. 2016.
464. Dental Board of Australia. Code of Conduct. 2014.
465. Pharmacy Board of Australia. Code of conduct. 2014.
466. Australian Psychological Society. APS Code of Ethics. 2007.
467. Iedema R, Piper D, Beitat K, Allen S, Bower K, Hor S. Risk and Clinical Incident Disclosure: Navigating between Morality and Liability. In: Crichton J, Credlin CN, Firkins AS, editors. *Communicating Risk*. UK: Palgrave MacMillan; 2016.
468. Piper LE, Tallman E. The Ethical Leadership Challenge for Effective Resolution of Patient and Family Complaints and Grievances: Proven Methods and Models. *The Health Care Manager*. 2015;34(1):62-8.
469. General Medical Council and Nursing & Midwifery Council. Openness and honesty when things go wrong: the professional duty of candour. 2015.
470. Chiu Y-C. What drives patients to sue doctors? The role of cultural factors in the pursuit of malpractice claims in Taiwan. *Social Science & Medicine*. 2010;71:702-7.
471. Walker B. Final Report of the Special Commission of Inquiry into Campbelltown and Camden Hospitals. 2004.
472. Snowball K. Independent Review of the National Registration and Accreditation Scheme for health professions. 2014.
473. Health Professional Councils Authority of New South Wales. NSW Health Professional Councils Annual Report 2015-16. 2016.
474. Health Professional Councils Authority of New South Wales. NSW Health Professional Councils Combined Annual Report 2014-15. 2015.
475. Health Care Complaints Commission. Health Care Complaints Commission Annual Report 2014-15. 2015.
476. Vincent C, Coulter A. Patient safety: what about the patient? *Qual Saf Health Care*. 2002;11:76-80.
477. Shaw K, Cassel CK, Black C, Levinson W. Shared Medical Regulation in a Time of Increasing Calls for Accountability and Transparency Comparison of Recertification in the United States, Canada, and the United Kingdom. *JAMA*. 2009;302(18):2008-14.

478. Health Professional Councils Authority. Making a Notification (Complaint) 2017 [
479. Health Care Complaints Commission. Complaints Process 2017 [Available from: <https://www.hccc.nsw.gov.au/Complaints/Complaint-process/Default>.
480. Australian Health Practitioner Regulation Agency. Find out about the complaints process 2017 [Available from: <http://www.ahpra.gov.au/Notifications/Find-out-about-the-complaints-process.aspx>.
481. Crigger N, Godfrey NS. Professional Wrongdoing: Reconciliation and Recovery. *Journal of Nursing Regulation*. 2014;4(4):40-7.
482. Bourne T, Wynants L, Peters M, Van Audenhove C, Timmerman D, Van Calster B, et al. The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK: a cross-sectional survey. *BMJ Open*. 2015;4:e006687.
483. Professional Standards Authority. The Performance Review Standards: Standards of Good Regulation. 2016.
484. Spittal MJ, Studdert DM, Paterson R, Bismark MM. Outcomes of notifications to health practitioner boards: a retrospective cohort study. *MBMC Medicine*. 2016;14(198):1-10.
485. Allsop J, Mulcahy L. Maintaining professional identity: doctors' responses to complaints *Sociology of Health & Illness*. 1998;20(6):802-24.
486. Medical Board of Australia. Options for revalidation in Australia: Discussion paper. 2016.
487. Senator Humphries initiates Senate Inquiry into health-workers accreditation [press release]. 19 March 2009

Appendix 1: Chapter 1 (background) additional tables

Table A1.1: Major Australian and influential UK inquiries into hospitals, health practitioners and complaint management 2000 – 2010: inquiry prompts and identified issues

Year, Title, Inquiry prompt	Culture 1	Resource 2	Safety quality 3	Staff 4	Over-sight 5	Care 6	Deny Cplt. 7	Source 8	Time Cost 9
2008 NSW Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals ('Garling Report') Prompt: Incidents RNSH (below)	√	√	√	√		√		CP	10M
Recommendations: (adopted) 'Four Pillars': institutions to manage the dimensions of a sustainable and quality health system, being the Clinical Innovation and Enhancement Agency; Bureau of Health Information; Institute of Clinical Education and Training; Clinical Excellence Commission. Other: Recs [77-78]: Patient Care performance criteria to include patient experience and satisfaction reported quarterly; [131] explore implementation of a charter enabling community participation in hospital affairs. Other observations include bullying and intolerance of dissent undermining transparency and accountability									
2008 NSW Part Joint Committee on the HCCC <i>Report on the investigations by the HCCC into the complaints made against Mr Graeme Reeves</i> Prompt: Management of multiple complaints over a period of years relating to conduct, competence	√	√						SR	
Response: significant legislative and policy reforms HCCC and health system more broadly (influenced by other reviews undertaken: including O'Connor, D. (2008) <i>Review of the appointment, management and termination of Dr Graeme Reeves as a visiting medical officer in the NSW public health system</i>)									
2007 NSW Part Joint Committee on the HCCC <i>Report on the Inquiry into Royal North Shore Hospital</i> Prompt: Systemic issues; inadequate pt. care	√	√	√	√		√		CP	2M
2005 Queensland Public Hospitals Commission of Inquiry ('Davies Report'); Prompt: Conduct, care standard, 17 patient deaths	√	√	√	√	√	√	√	PR/W (NMW)	2M
2005 UK The Kerr/Haslam Inquiry Volumes 1 and 2 Prompt: Sexual abuse, assault patients over 2 decades	√		√	√	√		√	CP PR/W	3Y £3.2M
2004 NSW Special Commission of Inquiry into Campbelltown and Camden Hospitals ('Walker Report') Prompt: ~17 deaths, unsafe inadequate care <i>Cplt system:</i> unresponsive; HCCC focus on systems; not treat as cplt.	√		√			√	√	PR/W (NMW)	6M
Findings, observations: Significant delays; misclassification of complaints against service rather than practitioners, affecting exercise of powers and courses of action and accountability of those involved. Statutory cplt. framework adequate but not exercised. Response: HCC Commissioner appointment terminated; Clinical Excellence Commission established; legislative reforms									
2004 UK Fifth Report - Safeguarding Patients: Lessons from the Past- Proposals for the future ('Shipman Inquiry') Prompt: Murder of ~215 patients <i>Cplt system:</i> handling of GP cplts; GMC procedures and revalidation proposals	√	√	√	√	√	√	√	CP Prev. PR/W	3Y £21M
Findings, observations: Data (standardise, centralise); information sharing; Cplts value (early warning); Cplt limits (unwillingness to complain/defer to authority; practitioners unwilling to report colleagues; not cover private sector/GPs); Fitness to practice: fairness to doctors privileged over pt safety; Revalidation GMC proposals weakened original intent; annual appraisal insufficient Response: Statutory and policy reform: 'Learning from tragedy, keeping patients safe' (2007) Home Secretary and Secretary of State for Health; 'Safeguarding patients: the Government's response to the recommendations of the Shipman Inquiry's Fifth Report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries' (2007); 'Trust, Assurance and Safety- The Regulation of Health Professionals in the 21 st Century' (2007) Secretary of State for Health; Good Doctors, safer patients (2006) Sir Liam Donaldson, CMO									
2004 UK To Investigate how the NHS handled allegations about the performance and conduct of Richard Neale Prompt: Care standard, complications ~60 cases. Previously struck off in Canada for deaths 2 pts. <i>Cplt system:</i> GMC aware of record; not responsive to cplts	√		√	√		√	√	CP	2Y
2003 ACT Report of the Investigation into Adverse Patient Outcomes of Neurosurgical Services Provided by the Canberra Hospital Prompt: Neurosurgical care quality and outcomes <i>Cplt system:</i> unwillingness to respond; exercise of powers	√		√		√	√		PR/W (DR)	3Y
2002 UK Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995. Prompt: Death 29 babies, substandard practice; broad systems failure: safety, monitor, respond, secrecy	√	√	√	√	√	√	√	PR/W CP	3Y £14M
2002 Victoria Royal Melbourne Hospital Inquiry Prompt: Deaths; care quality care; conduct; lack oversight	√		√	√	√	√	Occ.	CP	5M \$55K
2001 Western Australia Inquiry into obstetric and gynaecological services at King Edward Memorial Hospital 1990-2000 ('Douglas Report'). Prompt: Serious errors; lack oversight junior Drs managing complex cases	√	√	√	√	√	√	√	PR/W (CEO) CR	18M \$7M

[1-8] relate to deficiencies: [1] Culture: stability; senior leadership; accountability. [2] Resources: management; staffing; system stress. [3] Safety, quality: clinical governance; systems to record, report incidents/errors/AEs; policies, guides; use of data. [4] Supervision/support junior/senior staff; morale; education. [5] External oversight: performance transparency. [6] Patient care, safety, information about options, risk, support. [7] Resistance, denial problems, responsiveness of senior clinicians, administrators. [8] Source: PR/W=practitioner or 'whistle-blower' complaint; Cplt=family, carer, patient, member of public complaint; SR=review by oversight body. [9] Cost (excluding compensation); inquiry timeframe M= months; Y= years.

Table A1.2: Timeline of major developments for the design and implementation of the national scheme

Jun 2004	COAG requests the Productivity Commission undertake a research study into health workforce issues on 24 June 2004
Dec 2005	Productivity Commission report released 22 December, <i>Australia's Health Workforce</i> 19 recommendations for reform, including: - Streamlined and integrated workforce planning and management, including establishment of an advisory health workforce improvement agency; a single national registration board for health professionals; uniform national registration standards and a single national accreditation board for health professionals (separate to the single registration board) - Incentivising behaviour through funding and payment mechanisms; and extending access to non-medical professions - Measures to address specific health needs e.g. for rural areas; for Aboriginal and Torres Strait Islander peoples
Jul 2006	COAG agrees to the establishment of a national scheme at its meeting on 14 July, (starting with nine professions then registered in all professions), elements of the preferred scheme including a single (cross-profession) national registration Board and be self-funding
Mar 2008	COAG signs Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions on 26 March 2008, to commence 1 July 2010 - Health Ministers to manage implementation, including consultation on legislative framework (IGA 6.12) - Objectives of the national scheme include (IGA 5.3 (a-e): protect public by ensuring only practitioners suitably trained and qualified to practice in a competent and ethical manner are registered; facilitate workforce mobility; high quality education and training and rigorous and responsive assessment of overseas-trained practitioners; have regard to the public interest in promoting access to health services; and the need to enable a flexible, responsive and sustainable health workforce and innovation in education and service delivery - Legislation to include principles for the scheme (IGA 5.4 (a-c): operate in a transparent, accountable, efficient, effective and fair manner; ensure fees and charges are reasonable; restrictions on practice of a profession should only occur where the benefits of the restriction to the community as a whole outweigh the costs - Queensland to host substantive legislation (IGA 6.3), with other jurisdictions (barring WA) adopting the Qld law, WA enacting corresponding legislation - Profession-specific Boards to be established, responsible for registration and accreditation functions (IGA Attachment A 1.4; 1.22-1.26); roles to include establishment of committees to undertake roles "in a manner that provides effective and timely local responses" (IGA Att. A 1.25(a); including setting standards; receipt and investigation of complaints; referral of serious matters to a tribunal; disciplinary processes in relation to less serious matters; management of impaired registrants; internal merits review of decisions (IGA Att. A 1.25(b-n) - Hearing of serious matters that may result in suspension or cancellation; and appeals of decisions on less serious matters to be undertaken by external body (IGA Att. A 2.1-2.4)
Jul 2008	Stage 1 of 3 for implementation of legislative framework (Bill A) <i>Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008</i> (Qld) receives assent 25 July 2008. Establishes AHPRA; national Boards; initial functions and powers to commence implementation
Oct 2008	Practitioner Regulation Subcommittee on behalf of the Australian Health Ministers' Advisory Council releases <i>Consultation Paper: Proposed arrangements for handling complaints, and dealing with performance, health and conduct matters</i> The paper sets out the proposed features, including who and how complaints or concerns (notifications) can be made; roles of the national Boards and committees; powers and responsibilities for assessment, investigation and disciplinary action; proposed definitions including those relating to conduct; mandatory reporting provisions; and composition of assessment committees, panels and tribunals
Dec 2008	Practitioner Regulation Subcommittee on behalf of the Australian Health Ministers' Advisory Council releases <i>Consultation Paper: Proposed arrangements for information sharing and privacy</i> The paper proposes limited information be made publicly available on the register. In the case of conditions associated with impairment only that a health condition applies, with no further details; however specific restrictions on professional practice would appear. Concluding there was a public interest in decisions about conduct matters being made public, two options were proposed. The first that all conduct decisions were published (patient details de-identified); the second empowered Boards to order certain decisions confidential with a notice to this effect. The preferred option for professionals deregistered for conduct reasons would appear on the register with notice to this effect
Mar 2009	Senate Community Affairs Committee referral made 19 March 2009 Terms of Reference include the impact of the scheme on health services; patient care and safety; standards of training and qualification; complaints management and disciplinary processes; the role for state and territory registration boards. In moving for the referral, it was noted that: <i>there is real concern in the medical community about the design of this scheme, and I am very happy that the Senate has agreed to an inquiry into the issue. At the core of those concerns is that the administration and accreditation of doctors and other health workers may pass from health professionals to bureaucrats; which in turn may lead to a lowering of the bar on health standards...</i> (487)
Mar 2009	Australian Health Workforce Ministerial Council Communique: Mandatory reporting requirements for practitioners, employers where public at risk of harm; criminal history and identity checks for first time registrants
May 2009	Australian Health Workforce Ministerial Council Communique: changes to scheme announced: - Accreditation functions to be independent of government (national Boards responsible) - Complaints model to be determined by jurisdictions; definition of offences, breaches and outcomes recorded as part of national framework; assistance to be provided to people who need help to make a complaint - Must demonstrate CPD requirements set by Boards met as part of annual registration renewal - Reportable conduct to include placing public at substantial risk of harm through physical/mental impairment or departure from accepted prof. standards; practising under influence of alcohol/drugs; sexual misconduct
Jun 2009	Australian Health Workforce Ministerial Council releases Health Practitioner Regulation National Law (Bill B) 12 June for public consultation; containing the substantive provisions of the scheme
Aug 2009	Senate Community Affairs Legislation Committee Report released <i>National registration and accreditation scheme for doctors and other health workers</i> Recommendations focus on the independence of the profession to set accreditation standards and greater flexibility for

	professions in determining the composition of national Boards, in particular: reconsidering the proposed power of the Ministerial Council to amend accreditation standards, and adopting amendments proposed by the AMA (these including limits on Ministerial Council powers in this regard; requirement to apply a public interest test, consult and reach a unanimous decision on any directions); and making the reasons for any directions public. The report notes but does not make recommendations on: • Concerns by the Australian Medical Council that complaint and performance management processes be more clearly separated (s 2.81-2.83) • Objections by professions to the proposed role of a Public Interest Assessor (PIA) to assess complaints or that the costs be borne by registrants; and in-principle support for the PIA by community groups, albeit with expressed need for further particulars on their powers and resources to be made available (s 2.84-2.96)
Sep 2009	Governance Committee of the National Registration and Accreditation Implementation Project provides the Regulatory Impact Statement Australian Health Ministers' Advisory Council <i>Regulatory Impact Statement for the Decision to Implement the Health Practitioner Regulation National Law</i> including options and the preferred option for complaint handling arrangements. Option 1 - Create a new national complaints agency that adopts the NSW model of an independent entity undertaking assessment, prosecution and investigation functions on a national basis. Benefit: "clear separation of powers between the boards and the prosecution and investigation functions, with an arms-length relationship between the boards, where the majority of members are practitioners and the new national agency" Cost: increase Option 2 - Create a new independent Public Interest Assessor with a potentially determinative role at the preliminary assessment and post investigation stages as to how a case should be handled by a board but leave the investigations and prosecution functions with the boards, except for NSW which would retain its existing complaints system. Benefit: "increased public interest protection in the form of an independent and dedicated public interest assessment function. It would be a driver for consistent treatment across boards". Cost: added regulatory tier Option 3 - Utilise existing State and Territory Health Complaints Entities to provide an independent and potentially determinative role in relation to whether or not a board will take a matter further but leave the investigations and prosecution functions with the boards, except for NSW which would retain its existing complaints system. Benefit: "best utilises the complaints handling structures and procedures currently in existence in each jurisdiction. The HCEs provide the public interest assessment function at the preliminary assessment stage, negating the need for a new and separate public interest assessment function" Preferred option: "Option 3 provides the most flexible arrangement for handling complaints within the national model. It is also the most cost effective measure, as it utilises existing State and Territory arrangements and works in concert with them. It provides the best option to strengthen public accountability and public protection measures without any significant increase in regulation" RIS notes preference for self-regulation model "most practitioner submissions from States and Territories other than NSW tended to oppose any additional separation of powers and advocated retaining complaints investigation and prosecution within the individual boards" (p19)
Nov 2009	NSW Government passes legislation to join registration and accreditation components of NRAS but not provisions relating to complaints and discipline (health, conduct and performance) <i>Health Practitioner Regulation (Adoption of National Law) Act (No 86) 2009</i> (NSW) receives assent 19 November 2009
Nov 2009	Stage 2 of 3 for implementation of legislative framework (Bill B) <i>Health Practitioner Regulation National Law Act 2009</i> (Qld) receives assent 3 November 2009. Establishes remaining (substantive) provisions of national scheme
2009-10	Stage 3 of 3 for implementation of legislative framework (Bill C) Each jurisdiction (State/Territory) prepares and passes legislation to give effect to the national scheme in that jurisdiction
Jun 2010	<i>Health Practitioner Regulation Amendment Act (No 34) 2010</i> (NSW) receives assent 15 Jun 2010 Amends 2009 NSW Act to make provision for separate complaints and disciplinary scheme in NSW
Jul 2010	NRAS commences 1 July 2010 (except Western Australia) • Ten professions (chiropractors; dental care practitioners (including dentists, dental hygienists, dental prosthetists and dental therapists); medical practitioners; nurses and midwives; optometrists; osteopaths; pharmacists; physiotherapists; podiatrists; psychologists) • Four partially regulated professions join from July 2012 (Aboriginal and Torres Strait Islander health practitioners, Chinese medicine, medical radiation and occupational therapy)
Aug 2010	<i>Health Practitioner Regulation National Law (WA) Act 2010</i> receives assent 30 August 2010 with further amendments, taking effect 18 October; including exemption to mandatory reporting for treating practitioners

Table A1.3: Select provisions of the national and NSW schemes

Note: relevant legislative provisions in brackets

Hearings

In the national scheme, panel hearings are not open to the public (s189). Notifiers may make a submission only with leave from a panel (s187); do not have appeal rights; and must be given notice of the decision, but information only to the extent of what is available on the national register (s192).

Notifiers do not have standing in tribunal hearings, parties to proceedings being the board and practitioner concerned. Tribunals must give boards notice and reasons for decisions and any action the board must take (s204). Boards must advise employers in writing of a decision by the board, a tribunal or a co-regulatory authority to take health, conduct or performance action.

Available action and powers

Unless declined, a national Board may investigate (s160), refer a matter for a health or performance assessment (s169-170); establish a health or a performance and professional standards (PPS) panel (s181-182), or in the case of professional misconduct or improperly obtained registration, to a tribunal (s193). Available board powers (s178) include referring the matter elsewhere; accepting undertakings; giving a caution; or imposing conditions (undertake education, be supervised, do or refrain from doing certain things; report). Panel powers to impose conditions are similar except health panels may also suspend registration and PPS panels may also issue a caution or reprimand (S 191). Both are required to refer a matter to a tribunal should misconduct arise (s190). Additional powers to caution, reprimand or impose conditions that are available to tribunals (s196) include imposition of fines; suspension or cancellation of registration; disqualification from reapplying for registration for a certain period; prohibition from using specified titles or providing certain services.

A NSW Council may deal with a complaint through making inquiries; through an inquiry by a meeting of Council in professions other than medicine nursing or midwifery; direct the practitioner attend counselling; refer the complaint - for a performance or health assessment; to an Impaired Registrants Panel (IRP); to a committee of Council; to the HCCC for conciliation or investigation; to a tribunal; or to another entity (s145B); or direct a practitioner undergo examination (145E). Serious matters that could result in suspension or cancellation of registration (unless involving impairment) must be referred to a tribunal (s 145D), although Council committees may refer impairment matters to tribunals and recommend suspension or cancellation (s 146D). A Professional Standards Committee (PSC) (s146B) may issue a caution or reprimand; impose conditions; order the practitioner undergo treatment or counselling; undertake education; report or be supervised (take advice or direction). Where failure to comply can result in cancellation of registration, the order or condition is known as a critical compliance order or condition. PSCs may impose fines in particular circumstances, including when unsatisfactory professional conduct is found. Matters may be referred to an Assessment Committee (AC) if it concerns a medical, nursing or midwifery practitioner, the Commission has decided to not investigate it or not refer it to a tribunal post-investigation. The AC may obtain any advice it thinks necessary; endeavour to settle the matter by consent between the parties and report to Council (s147B). Tribunal powers (s149A-E) are per those outlined in the national regime.

Following an investigation, the HCCC (s39) may decide to take no further action, make comments to the practitioner; make interim prohibition orders (in cases of serious risk to the public); refer the complaint to a Council, to the Director of Public Prosecutions (in criminal matters) or to the Director of Proceedings, who can refer a complaint to a Professional Standards Committee (PSC) or to a tribunal. In reaching their decision, the Director must consider protection of public health and safety; seriousness of allegations; likelihood of proving the alleged conduct; and submissions made by the practitioner (s90C).

Consumer representation and participation

Health panels in the national scheme (s181) must consist of at least three members, at least one of which must be a registered practitioner in the subject profession ('the profession'), one a medical practitioner expert in a relevant health field and one member who is not and has never been a registered health practitioner in the profession. No more than half the members may be registered in the profession; the board required when choosing members to choose if possible from the jurisdiction the matter is being heard in; and persons involved in any proceedings relating to the matter may not be appointed. Performance and professional standards panels (s 182) vary insofar as at least half but no more than two thirds must be a registered practitioner in the profession, and at least one must be a person who represents the community.

In NSW, Council committees established to inquire into complaints (s169B) consist of four persons - two registered in the profession, one lawyer who is not a registered practitioner and one person who is not and has never been registered in the same profession. Assessment Committees (s172B) include three members registered in the profession and one member who is not and never has been; Impaired Registrant Panels (s173) two to three persons, at least one registered in the same profession and one medical practitioner; Performance Review Panels (s174) three persons, two in the same profession and one member who is not and has never been. Professional Standards Committee (PSCs) disciplinary functions may be exercised by two or more members of Council (s41G). Tribunals (s165B) consist of a legal member, two members registered in the profession and one lay person. When constituted for appeals, the tribunal consists of one legal member.

Table A1.4: Select recommendations from the 2014 Review of the National Registration and Accreditation Scheme for health professions and the Australian Government response

Recommendation 9

Measures to be taken within the National Scheme to ensure the following principles are met within the design and operation of the complaints and notifications process in particular:

- a. establish a process where complaints and notifications involve a shared assessment of the appropriate means of investigating and addressing the issues between the Australian Health Practitioner Regulation Agency (AHPRA) and Health Complaints Entities (HCEs). Complainants whose issue is referred to a National Board as a notification are to be interviewed to determine their expectation and be advised of the relevant processes
- b. investigations and reports to be shared between National Boards, AHPRA and HCEs as required
- c. establish benchmark timeframes for completion of key aspects of notification management
- d. rationale for deliberations and progress reports to be routinely and quarterly conveyed to notifiers and health practitioners in plain language
- e. National Boards to be authorised to refer matters for Alternative Dispute Resolution to HCEs
- f. any adverse findings and disciplinary decisions to include the timeframe for inclusion of the decision or finding on the registrants' record. These decisions should be supported by strengthened monitoring of practitioner compliance with restrictions on registration, including adequacy of supervision
- g. the Health Practitioner Regulation National Law 2009 (the National Law) to be amended so that notifiers personally impacted by practitioner conduct can be informed in confidence by the National Board about the process, decision and rationale for the decision regarding their case. This complements the amendments to the National Law approved by Ministerial Council in 2011 as detailed in Appendix 11
- h. National Boards and AHPRA to review correspondence standards with notifiers to ensure improved clarity and sensitivity in communication
- i. HCEs to file complaints so practitioners can be searched according to their AHPRA registration number to allow authorised persons to access data for research into the predictability of professional misconduct.

Response: accepted

Recommendation 26

That the Health Practitioner Regulation National Law 2009 be amended to enable the Australian Health Workforce Ministerial Council to appoint either a practitioner member or a community member of a National Board as Chairperson.

Response: accepted

Recommendation 28

That the Australian Health Practitioner Regulation Agency conduct specific education and training programs for investigators. These should be designed in consultation with National Boards, Tribunals and Panel members to develop more consistent and appropriate investigative standards and approaches, consistent with the requirements of the Health Practitioner Regulation National Law 2009, including the primacy of public safety over other considerations within the matters.

Response: accepted. Progress report requested by Ministers by December 2015

Recommendation 10

The Health Practitioner Regulation National Law 2009 (the National Law) to be amended to reflect the same mandatory notification exemptions for treating practitioners established in the Western Australian law.

Response: not accepted at this time – to be considered pending further research

Recommendation 18

A standing committee is needed within the National Registration and Accreditation Scheme involving the education sector, National Boards, Accreditation Authorities and representation from employers and jurisdictions to:

- a. discuss the means by which health workforce reform and health service access gaps can be best addressed in the education and training of health professionals
- b. consider the evidence and value of alternative innovations in the delivery of health education and training. (An example is that simulated learning is accepted by some but not all accreditors)
- c. share an understanding of workforce distribution and projected workforce need
- d. ensure that education opportunities exist for students to meet the minimum standard of entry.

Response: accepted in Principle – to be considered pending further work

Recommendation 11

Make amendments to the *Health Practitioner Regulation National Law 2009* provision preventing the use of testimonials on platforms and sites that are managed or controlled by the practitioner or business.

Response: not accepted – issues surrounding testimonials should continue to be dealt with through National Board guidelines

Table A1.5: Comparative objects and principles in co-regulatory regimes of NSW and Queensland and jurisdictional complaint entities

Jurisdiction Statute	Resolution role	Public interest Quality and safety; improvement, systemic issues Education, support [ES]	Rights and Principles [in legislation; on website]
NSW Health Care Complaints Commission http://www.hccc.nsw.gov.au/ <i>Health Care Complaints Act 1993</i> Part 1 s3 Act Objects and principles; s3A HCCC & others roles, principles	s3(d) resolving or overseeing the resolution of complaints (Part 2 Division 8 Conciliation; Division 9 Complaint resolution)	s3(2) In exercise functions protection of the health and safety of the public must be the paramount consideration s3(1)(a) receive, assess complaints; (b) investigate and assess if serious and if should prosecute; (c) prosecute serious complaints s3A(5B) principles (a) accountable; (b) processes open, clear, understandable; (d) effective in protecting public from harm; (e) efficient; (f) flexible, responsive as health system evolves	Part 2 Div.1 Right to complain s3A(5B) principles (c) an acceptable balance is to be maintained between protecting the rights and interests of clients and health service providers Australian Charter of Healthcare Rights [on website] Access; Safety; Respect; Communication (informed about services, treatment, options, costs in a clear and open way); Participation (included in decisions, choices about care); Privacy; Comment (right to comment on care and have concerns addressed)
NSW Health Professional Councils Authority http://www.hpca.nsw.gov.au/ <i>Health Practitioner Regulation National Law (NSW) Part 1 s3</i> Objects and principles; s3A NSW objective, principle	<i>s145B course of action available to Council (h) refer to HCCC for conciliation or resolution</i>	s3(2)(a) provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practice in a competent and ethical manner are registered s3(3)(a) transparent, accountable, efficient, effective, fair s3A In exercise functions under a NSW provision, protection of the health and safety of the public must be the paramount consideration	
Queensland Office of the Health Ombudsman http://www.oho.qld.gov.au/ <i>Health Ombudsman Act 2013</i> Div. 1 s3 Main objects s4 Paramount guiding principle s25 Functions Health Ombudsman	s14(1) may facilitate local resolution s15 timeliness; s27 must act independently, impartially, in public interest	s3(1)(a) to protect the health and safety of the public ; (b) promote (i) professional, safe, competent practice; (ii) high standards service delivery by organisations (c) maintain public confidence in management of complaints; s3(2) transparent, accountable, fair system for effectively, expeditiously dealing with complaints; ss4(1) health and safety of the public are paramount s25(a) receive complaints, take relevant action; (c) identify, report on systemic issues; (d), (f), (g) monitor, report on performance ES: s25(e) provide information on minimising, resolving complaints	Australian Charter of Healthcare Rights [on website] Access; Safety; Respect; Communication (informed about services, treatment, options, costs in a clear and open way); Participation (included in decisions, choices about care); Privacy; Comment (right to comment on care and have concerns addressed)
Victoria Health Complaints Commissioner https://hcc.vic.gov.au/ <i>Health Complaints Act 2016</i> Div. 3 s123 Commissioner guiding principles	s123(c) encourage complainant, provider to participate in complaint process	s123(b) act in the public interest ; (e) protect public from any serious risk that provider poses to health, safety, welfare of public s123(a) fair, impartial, independent; (f) transparent, accountable, consistent; (g) efficient, effective, flexible; avoid unnecessary formality; (h) least intrusive, onerous; (i) consultative (d) seek to resolve complaints promptly and improve the quality of health services	Part 4 Health Service Principles (a) service able to be accessed; (b) service safe, of high quality; (c) provided with appropriate care and attention; (d) service user, carer treated with respect, dignity, consideration; (e) adequate, clear information about treatment, options, costs in a transparent manner; (f) inclusive approach in making decisions; (g) privacy and confidentiality; (h) provider makes provision for making comments or complaints and these are addressed
Western Australia Health and Disability Services Complaints Office https://www.hadscow.a.gov.au/home/ <i>Health and Disability Services Complaints Act 1995</i> ; Pt 2 s10(1) Director Functions	s10(1)(a) to deal with complaints in accordance with Part 3 (Division 3A – Negotiated settlement; Division 3- Conciliation)	(b) in collaboration with groups of providers/service users, review and identify causes of complaints , suggest ways of removing and minimizing causes and bring them to the notice of the public (e) with the approval of the Minister, to inquire into broader issues of health care arising out of complaints received ES: (d) assist providers in developing and improving complaints procedures, and training of staff in handling	Part 1 s4 Guiding principles for health services (a) quality care (b) respect privacy, dignity (c) adequate information on services, treatment available, effects/costs, in terms that are understandable; (d) participation in decision-making affecting individual care; (e) informed choice accepting/ refusal of treatment, participation in education/research; (f) reasonable access to information in records; (g) protect personal information

South Australia Health and Community Services Complaints Commissioner http://www.hcsc.sa.gov.au/ <i>Health and Community Services Complaints Act 2004 s3 Objects</i>	s3(b) provide effective alternative dispute resolution mechanisms for users, providers health, community services to resolve complaints	(a) to improve quality and safety of health and community services through provision fair, independent means for assessment, conciliation, investigation, resolution of complaints; (d) monitor trends in complaints; (e) identify, investigate, report systemic issues ES: (c) promote development/application principles and practices of the highest standard in the handling of complaints	HSCC Charter of Rights 2010 1. Access 2. Safety; 3. Quality; 4. Respect; 5. Information; 6. Participation (actively participate); 7. Privacy; 8. Comment - right to comment and/or complain [listened to; comment, make complaint; dealt with properly, promptly, no retribution; choose advocate; managed openly to ensure improvements]
Tasmania Health Complaints Commissioner [also the Ombudsman] http://www.healthcomplaints.tas.gov.au/ <i>Health Complaints Act 1995 s6 Commissioner Functions</i>	s6(d) receive, assess and resolve complaints (e) encourage and assist service users to resolve complaints directly with providers	(b) identify, review issues arising from complaints , suggest ways improving services (g) inquire into and report on any matter relating to health services at own discretion or on direction of the Health Minister (i) provide information, advice and reports to registration boards ES: (f) assist health service providers to develop procedures to resolve complaints	(b) identify, review issues arising from complaints, suggest ways preserving and increasing health rights
Australian Capital Territory Human Rights Commission http://hrc.act.gov.au/health/ <i>Human Rights Commission Act 2005</i> Part 2 s6 Main Objects	s6(f)(i) provide an independent, fair and accessible process for the resolution of complaints (discrimination; disability, health, Older persons' services)	(a)(ii) identify, examine issues affecting human rights, welfare of vulnerable groups; (iii) make recommendations to government and non-government agencies on legislation, policies, practices and services that affect vulnerable groups; (c) promote improvements in the provision of services (f) (ii) provide a process to encourage and assist service users/providers to make improvements in service provision particularly by encouraging/assisting users/providers to contribute to the review and improvement of service quality ES: (a)(i) promoting the provision of community education, information, advice re human rights	(d) to promote the rights of users of disability and health services and services for older people; (e) to promote an awareness of the rights and responsibilities of users and providers of services
Northern Territory Health and Community Complaints Commission http://www.hcsc.nt.gov.au/ <i>Health and Community Services Complaints Act 2016 (originally 2001)</i> Part 1 s3 Objects	s3(a)(i) provide independent, just, fair, accessible mechanism for resolving complaints between users and providers (health, community services) (ii) encourage, assist users and providers to resolve complaints directly with each other	(a)(iii) leads to improvements in services and enables users and providers to contribute to the review and improvement of health, community services	(a)(iv) promotes the rights of service users (a)(v) encourages an awareness of the rights and responsibilities of users and providers Code of Health and Community Rights and Responsibilities 1. Service standards; 2. Communication and information; 3. Decision Making; 4. Decision Making; 5. Relationship between User and Provider- respect and consideration; 6. Involvement of Family, Friends, Carers and Advocates [right to]; 7. Research, experiments and teaching exercises; 8. Complaints and feedback [provider responsibility to provide complaint mechanism, inform users, ensure complaints dealt with in an open, fair, effective and prompt way without reprisal/penalty; user responsibility to be fair, truthful and accurate]

Appendix 2: Chapter 2 (literature) additional tables

Table A2.1: Initial search terms

Source	Profession	Complaint	Legal
Complaint\$	Health professional	Complaint process	Medico-legal
Grievance\$	Health provider\$	Complaint handling	Litigation
Patient complaint\$	Health care	Complaint management system\$	Medico-legal dispute\$
Organisation\$ complaint\$	Provider\$	Professional review	Discipl\$ hearing\$
Peer, colleague complaint\$	Dent\$	Peer review	
Professional complaint\$	Dent\$ practitioner\$	Health complaint commission\$	
Health care complaint\$	Doctor	Health complaint organisation\$	
Notification\$	Medical practitioner\$	Complaint assessment	
Health consumer\$	Nurs\$	Complaint review	
Patient right\$	Midwi\$		
Patient advoc\$	Pharmacist\$		
Patient empower\$	Psychologist\$		

Concepts	Regulation	Relationships
Error\$	Regulat\$	Professional-patient relation\$
Accountability	Regulatory theor\$	Doctor-patient relation\$
Practitioner competence	Regulatory practice	Dent\$-patient relation\$
Practitioner impair\$	Regulatory strategy	Nurs\$-patient relation\$
Patient satisfaction	Risk, risk management	Pharmac\$-patient relation\$
Patient expectation\$		Psychol\$-patient relation\$
Patient experience		
Patient dissatisfaction		
Professional competence		
Standard\$ of care		
Quality of health care		

Figure A2.1: Initial literature schematic: broad domains of regulation and complaints literature and research methods used in relevant studies

Infrastructure • Law, regulation • Standards • Policy, programs, systems • Data, reporting • Guides, good practice	Design, operation • Theory, rationale, principles • Role, powers • Strategies, priorities • Performance • Funding, control, independence, interests • Publicly available info.	Complainant • Issues, context • Profile of who does, doesn't complain; whistle-blowers • Reasons, expect, experience • Impacts: health, financial, professional, service access • Views: process, outcome • Rights, standing,	Subject practitioner • Profession • Profile • Attitudes, responses & influencing factors • Impacts: personal, professional, practice • View: process, outcome • Rights, standing	
Responses (available, sought, impact) • Practitioner: info, apology, acknowledge, rectify • Cplt/ regulator: NFA, refer, assess, investing., mediate, conciliate, support, educate, monitor, counsel, warn, fine, conditions, suspend, cancel • Intended, unintended conseq. perverse impacts	Measures • Efficiency, effectiveness • Cplt. rates, trends • Error, AE • Accountability: individual, team, system • Meaning of professionalism, role of ethics • Reporting (voluntary, required)	Advisories • Requirement • How to • Theories • Challenges	Value • Issue ID, Red flag • Prevention • Predictive, deter • Learning, education • Improved care, outcomes • Resolution • Confidence, trust: profession, regulator • Cost-benefit: social, financial, profession	Roles, r'ships: entities, systems • Cplt.: generic, health, other • Reg.: health, other • Oversight agencies • Quality TQM, QI, QA • Ed., prof. develop • Standard setting • Medico legal
Research scale • Individual, unit, team, institution • Profession (sole, mixed) • Speciality • Health condition • Sector: public, private • System • Inter-jurisdictional	Research methods, sources • Quantitative, qualitative, mixed • Literature reviews • Statistical: data base, records, analysis • Observational: notes, video • Surveys, interviews, case studies, focus groups • Inquiries, reviews, reports • Websites, press, social media		Conceptual lens • Psychological • Personality • Environmental • Systems • Culture, values • Socio-political/economic • Service theory	

Table A2.2: Major studies: reasons for complaints and/or legal action; expectations and experience of process and outcome

	Research methods	Outcome sought, cplt reasons [%]		Issues [original event] Impacts [I]; emotions [E]; outcomes [O] Satisfaction [S]; dissatisfaction [DS]	Information, explanation, attitude Other finding	Steps to prevent recurring [P] Recs, conclusions [R]
Bark et al. 1994 UK	Postal survey hospital cplts. Period: 6M Distributed: 1007 Returned: 491	Not recur Explanation Apology Awareness [1] Discipline Treatment Compensation	90 74 50 80 37 35 9	Mix clinical events + insensitive response + poor communication I: deteriorated 42%; additional treatment reqd. 49%; time off work reqd. 25% E: Anger 84%; distress 75%, worry 68% S: 1% very good, satisfactory	Original event: 41% received an expln. Of these: 43% fully understood; 34% no opportunity to ask questions. Adequacy of expln: Didn't deal with issue 59%; Excuses, fobbed off 34%; Vague, inaccurate 20%; Letter impersonal 6% Believed seldom taken seriously: Patronising 10%; Reply received 14%; Ack. quickly 12%; Apology 10%. Of importance: tone of response	P: Lack effective action – 8% reported action taken. R: Improve response to cplts by practitioners, services Use cplts to improve 26%; Pt advisory svce 23%; Staff training to prevent recurrence 33%; Improve communication and information 28%; Respect patient 20%
Lloyd-Bostock & Mulcahy 1994 UK	Analysis hospital cplts. Period: 1Y using 'account model' N= 399 l'view N=74	Not recur Explanation Not indicated	20 21 29	34% wholly or partly clinical. 51% made on others' behalf No evidence progressed beyond hospital Wanted: no indication 29%. Of others: general comment 21%; remedy for complainant 16% or others 20%; information, investigation 21%. DS: 58%	Unsatisfactory explanation 41% Assessment of response by researchers: no acceptance of responsibility 36%; defensive response 57%	P: Strong correlation between satisfaction and belief that intended to "improve things for future"
Nettleton & Harding 1994 UK	Analysis of informal cplt. letters to one Family Health Svce. Authority [N=107] Period 1Y	<i>Understand what people are complaining about and how managed</i>		Inadequate treatment 28%; practitioner uncooperative 28%; Personal attributes (manner) 25%; organisation 10%; financial 7%; error 4% Response letters: standard format: apology; explanation of power to investigate only where breach of contract (and issue raised does not meet this threshold); thanks for raising issues; advice (in some cases) to take further action. Five formal investigations in the period Staff screening letters: lowly paid; screening only part of duties	Historical context: Winkler (1987) <i>supermarket model where no control over what's on the shelf</i> ; Plamping and Delamothe (1991) <i>conflation of consumer and citizen rights</i> ; Panting (1990) <i>introduction of informal process- only by consent and cannot take action on breaches even if identified- therefore still favours professionals</i> ; Longley (1993) <i>may individualise and channel grievances rather than confronting real or underlying issues</i>	R: Impeding reform cplt process: (1) professional self-regulation; (2) new managerialism, which emphasises consumerism but paradoxically reinforces the role and control of managers.
Vincent et al. 1994 UK	Survey of medico-legal actions Distributed: 466 Returned: 227	Not recur Explanation Awareness [2] Discipline Compensation	91 91 90 48 66	Why people take legal action 49% had independent expert reports suggesting negligence; 67% expected to proceed; >70% severely affected; 43% legal action due to attitude of staff post-event E: Anger 90%; bitter 85%; betrayed 55%; humiliated 40%	Adequacy of expln: Where provided N=128), < 40% felt it was given sympathetically; 24% satisfied w/ clarity of expln.; 20% w/ its accuracy Litigation could have been avoided: 41%: by expln, apology 37%; correct error 25%; comp. 17%; correct Tx 15%; admit negligence 14%	R: Incidents serious w/ profound impacts but litigation not just about \$. People want honesty; full explanation; acknowledgement of harm; assurance of lessons learned
Daniel et al 1999 NSW AUS	Postal survey Closed HCCC cases re DRs Period 18M Distrib: 500 Returned: 290	Apology Discipline Compensation	16 56 3	Clinical 64%, communication 22%, conduct 14% (44% for other) At start 63% satisfied did right thing to complain E: Anger 84%; shock 57%; betrayal 35%; fright 33%; insult 32%; confused 30%; humiliated 28% O: dismissed 37%; unknown 21%; retired/ dismissed 2%; counselled 18%; disciplined 20% S: 23%; DS: 61% Few successfully conciliated [N=5; <2%]	Satisfaction associated with outcome: where discipline/counsel ("stern action") 42% satisfied; where cplt. dismissed 6% satisfied- expectation gap (public protection v. punish, restitution) Clinical matters associated with intent to sue Most complainants of high socio-economic status	R: Better understand issues leading to complaints; understand and manage expectations of what can be achieved

Anderson et al. 2000 SA AUS	Retrospective data analysis hospital cplts. Period: 1Y N=505	<i>Whether older people complain less</i>	People aged 65+ accounted for 23% services and 25% cplts. But 73% made by others on behalf of pt Majority treatment or communication (or mix of both) O: 60% verbal response; 20% letter expln. and apology; 13% written response; 3% verbal apology	Satisfaction with outcomes not known No cases of cplt. leading to litigation identified	R: anticipate; respond positively to expected increase in cplts assoc. with more knowledgeable consumers, technology, QI opportunity
Anderson et al. 2001 SA AUS	Audit formal cplts Period: 30M N=1308	<i>Understand who is complaining and why</i>	Communication 45%; treatment 26%; access 19% Mean age 49; Women 54%; Cplt x advocate 62%, staff 10% O: verbal (57%) or written (18%) response; verbal apology 12%; letter explanation and apology 10%	No cases of cplt. leading to litigation identified- suggest indicates some degree satisfaction	R: lack of published comparable data collections to compare findings with other institutions
Jones et al. 2006 VIC AUS	Postal survey households 8 communities: 100% sample small and sample (10, 20, 50%) in larger Posted: 5965 Returned: 983	<i>Comparative focus those making [N=104] and those not; rural, socio economic disadvantage are under- represented</i>	Most common issue: lack access to services (55% of complainants; 72% non-complainants); treatment (39% and 32% respectively); communication (29% and 24%) and costs (27% and 28%); most often about DRs (60%) & hosps (32%) Complainants: 58% no change as a result of cplt. Non-complainant reasons: Futile 49%; Fear conseq. 27%; Not know how 15%; System issue 14%: Time, too hard 7% O: no effect (58%); resolved (34%) Under-representation of rural residents in cplts; lack of knowledge about and scepticism of efficacy of process	If had future cplt: Discuss with health service (62%); discuss with family or friends 64%); make cplt to provider 55% (29% of complainants; 26% that thought cplts futile) Few would complain to Commissioner (7%); researchers link to access as primary issue- resource dependant Poor understanding HSC role; how to make cplt	P: 58% that complained reported no effect (no change, no response, not taken seriously)
Friele & Sluijs 2006 NETH	Survey all hosp. cplts made at time of cplt. 6M [74/94 cttees] Distrib: 563 Returned: 424 Survey based on i'view of 15 closed cplts.	Not recur: to others 94 Awareness [3] 75 Unjust 70 Duty to make cplt. 68 Not recur: to me 67 Incident not kept private 52	2/3 DRs clinical care, conduct communication Procedural expectations [5]: Change 89%; adjudicate validity of cplt 82%; Give reason for decision 79%; Investigate 78%; Explain cplt process 59%; Opp. to tell story 52%; Timely 44%. Expect of cplt cttee: Impartial 87%; Respectful 82%; Understanding 73%; Listen 71%; Sympathetic 47%. Expect of hospital: raise with those involved 80%; Inform complainant corrective action taken 79% and what actions 68%; Punitive measures for mistakes 39%. Expect of professional: Admit error 84%; Explain why/how occur 65%; Apology 41%; Symp 38%; Try mend r'ship 15%		
Bismark et al 2006 NZ	Comparison hospital AEs when made compensation claim [N=582] or complaint [N=254]	<i>Of complainants</i> Not recur, correct 50 Communication 40 <i>Explanation</i> 34 <i>Apology, ackn.</i> 10 Compensation 18 Discipl. sanction 14	Identified categories outcomes sought: communication (expln, apology, acknowledge); correction (competence review; system change); restoration (compensation; intervention); sanction (discipline, punish). Of 50% want avoid recurrence: 45% system change; 6% assessment of practitioner. Compensation: associated with working age; permanent disability (41% in claims group; 21% in complaints); death > assoc. with cplts (33%); claims (5%)	Those pursuing legal action: four categories of accountability. Complainants > emphasis on communication outcomes and corrective action to prevent recurrence; less on restoration or sanction. Economic issues (income; costs) underpin claims.	Systems with medico-legal claims as sole/main mechanism won't address non-monetary interests e.g. avoid recurrence; subset may resort to litigation absent other options; complaint mechanisms won't address financial issues
Gal & Doron 2007 ISR	Phone survey 1500 people age 21+	<i>Prevalence of complaints to health services and demographics</i>	25% cause to complain but only 9% did so [i.e. 37%, N=143] Of those that did, 75% local and informal; 17% to official bodies established for purpose Arab residential areas: half as likely; Jewish areas: up to x4 times more likely to complain; immigrants less likely	Rates similar for age, gender, education	

Friele 2008 NTH	Follow up survey [to 2006 study cohort that consented] 5M later at completion of cplt. process Distributed: 376 Returned: 279	Per 2006 study report above	S: 31% felt they had received justice: 60% if advised cplt. well-founded; 36% if partially; 21% if determined unfounded. 63% satisfied with complaints committee handling; only 29% (hospital), 18% (health professional) response DS: doctors not admitting errors; lack information from hospitals on corrective measures taken. Gaps: 53% didn't receive advice of change (of 94% ranked important). 42% not given explanation (83% had ranked important). 36% cttee not impartial (92% ranked important). Error disclosed to 21% (89% ranked important) Most sig. satisfaction factors cttee: Impartiality. Other imp: recommend change; procedural information cplt process; timely; sympathy. Hospital: advise complainant discussed w/those involved; corrective measures. Professional: apology; sympathy; explanation; restorative effort	Justice perception: 4 main factors: outcome (cplt well founded); and satisfaction with conduct of the cttee, the hospital, and the professional. Impact of cplt (e.g. physical, mental harm) relevant Disclosure gap: may be explained by perception error occurred; fear of liability – “ <i>Although...allowed to give an explanation of what happened, they must refrain from any accountability</i> ”	P: satisfaction (after impartiality of cttee) associated with recommendations for change R: Include dealing with complaints in medical training; consider 'no fault' compensation scheme to facilitate open disclosure; learning and safety. Process: engage at outset with complainants and act impartially (cttee); offer apology (health professional); provide explanation of lessons learned
Kent 2008 SWE	In depth interviews [6 at time of publication]	<i>Patient experience of complaint process</i>	Seeking moral redress and restoration of trust Complaint was 'last ditch' effort Patient interviews indicate complaints provoke collegiality and 'rallying' to practitioner rather than objective assessment of merits of complaint. May also result in loss (future refusal) of care. Disciplinary process ineffective; system focuses on practitioner and authorities' responsibilities rather than patient rights. Focus on safety and risk – range of other behaviours of importance (e.g. consent; communication; attitude) not addressed	Swedish National Medical Responsibility Board: disciplinary powers dismisses all but 3% and as a result “ <i>the Board often appears to patients to be sanctioning care that they deem substandard</i> ” p488. Lack power to limit practice; findings inconsistent “ <i>perhaps partly because the Board lacks clear directives about what particular transgressions should prompt disciplinary action</i> ”	
Wu et al. 2009 TAI	Review of cplt. that may have led to legal action [N=147]	<i>Factors leading to medico-legal action</i>	Risks associated with admission via A&E, surgical speciality and living in an urban area. Urban living only independent factor for both making cplt. and taking legal action but not on outcome. Injury and degree of harm infl. likelihood comp claim, quantum	Did not have socioeconomic [SE] data-urban area possibly associated with higher SE status; better access to courts; awareness of process	Predictive use in understanding characteristics
Valimaki et al. 2009 FIN		<i>Factors affecting psychiatric care patients use of complaint process</i>	Right to complain embedded in law and quality framework and have patient ombudsman. However, complaint process is complex and particularly difficult if have cognitive impairment; compounded by lack of information, imbalance of power; delays in appeal decisions	Cuts in resources to psychiatric care services may further undermine ability to exercise rights	
Chiu 2010 TAI	Interviews [N=13] with people taking legal action or negotiating a settlement following AE	<i>Cultural factors for taking legal action when lawsuits normally avoided</i>	Important: revenge, guilt and filial piety – obligation to act; seek justice. Per previous studies- explanation, apology and compensation may influence but major factor: need for <i>jiau dai</i> (satisfactory resolution offered by hospital or practitioner) Not always clear about form <i>jiau dai</i> should take. Decision to take legal action strongly influenced by attitude, sincerity of practitioners, hospitals	Context: dispute options: litigation; negot'n with hospital time consuming & costly. Cultural norm: reciprocity; filial piety: favours, harms must be responded to Influence of consumer movement, patient rights affecting traditional 'reverence' for DRs	R: families need support [legal, emotional] to approach hospital, practitioner and formulating what want
Gal et al 2010 ISR	2 surveys PWD [N=243] PWNoD [N=956]	<i>Rate of complaint of people with and without disabilities who wanted or had cause to complain</i>	PWD much higher rate of service use- would expect to see higher rate of complaint Only one third complain (with/without disability) Complaint rate PWD only slightly higher than PWNoD Majority of complaints submitted locally, informally	Majority disability (73%) physical; 9% mental impairment	Need for policy and advocacy to support people to raise issues

Bismark et al. 2011 VIC AUS	Remedies sought, obtained [N=218]	Restoration Communication Correction Sanction	87 57 46 17	Subset of conciliated informed consent cplts Expectation gap fairness, quality of interactions % obtained: Communication: 94%; Gap: Restoration 31%; Correction (avoid recurrence) 17%; Sanction 8% 2.7% made cplt [N=23]; 18.5% [N=159] said had reason but didn't Why didn't: lacked strength; not know how; makes no difference	Litigation limits in addressing needs, wants. Commissions have remedies but may not have authority to deliver outcomes sought or deem them appropriate (not advocate)	R: Better understand what people want; manage unrealistic expectations; facilitate feasible outcomes
Doron et al 2011 ISR	2 phone surveys 2Y older [N=372] young [N=796]	<i>Complaint rates older and younger people who have cause to complain</i>		Older [65+]: 23% rate of complaint; Older not complain 76%; younger 66% If 75+ and below average income: 2.5 times less likely to complain than people <65 years Reasons not complain: lack motivation, time; low expectations of getting a response; don't know how; not used to complaining; health conditions	No statistically significant differences between younger and older people reasons for complaint	Need for specific mechanisms to facilitate and capture older people concerns
Wessel et al 2012 SWE	Sample 1500 gen pop if made cplt	<i>Test if AE are under-reported; understand barriers to cplts</i>		2.7% made cplt [N=23]; 18.5% [N=159] said had reason but didn't Why didn't: lacked strength; not know how; makes no difference	People with pos. experiences care 98% high trust; with neg. experience 66%	
Health Services Commission 2013 VIC AUS	Phone survey N=436 of cplt managed by enquiry, assessment, conciliation	Change Apology Compensation	44 21 19	Understand satisfac. gap outcome of cplt handled by Comm. Prior year: complainants 58% [of N=233]; providers 90% [of N=257] 53% clinical; 26% communication; 11% costs; 40% doctors. Reasons for escalation: provider not take responsibility; mistake not admitted; complaint ignored or not taken seriously D: 65%; S: 22%; ambivalent: 11%. D 42% outcome + process e.g. comm., attitude; lack power to effect system/practice change. 70% unfair; 71%: unresolved but 66% would recommend process	86% had accurate expectation of Commission Expect 'active engagement' – diff. understand of what means: impartial resolution, assistance, get provider to resolve, protect public Significant: 'gap' in perceived outcome recorded in commission files & complainant view – possible poor understanding why closed	R: unreasonable/unrealistic expectation hypothesis in lit not shown; but gap in what wanted & achieved. Did not ask specific q. re lodgement or closure part of process- highlighted in responses
Howard et al. 2013 QLD AUS	In depth l'views [N=16] with patients, advocates that made cplt over 10Y period	Prevent recurrence Contribute to improv'ts Be heard Receive apology Acknowledge errors		15 of 16 did not voice complaint at time of event Themes: ineffective communication; unacceptable standard of care; treated with disrespect; ineffective complaint handling systems; perceptions of negligence E: anxiety dominated	Wanted: to be listened to, be acknowledged, believed; practitioners take responsibility for error; prevent recurrence; receive an apology.	R: healthcare professionals be more proactive to patients dissatisfied but not actively complaining
Community research 2014 UK	In depth l'views [N=44] with complainants FTP process	Justice for harm Gain answers Protect other patients		Lack of understanding of the role/remit of the GMC means many initial expectations unlikely to be met through process Expected to be given the opportunity to explain or elaborate on their issues as part of the process Expected impartiality, fairness	Need to improve information and communication; less jargon; explain process Need to better support complainants through process Improve timeliness	
Jiang et al. 2014 CHIN	In depth l'views policy & patients [N=35]	<i>Examine complaint handling system and barriers to use</i>		Barriers: low awareness of system; poor capacity and skills of providers; complaint managers lack competence and powers; lack transparency; conflict of interests; weak enforcement	System established in last decade (immature); hospitals mainly responsible for handling; fragmented	

Research Works 2015 UK	Deliberative workshops with pts [N=24]	<i>Understand pt views of harm; expectations of oversight; role of service users</i>	Physical and mental harm from 'criminal' or unethical behavior identified- general poor practice less a focal point Reluctant to blame individual practitioners rather than services. Vulnerable: mental health; older/younger; with disability Expects regulator approach: process to ensure FTP and adhere to standards; only younger (31-55) age group had good understanding of how regulation works but still gaps in knowledge; assumptions that professionals are supervised	Long term subtle harms may only emerge through cplt or claim- therefore imp to invite feedback- must be prompt, transparent, demonstrate action Potential to use 'experts by experience' patients in regulatory process: well received	Discussion of regulatory complexities stimulated interest in more information
Skalen et al. 2016 SWE	Review of complaints to a Patient Advisory Cttee [N=618]	<i>Examine association between provider statements and reported satisfaction</i>	Treatment 59%; organisation 37%; attitude, comms 35% 72% dissatisfied; 28% satisfied with practitioner statements. Reasons: provider didn't tell truth 26%; gave insufficient information 26%. Defensive responses statistically significant for dissatisfaction. Conversely, if contained two or more of the following, statistically significant for satisfaction: acknowledged mistake; refers to internal probs; describes changes intended; expresses regrets	Context: Patient Advisory Cttee.: support pts.; improve care quality; no powers over providers. Medical Responsibility Board licenses health professionals; Health and Social Care Inspectorate (IVO) oversees services	
Friele et al. 2015 NTH	Comparative survey [7] of physician views Distrib: 3366 Ret: 1935 [online survey] and public views Distrib: 1422 Returned: 987 [online, post]	<i>What are expectations and are there differences between public [PB] and physician [PH] views</i>	Clinicians should ask about welfare, if any cplts [PB 90%; PH 63%]; Access: clear where can complain [PB 41%; PH 71%]; Process fair [PB 39%; PH 87%]; Cplt taken seriously [PB 37%; PH 89%]; Process impartial [PB 24%; PH 77%]; Clinicians 'protect' each other [PB 60%; PH 13%]; Open about AEs [PB 5%; PH 25%]. 14% PB said had made cplt; 78% PH said had received one+ cplt. Experience of making cplt: people w/ higher education Expectation gap of how cplts are handled: public have negative expectations; physicians more positive. Notable ~50% gap in relation to perceived fairness, impartiality, taken seriously Limit: lack of people <30yo from public survey	'Expectancy Disconfirmation Theory' may be relevant: people experience/look for evidence of what expect: may add to misunderstandings even with good intentions. But expectation of transparency when things go wrong low, both public and DRs even though guidelines for open disclosure. Key difference between open disclosure and complaint is who initiates. Pts frequently raise issues not contained in records – therefore clinicians need to proactively question safety; concerns	R: Implement, demonstrate and promote a process that can be seen and is experienced as accessible, impartial and fair
Bouwman et al. 2016 NTH	Survey of cplts to regulator 2012 over 4M Distrib: 343 Returned: 169 Survey based on previous surveys and 11 i'views closed cplts.	<i>What do complainants expect from a regulator and are there differences between those whose complaint is/ is not accepted</i>	Most Important: Broad benefit <i>improve, learn, not recur</i> ; 2. Personal benefit <i>justice, resolve, not recur</i> 3. Provider consequence <i>stern action ranging from 'hard conversation to punishment and ban from practising, compensation</i> Of 343 cplts, N=92 (27%) accepted; N=251 (73%) not Of accepted: ~50% broad benefit achieved; <40% personal benefit, consequence for provider achieved except 'doing duty' (88%). Not accepted: < 20% all factors except 'doing duty' (66%) Self-reported severity of physical injury of complaints not acted on were lower than complaints that were Expectations of two groups (accepted / did not) broadly the same. Regulator, complainant share goal improve care quality; but perceptions of relevance, seriousness safety differ	Context: Inspectorate role: act on 'structural and severe' problems: severe deviation from professional standards; absence, severe failure of quality system; severe harm; high probability of recurrence. Provider to investigate in first instance. Regulator uses complaints for risk analyses. Expectation gap: what is sought & what is achieved (improvement) Reasons: strong sense of duty; desire to contribute to improvement; stakeholder in process	R: regulators go beyond sole focus on clinical standards to social issues that underpin healthcare complaints. Shift from standardised to more responsive and strategic approaches. Patients provide 'soft intelligence' and window to safety issues - public participation will enhance accountability and detection of problems, including systems failures

[1] Awareness = staff aware of what occurred and the effect on the patient; [2] Awareness = doctor to realise what they had done; [3] Awareness= awareness at a "higher level"

Appendix 3: Chapter 3 (methods) additional tables

Table A3.1: Full interview script and questions: semi structured telephone interview with complainants that have lodged an expression of interest and have given their consent

INTRODUCTORY REMARKS

Hello, this is [name] from The University of Sydney.

I am phoning in relation to the study *Community expectations and experiences of health complaints*.

I just want to confirm that this is a suitable time to speak?

Thank you once again for taking the time to be interviewed.

There are a few things I need to remind you about at the beginning.

- Firstly, this is an anonymous interview - you will not be identified.
- Secondly, this interview is being recorded. This is to help me accurately capture everything that you tell me. It will not have your name on it, and it will be destroyed in accordance with University guidelines.

Prompt: is this still acceptable to you?

- Third, this interview is voluntary. You can stop the interview at any time. If you don't want to continue, I will destroy any information that you have given me and that information will not be included in the study.
- Finally, if you are unhappy with this interview, you can lodge a complaint with the university. Your Participant Information Sheet has details about who to contact. Similarly, if talking about your complaint causes any distress and you want to speak to someone, that information sheet also has details for you.

OPEN QUESTIONS (as appropriate)

1. Is there anything about the survey that you would like to comment on?
2. What things about the complaints process would you like to talk about?
3. Thinking back on the process, what are the most important things that made you satisfied or dissatisfied as you went through the process?

Prompt: what stood out for you the most?

Prompt: if someone was about to make a complaint, what is the most important thing that they should know or be told about the process?

SCHEDULED: understanding/role of complaint processes

4. What do you think the role or purpose of the complaint system is?

Prompt: Do you think complaints processes are for improving the health system or helping individuals, for example, to obtain redress or compensation?

Prompt: Why do you think that?

5. Do you think there might be differences or even a conflict sometimes between the public interest and what an individual making a complaint may want?

Prompt: for example, a complaint may raise a safety issue that has since been dealt with. Therefore, the complaint body might not see the need to pursue the matter, even though it remains important to the person who complained.

Prompt: If there is, how do you think it should be resolved?

6. Do you see complaints as an alternative to making medical negligence or other legal claims?

Prompt: Why do you think that?

7. Do you think complaints like the one you made can lead to changes in education or changes to how health professionals practice – such as [insert profession type as relevant to the person interviewed]?

Prompt: Why do you think that?

Prompt: Should they (lead to changes)?

Prompt: What about education (if not mentioned) / practice (if not mentioned)

Prompt: Do you think people learned from this?

SCHEDULED: ideas of error and accountability

8. Do you think mistakes by health professionals are rare or common?

Prompt: Why do you think that?

Prompt: When you hear the word 'mistakes', what comes to your mind?

Prompt: What kind of things would come into the category of 'mistake' for you?

9. Do you think the public expects health professionals to make mistakes?

Prompt: Do you think the public expects [insert relevant type of health professionals] to make perfect decisions all of the time;

Prompt: Do you think the public believes that mistakes are inevitable, and will happen even when you take steps to prevent them?

Prompt: Why do you think that?

Prompt: What if the question was asked about: a pilot? a teacher?

Prompt: Do you think public expectations are reasonable or unreasonable in this regard?

OTHER

That is the end of the set questions. Do you have any other comments you would like to make?

CLOSE

Thank you once again for taking the time to speak with me.

Table A3.2: Survey 1: comparative responses by major jurisdictions

	NSW		VIC		QLD		SA		WA	
	N	%	N	%	N	%	N	%	N	%
Delays reported	136	23	64	28	72	34	24	21	42	34
Outcome major categories										
Don't know	80	13	29	12	42	20	8	7	9	7
No action	417	68	163	68	125	58	80	66	84	64
Apology explanation information	169	27	43	18	31	14	23	19	17	13
Conditions excl. suspend cancel	65	11	37	15	49	23	28	23	34	26
Satisfaction Process										
Very dissatisfied	283	46	127	53	103	48	69	58	75	58
Dissatisfied	130	21	53	22	37	17	21	18	23	18
Satisfaction Outcome										
Very dissatisfied	341	57	138	58	113	54	74	62	85	65
Dissatisfied	121	20	52	22	35	17	20	17	21	16
Whether would recommend process										
Definitely wouldn't	214	35	96	41	79	37	39	33	49	38
Probably wouldn't	87	14	35	15	24	11	28	24	19	15
Definitely would	118	20	52	22	53	25	20	17	22	17

Appendix 4: Chapter 4 (respondents) additional tables

Table A4.1: Survey 1: responses by agency, subject practitioner and category of respondent

	Consumer		Practitioner		All individuals		Organisation		Total		Prop
	N	%	N	%	N	%	N	%	N	%	
ALL RESPONSES											
Medical practitioner (DR)	808	71	180	50	988	66	58	24	1046	60	
Nurse/midwife practitioner (NMW)	68	6	107	30	175	12	152	63	327	19	
Pharmacy practitioner (PHARM)	49	4	23	6	72	5	12	5	84	5	
Dental practitioner (DENT)	137	12	18	5	155	10	4	2	159	9	
Psychology practitioner (PSY)	71	6	29	8	100	7	15	6	115	7	
All practitioner x source	1133	66	357	21	1490	86	241	14	1731		
All practitioners excl. DRs x source	325	47	177	26			183	27	685		
DR x source proportion of total	808	77	180	17	988	95	58	6			
NMW x source proportion of total	68	21	107	33	175	54	152	47			
PHARM x source proportion of total	137	86	18	11	72	86	12	14			
DENT x source proportion of total	49	58	23	27	155	98	4	3			
PSY x source proportion of total	71	62	29	25	100	87	15	13			
AHPRA	N	%	N	%	N	%	N	%	N	%	
Medical practitioner	433	69	115	48	548	63	41	24	589	57	56
Nurse/midwife practitioner	40	6	81	34	121	14	108	64	229	22	70
Pharmacy practitioner	35	6	12	5	47	5	6	4	53	5	63
Dental practitioner	72	11	13	5	85	10	2	1	87	8	55
Psychology practitioner	51	8	21	9	72	8	12	7	84	8	73
Total (proportion x source)	631	61	242	23	873		169	16			
Total (proportion x agency)	631	56	242	68	873	59	169	70	1042	60	
NSW	N	%	N	%	N	%	N	%	N	%	
Medical practitioner	375	75	65	57	440	71	17	24	457	66	44
Nurse/midwife practitioner	28	6	26	23	54	9	44	61	98	14	30
Pharmacy practitioner	14	3	11	10	25	4	6	8	31	5	37
Dental practitioner	65	13	5	4	70	12	2	3	72	10	45
Psychology practitioner	20	4	8	7	28	5	3	4	31	5	27
Total (proportion x source)	502	73	115	17	617		72	10	689		
Total (proportion x NSW)	502	44	115	32			72	30	689	40	
HPCA	N	%	N	%	N	%	N	%	N	%	
Medical practitioner	125	68	21	49	146	64	13	22	159	56	15
Nurse/midwife practitioner	9	5	8	19	17	8	36	62	53	19	16
Pharmacy practitioner	10	5	8	19	18	8	6	10	24	8	29
Dental practitioner	29	16	2	5	31	15	2	3	33	12	21
Psychology practitioner	12	7	4	9	16	7	1	2	17	6	15
Total (proportion x source)	185	65	43	15	228		58	20			
Total (proportion x agency)	185	16	43	12	228	15	58	24	286	17	
HCCC	N	%	N	%	N	%	N	%	N	%	
Medical practitioner	250	79	44	61	294	76	4	29	298	74	29
Nurse/midwife practitioner	19	6	18	25	37	10	8	57	45	11	14
Pharmacy practitioner	4	1	3	4	7	2	0	0	7	2	8
Dental practitioner	36	11	3	4	39	10	0	0	39	10	25
Psychology practitioner	8	3	4	6	12	3	2	6	14	4	12
Total (proportion x source)	317	79	72	18	389		14	3			
Total (proportion x agency)	317	28	72	20	389	26	14	6	403	23	

Table A4.2: Survey 1: demographic profile of individual respondents

	Respondent type				Agency managing						Total	
	Consumer		Practitioner		AHPRA		HPCA		HCCC			
	N	%	N	%	N	%	N	%	N	%	N	%
Male	442	31	110	39	312	36	100	44	140	36	552	37
Female	683	69	244	61	552	64	127	56	248	64	927	63
Total	1125		354		864		227		388		1479	
Age - <20	4	<1	0	0	3	<1	0	0	1	<1	4	<1
Age - 20-29	47	4	20	6	44	5	5	2	18	5	67	5
Age - 30-39	137	13	49	14	104	12	30	14	52	14	186	13
Age - 40-49	221	20	87	25	186	22	37	17	85	22	308	21
Age - 50-59	294	27	118	34	258	31	65	29	89	23	412	29
Age - 60-69	278	25	71	20	175	21	68	31	106	28	349	24
Age - 70-79	94	9	5	1	60	7	14	6	25	7	99	7
Age - 80+	21	2	2	1	14	2	4	2	5	1	23	2
Total	1096		352		844		223		381		1448	
Aboriginal or Torres Strait Islander peoples (ATSI)	25	2	3	1	11	1	6	3	11	3	28	2
ATSI - no	1084	98	348	99	840	99	221	97	371	97	1432	98
Total	1109		351		851		227		382		1460	
English - 1st language	996	89	333	94	795	92	195	86	339	88	1329	90
Other - 1st language	123	11	21	6	65	8	32	14	47	12	144	10
Total	1119		354		860		227		386		1473	
Disability - yes	282	26	26	7	175	21	52	23	81	21	308	21
Disability - no	819	74	324	93	674	79	171	77	298	79	1143	79
Total	1101		350		849		223		379		1451	
Live - city	591	53	203	57	480	56	119	52	195	51	794	54
Live - regional centre	203	18	77	22	156	18	51	23	73	19	280	19
Live - town	186	17	31	9	114	13	29	13	74	19	217	15
Live - rural or remote	136	12	45	13	110	13	28	12	43	11	181	12
Total	1116		356		860		227		385		1472	
Education-Nil, Primary	25	2	0	0	18	2	4	2	3	<1	25	2
Education-High school	280	26	0	0	163	19	45	20	72	19	280	19
Education-Trade certificate	165	15	12	3	98	12	33	15	46	12	177	12
Education-Diploma	214	20	28	8	125	15	47	21	70	18	242	17
Education-Bachelor	284	26	161	45	286	34	55	24	104	27	445	31
Education-Masters, Doctorate	130	12	154	43	155	18	42	19	87	23	284	20
Total	1098		355		845		226		382		1453	

Totals may not equal 100% due to rounding

Table A4.3: Survey 1: gender and age of practitioner respondents where the subject was a medical practitioner and where the subject was all other professions excluding medical practitioners

Gender					Select age groups				
Subject: DR			Subject: all excluding DR		Subject: DR			Subject: all excluding DR	
N		%	N	%	N	%	N	%	
Male	69	38	41	23	Age - 30-39	24	14	25	14
Female	109	61	135	77	Age - 40-49	29	16	58	33
					Age - 50-59	65	37	53	31
					Age - 60-69	45	25	26	15

Table A4.4: Survey 1: whether the practitioner respondent was in the same profession as the subject practitioner and if the same, whether junior, senior or a peer

Profession	DR		NMW		PHARM		DENT		PSY		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Same profession*	84	47	93	89	12	52	10	56	15	54	214	61
Different profession	93	53	12	11	11	48	8	44	13	46	137	39
Total	177		105		23		18		28		351	
If same profession, relationship												
Junior	8	11	11	14	1	9	0	0	1	8	21	12
Senior	23	31	43	54	2	18	3	60	2	15	73	41
Peer	41	57	22	28	8	73	2	40	10	77	83	47
Total	72	41	76	43	11	6	5	3	13	7	177	

* Including self-notification

Table A4.5: Survey 1: consumer and practitioner respondents that acted for others by subject profession and agency

	Subject practitioner type										Total		Agency					
	DR		NMW		PHARM		DENT		PSY		N	%	AHPRA		HPCA		HCCC	
	N	%	N	%	N	%	N	%	N	%			N	%	N	%	N	%
All	277	28	58	33	23	32	21	14	28	28	407	27	260	30	47	21	100	26
CONS	212	26	19	28	11	22	13	10	15	21	270	24	161	26	32	17	77	24
PRACT	65	36	39	36	12	52	8	44	13	45	137	38	99	41	15	35	23	32

A further 28 respondents indicated they acted both for self and others; this does not affect the distribution

Table A4.6: Survey 1: gender of subject practitioner

	DR		NMW		PHARM		DENT		PSY		All	
	N	%	N	%	N	%	N	%	N	%	N	%
All survey responses												
Male	846	81	56	17	51	62	111	71	46	41	1110	65
Female	196	19	270	83	31	38	45	29	67	59	609	35
Total	1042		326		82		156		113		1719	
Registrants 2013-14												
Male		60		10		40		52		21		
Female		40		90		60		48		79		
AHPRA managed: survey returns												
Male	468	80	42	18	29	55	59	55	35	42	633	61
Female	120	20	187	82	24	45	28	45	49	58	408	39
Total	588		229		53		87		84		1041	
HPCA managed: survey returns												
Male	134	84	9	17	18	82	24	75	6	35	191	68
Female	25	16	44	83	4	18	8	25	11	65	92	32
Total	159		53		22		32		17		283	
HCCC managed: survey returns												
Male	244	83	5	11	4	57	28	76	5	42	286	72
Female	51	17	39	89	3	43	9	24	7	58	109	28
Total	295		44		7		37		12		395	
Source: Consumers												
Male	651	81	9	13	28	58	98	73	26	38	812	72
Female	153	19	59	87	20	42	36	27	43	62	311	28
Total	804		68		48		134		69		1123	
Source: Practitioner												
Male	151	84	18	17	15	68	11	61	14	48	209	59
Female	29	16	89	83	7	32	7	39	15	51	147	41
Total	180		107		22		18		29		356	
Source: Organisation												
Male	44	76	29	19	8	67	2	50	6	40	89	37
Female	14	24	122	81	4	33	2	50	9	60	151	63
Total	58		151		12		4		15		240	

Totals may not equal 100% due to rounding

Table A4.7: Survey 1: where events that gave rise to the complaint/notification occurred by subject practitioner type, agency and source (respondent) type

	All		DR		All excl. DR		NMW		PHARM		DENT		PSY	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Public hospital <i>in-patient</i>	263	15	131	13	132	19	122	38	3	4	2	1	5	4
Public hospital <i>out-patient</i>	72	4	53	5	19	3	15	5	0	0	1	1	3	3
Private hospital	191	11	152	15	39	6	35	11	0	0	3	2	1	1
Pharmacy	81	5	6	1	75	11	0	0	75	89	0	0	0	0
Day Centre	36	2	31	3	5	1	2	1	0	0	3	2	0	0
Community health centre	36	2	22	2	14	2	13	4	0	0	0	0	1	1
Sole practice	298	17	180	17	118	17	3	1	1	1	74	47	40	35
Group practice	462	27	352	34	110	16	9	3	0	0	69	44	32	28
Residential/aged care	99	6	32	3	67	10	64	20	3	4	0	0	0	0
Patient home	40	2	18	2	22	3	18	6	1	1	0	0	3	3
Unsure	9	1	2	<1	7	1	4	1	0	0	1	1	2	2
Other	125	7	54	5	71	11	40	12	1	1	4	3	26	23
Total	1712		1033		679		325		84		157		113	
Hospital all	526	31	336	33	190	28	172	53	3	4	6	4	9	8
Hospital (%)				64				33		1		1		2
Sole/group practice all	760	44	532	52			12	4	1	90	143	91	72	64
Sole/group practice (%)				70				2		<1		19		10

Table A4.7 continued

	Agency						Source							
	AHPRA		HPCA		HCCC		All individuals		Consumers		Practitioners		Organisations	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Public hospital <i>in-patient</i>	161	16	47	17	55	14	174	12	122	11	52	15	89	37
Public hospital <i>out-patient</i>	47	5	10	4	15	4	66	5	53	5	13	4	6	3
Private hospital	120	12	26	9	45	11	169	12	114	10	55	16	22	9
Pharmacy	52	5	23	8	6	2	72	5	50	5	22	6	9	4
Day Centre	19	2	6	2	11	3	36	2	28	3	8	2	0	0
Community health centre	24	2	5	2	7	2	33	2	24	2	9	3	3	1
Sole practice	169	16	54	19	75	19	279	19	232	21	47	13	19	8
Group practice	270	26	68	24	124	31	435	30	365	33	70	20	27	11
Residential/aged care	78	8	6	2	15	4	73	5	44	4	29	8	26	11
Patient home	21	2	7	3	12	3	33	2	28	3	5	1	72	3
Unsure	7	1	2	1	0	0	7	1	2	<1	5	1	2	1
Other	64	6	29	10	32	8	96	7	56	5	40	11	29	12
Total	1032		283		397		1473		1118		355		239	
Hospital all	328	32	83	29	115	29	409	28	289	26	120	34	117	49
Hospital (%)		62		16		22		78		55		22		23
Sole/group practice all	439	43	122	43	199	50	714	48	597	53	117	33	46	19
Sole/group practice (%)		58		16		26		94		79		15		6

Total percentage may not equal 100 due to rounding

Table A4.8: Survey 1: when events that gave rise to the complaint/notification occurred

	Total		DR		NMW		PHARM		DENT		PSY	
	N	%	N	%	N	%	N	%	N	%	N	%
Less than 6 months ago	360	21	209	20	69	22	24	29	39	25	19	17
6 to < 12 months ago	565	33	326	32	124	39	34	41	46	30	35	31
12 months to < 2 years ago	431	25	259	25	84	26	20	24	41	27	27	24
2 to < 5 years ago	267	16	174	17	38	12	4	5	27	17	24	21
5 to < 10 years ago	40	2	28	3	3	1	0	0	2	1	7	6
10 or more years ago	18	1	17	2	0	0	0	0	0	0	1	1
Events occurred over time	18	1	14	1	3	1	0	0	0	0	1	1
Total	1699		1027		321		82		155		114	
Less than 12 months		54		52		61		70		55		48
Less than 2 years		79		77		87		94		82		72
2 or more years		19		22		13		5		18		28

Table A4.8 continued

	AHPRA		HPCA		HCCC		CONS		PRACT		ORG	
	N	%	N	%	N	%	N	%	N	%	N	%
Less than 6 months ago	170	17	64	23	126	32	225	20	91	26	44	19
6 to < 12 months ago	318	31	101	36	146	37	360	33	112	32	93	39
12 months to < 2 years ago	288	28	79	28	64	16	275	25	86	24	70	29
2 to < 5 years ago	204	20	28	10	35	9	194	18	45	13	28	12
5 to < 10 years ago	26	3	7	3	7	2	27	2	11	3	2	1
10 or more years ago	9	1	3	1	6	2	15	1	3	1	0	0
Events occurred over time	9	1	1	<1	8	2	13	1	4	1	1	<1
Total	1024		283		392		1109		352		238	
Less than 12 months		48		59		69		53		58		58
Less than 2 years		76		87		85		78		82		87
2 or more years		24		14		13		21		17		13

Table A4.9: Survey 1: main category of issue that the complaint/notification was about

	Bill, Fees		Access, care arrangements		Discharge, transfer		Records		Reports		Communication		Consent	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
All	187	11	292	17	105	6	320	19	200	12	692	40	256	15
DR	104	10	212	21	77	7	195	19	136	13	482	46	175	17
NMW	9	3	50	15	21	6	68	21	28	9	78	24	25	8
PHARM	13	16	2	2	1	1	10	12	1	1	23	27	5	6
DENT	46	29	17	11	3	2	23	15	3	2	54	34	32	20
PSY	15	13	11	10	3	3	24	21	32	28	55	48	19	17
AHPRA	95	9	179	17	67	6	202	19	119	11	410	39	153	15
NSW	92	13	113	16	38	6	118	17	81	12	282	41	103	15
HPCA	23	8	34	12	8	3	43	15	28	10	100	35	38	13
HCCC	69	17	79	20	30	7	75	19	53	13	182	45	65	16
CONS	155	14	227	20	82	7	218	19	157	14	520	46	186	16
PRACT	23	6	40	11	18	5	69	19	30	8	125	35	55	15
ORG	9	4	25	10	5	2	33	14	13	5	47	20	15	6

Table A4.9 continued

	Medication, pharmacy		Care, treatment		Conduct		Health		Competence		Privacy, confidentiality		Complaints	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
All	404	23	984	57	806	47	196	11	538	31	171	10	393	23
DR	224	21	693	66	484	46	80	8	330	32	98	9	261	25
NMW	102	31	135	41	174	53	92	28	94	29	36	11	51	16
PHARM	65	77	5	6	24	29	5	6	10	12	7	8	21	25
DENT	9	6	118	74	58	37	3	2	62	39	4	3	35	22
PSY	4	4	33	29	66	57	16	14	42	37	26	23	25	22
AHPRA	259	25	585	56	497	48	135	13	347	33	118	11	245	24
NSW	145	21	399	58	309	45	61	9	191	28	53	8	148	22
HPCA	58	20	141	49	126	44	40	14	77	27	24	8	58	20
HCCC	87	22	258	64	183	45	21	5	114	28	29	7	90	22
CONS	241	21	740	65	496	44	54	5	360	32	115	10	292	26
PRACT	101	28	165	46	194	54	65	18	116	33	41	12	85	24
ORG	62	26	79	33	116	48	77	32	62	26	15	6	16	7

Table A4.10: Survey 1: whether the respondent would use the practitioner again

	Yes		No		Not sure		Prefer not, but may have to		They're the only one available	
	N	%	N	%	N	%	N	%	N	%
ALL	50	3	1362	79	34	2	80	5	10	1
AHPRA	33	3	814	79	19	2	47	5	6	1
HPCA	12	4	223	79	6	2	11	4	0	0
HCCC	5	1	325	81	9	2	22	6	4	1
DR	18	2	876	85	12	1	44	4	5	1
NMW	30	9	188	58	14	4	24	7	4	1
PHARM	2	2	57	69	2	2	6	7	1	1
DENT	0	0	144	91	5	3	4	3	0	0
PSY	0	0	97	84	1	1	2	2	0	0

Table A4.11: Survey 2: respondent organisation type and source

Organisation type	Population		Consumer		Professional		Total	
	N	%	N	%	N	%	N	%
All responses	29	36	11	14	40	50	80	
National (excluding NSW)	21	72	6	55	29	73	56	70
NSW	8	28	5	46	11	28	24	30

Table A4.12: Survey 2: demographic profile of respondent members/services users

	Our main target grp		Frequently use our service		Sometimes use our service		Rarely use our service		Outside our target grp	
	N	%	N	%	N	%	N	%	N	%
Aboriginal and Torres Strait Islander peoples	5	6	6	8	20	25	10	13	5	6
People from culturally & linguistically diverse communities	4	5	19	24	20	25	1	1	4	5
People living in rural & remote areas	7	9	20	25	16	20	2	3	3	4
People with a disability	5	6	15	19	23	29	3	4	2	3
People with a mental illness	10	13	18	23	18	23	2	3	2	3
People in care	3	4	7	9	18	23	8	10	9	12
Older people	7	9	16	20	14	18	1	1	8	10
Younger people	7	9	15	19	16	20	4	5	4	5
Carers	7	9	16	20	10	13	6	8	8	10
Refugees	3	4	2	3	11	14	18	23	11	14

Table A4.13: Survey 2: type of service provided by respondent organisations

Organisation type	Population		Consumer		Professional		Total	
	N	%	N	%	N	%	N	%
Information and advice	26	90	6	55	25	68	57	74
Policy and projects	22	76	10	91	21	57	53	69
Advocacy and legal representation [1]	20	69	5	46	24	65	49	64
Direct services [2]	7	24	1	9	6	16	14	18
Complaints service	4	14	1	9	6	15	11	14
Education; professional development [3]	1	3	1	9	7	19	9	12
Other	1	3	1	9	5	14	7	9

[1] Advocacy (individual, professional or systemic) and/or legal representation

[2] Direct services e.g. health; home-care; housing, transport

[3] Education may be for consumers, professionals, advocates

Table A4.14: Survey 2: whether in the last two years the respondent had contact with or engaged in specific activities about or with the agencies

	AHPRA		National Board		HCCC		HPCA		NSW Council		Other jurisdiction cplt. body ¹	
	N	%	N	%	N	%	N	%	N	%	N	%
Had no contact with them	20	29	26	38	40	57	50	74	47	68	25	36
National [excl. NSW] response	13	65	17	65								
% response from national source	13	23	17	30								
NSW response					6	15	13	26	10	21		
% of response from NSW source					6	25	13	54	10	42		
Population group	18		19		21		24		24		11	
Consumer, consumer health org.	2		4		5		7		7		3	
Health professional or defence org.	0		3		14		19		16		11	
Received information	31	46	23	34	11	16	3	4	6	9	16	23
Population group	5		2		3		0		0		6	
Consumer or consumer health org.	1		0		0		0		0		0	
Health professional or defence org.	25		21		8		3		6		10	
Commented on fact sheets, policies	17	25	17	25	2	3	1	2	2	3	7	10
Population group	0		1		0		0		0		2	
Consumer or consumer health org.	1		0		0		0		0		0	
Health professional or defence org.	16		16		2		1		2		5	
Made submission to reviews abt. them	21	31	20	29	5	7	0	0	3	4	12	17
Peak population group	1		1		1		0		0		5	
Peak consumer or consumer health org.	2		2		1		0		0		2	
Health professional or defence org.	18		17		3		0		3		5	
Member of committee or working gp.	9	13	11	16	5	7	1	2	4	6	4	6
Population group	0		1		1		0		1		1	
Consumer or consumer health org.	2		0		3		0		0		1	
Health professional or defence org.	7		10		1		1		3		2	
Had other type of contact	25	37	20	29	10	14	3	4	4	6	19	27

[1] This includes other jurisdiction bodies e.g. Health Complaint Commissioner or similar

Table A4.15: Survey 2: whether in the last two years the agencies asked about the needs or ability of the respondent members/service users to make a complaint/notification

	AHPRA		National Board		HCCC		HPCA		NSW Council		Other juris. cplt. body ¹	
	N	%	N	%	N	%	N	%	N	%	N	%
All - Yes	11	16	8	12	5	8	0	0	0	0	16	24
# % response from national source	8	14	7	13								
# % response from NSW source					5	21	0	0	0	0		
Population group	2		2		1						10	
Consumer or consumer health org.	1		0		3						3	
Health professional or defence org.	8		6		1						3	
All - No	43	63	43	64	49	77	52	84	52	83	38	58
# % response from National source	31	55	30	54								
# % response from NSW source					11	46	15	63	14	58		
Population group	18		18		20		21		21		10	
Consumer or consumer health org.	7		7		7		9		9		4	
Health professional or defence org.	18		18		22		22		22		24	
All - Unsure	14	21	16	24	10	16	10	16	11	18	12	18
# % response from National source	9	16	11	20								
# % response from NSW source					5	21	5	21	6	25		
Population group	5		5		4		4		4		5	
Consumer or consumer health org.	2		3		1		1		1		2	
Health professional or defence org.	7		8		5		5		6		5	

[1] Other jurisdiction complaint body. All jurisdictions represented in the 'Yes' responses received in relation to the question about other jurisdiction complaint bodies.

Table A4.16: Survey 2: respondent involvement in making or assisting a member/service user to make a complaint/notification and type of assistance provided

	Peak population group		Peak consumer or consumer health organisation		Health professional or defence organisation		Total	
	N	%	N	%	N	%	N	%
Made complaint/notification for one of our members/service users	5	19	3	27	4	13	12	17
Complaint/notification made by our organisation directly	3	12	1	9	6	19	10	15
Assisted a member/service user to make complaint/notification	12	46	3	27	11	34	26	38
Explained the process or options	12		4		13		29	42
Provided contact details for complaint or notification agencies	11		5		11		27	39
Made phone calls, wrote letters or took statements	8		2		5		15	22
Provided legal advice, advocacy or represented people	4		2		8		14	20
Made a complaint or notification on their behalf	7		2		4		13	18
Interpreted or translated information	5		2		4		11	16
Attended meetings, conciliation or disciplinary hearings	5		2		4		11	16
Managed or investigated the issue or complaint ourselves	5		1		2		8	12
Other	1		0		2		3	4

[1] Member= member or service user. Respondents could select more than one response.

Some inconsistency in answers to two questions re 'made complaint/ notification on behalf of member or service user'

Table A4.17: Survey 2: respondents that made or assisted with a complaint/notification, by agency managing the complaint/notification and subject profession

Organisation type	Population		Consumer		Professional		Total	
	N		N		N		N	%
AHPRA or a National Health Profession Board	1		2		14		17	25
NSW HCCC	4		1		3		8	12
HPCA or a NSW Health Professional Council	1		0		3		4	6
Other jurisdiction health complaint body	8		4		6		18	26
Mental Health Commission	2		1		0		3	4
Aged Care Complaint Commissioner	5		1		1		7	10
Ombudsman	4		2		3		9	13
A professional association	1		0		0		1	1
Other	2		3		1		6	9
Total	28		14		31		73	

Table A4.17 continued

DR	7		5		6		18	26
NMW	7		3		5		15	22
PHARM	0		2		4		6	9
DENT	2		2		2		6	9
PSY	2		2		4		8	12
Other	2		1		0		3	4
Total	20		15		21		56	

Table A4.18: Survey 2: respondents that provided assistance with making a complaint/notification in 2012 and 2013 by number of members/service users assisted

Organisation type	Population		Consumer		Professional		Total ¹	
	2012	2013	2012	2013	2012	2013	2012	2013
No. assisted								
1 to 9	7	3	1	1	7	6	15	10
10 to 49	3	4	1	1	4	5	8	10
50 to 99	1	2	1	0	0	0	2	2
100 to 249	0	0	0	1	1	0	1	1
250 to 499	1	1	0	0	0	0	1	1
500 plus	0	0	2	2	2	2	4	4
Total	12	10	5	5	14	13	31	28

[1] Total numbers provided.

Table A4.19: Survey 2: respondent comments on whether they felt equipped to assist their members/service users to make a complaint/notification by thematic response

		Outside role		Capacity		Information		Other
POP [1]	6	Would refer or assist to link person to support to assist them if outside scope or role	4	Need for staff, skills and training; depends on relative power imbalance between the complainant (even when on behalf of a client) and the health professional; need for independent advocacy organisations to refer mental health consumers to - current lack of specialised individual advocacy organisations of this type in NSW	1	Aside from HCCC no interaction with other complaint bodies or knowledge of their processes - would "be beneficial if those agencies are more active in engaging with us" and broader community sector	2	Yes where complaint relates to specific health professionals they deal with; yes but avenues of complaint are limited and noting inadequacy of some schemes is resulting in people not accessing the process
CHO [2]	3	Outside scope; would refer; advise them of available mechanisms	2	Need for more funding and general support (to undertake role); capacity varies depending on staff involved	2	Simple information from one source that explains the different roles and responsibilities of the different complaint bodies; although outside scope, would be helpful to have mechanism to inform and link e.g. fact sheet or post card with web links		
PDO [3]	3	Outside respondent scope- would refer; outside scope- supports members with a complaint about them	1	Resources not available to support practitioners through the process although needed - currently done on voluntary basis	1	Need clarification that under the legislation we can assist members (primarily advice) who have a concern or complaint about a health practitioner		

[1] POP= Population organisation

[2] CHO= Consumer or consumer health organisation

[3] PDO= Professional or professional defence organisation

Appendix 5: Chapter 5 (management) additional tables

Table A5.1: Survey 1: what the respondent was first told about how their complaint/notification would be handled

Practitioner subject of complaint	All		DR		NMW		PHARM		DENT		PSY	
	N	%	N	%	N	%	N	%	N	%	N	%
It would be assessed for investigation	1200	71	712	69	229	72	60	74	113	74	86	76
No action would be taken	195	12	144	14	17	5	6	7	21	14	7	6
More information was needed	128	8	69	7	36	11	5	6	6	4	12	11
Referred elsewhere	81	5	45	4	16	5	8	10	6	4	6	5
Urgent action would be taken	45	3	30	3	11	3	2	3	1	1	1	1
Referred to conciliation	36	2	22	2	9	3	0	0	5	3	0	0
Total	1691		1026		319		81		152		113	

Table 5.1 continued

	Body handling						Category of respondent					
	AHPRA		HPCA		HCCC		Consumer		Practitioner		Organisation	
	N	%	N	%	N	%	N	%	N	%	N	%
It would be assessed for investigation	721	71	199	71	280	72	784	71	240	69	176	74
No action would be taken	114	11	27	10	54	14	159	14	29	8	7	3
More information was needed	96	9	14	5	18	5	70	6	31	9	27	11
Referred elsewhere	39	4	26	9	16	4	46	4	24	7	11	5
Urgent action would be taken	28	3	10	4	7	2	20	2	16	5	9	4
Referred to conciliation	19	2	4	1	13	3	25	2	7	2	4	2
Total	1021		281		389		1105		349		237	

Total percentage may not equal 100 due to rounding

'Don't know' or 'other' responses not presented (N=6) but included in totals

Table A5.2: Survey 1: whether the complaint/notification was referred elsewhere, and if so, where by main categories of response

Practitioner subject of complaint	All		DR		NMW		PHARM		DENT		PSY	
	N	%	N	%	N	%	N	%	N	%	N	%
Referred elsewhere	680	40	421	40	128	39	29	38	59	38	43	38
Other health complaint body	366	21	235	23	63	19	18	23	28	18	22	20
Other type of complaint body	121	7	69	7	21	7	2	3	15	10	14	12
The practitioner	115	7	87	8	9	3	4	5	9	6	6	5
Practitioner's workplace	76	4	47	5	19	6	3	4	3	2	4	4

Table A5.2 continued

	Body handling						Category of respondent					
	AHPRA		HPCA		HCCC		Consumer		Practitioner		Organisation	
	N	%	N	%	N	%	N	%	N	%	N	%
Referred elsewhere	390	38	141	50	149	38	466	42	131	37	83	36
Other health complaint body	203	20	98	35	65	17	251	23	72	20	43	18
Other type of complaint body	73	7	17	6	31	8	86	8	24	7	11	5
The practitioner	67	7	20	7	28	7	87	8	20	6	8	3
Practitioner's workplace	55	5	9	3	12	3	53	5	16	5	7	3

Total percentage may not equal 100 due to rounding

Respondents could select more than one response

Not presented: Police (N=41); 'Other' (N=33); 'Don't know' (N=26); and 'the Coroner' (N=22)

Table A5.3: Survey 1: major categories of complaints/notifications referred for investigation

Agency	All		AHPRA		NSW		HPCA		HCCC	
	N	%	N	%	N	%	N	%	N	%
Care, treatment	531	55	344	55	187	55	75	46	112	63
Conduct	413	43	279	45	134	39	61	37	73	41
Communication	348	36	226	36	122	36	51	31	71	40
Competence	301	31	210	34	91	27	40	25	51	29

Table A5.3 continued

Practitioner type	DR		NMW		PHARM		DENT		PSY	
	N	%	N	%	N	%	N	%	N	%
Care, treatment	375	67	78	38	2	4	56	75	20	31
Conduct	233	42	105	51	15	26	24	32	36	55
Communication	237	42	44	21	12	21	23	31	32	49
Competence	178	32	59	29	5	8	36	48	23	35

Table A5.4: Survey 1: whether the complaint/notification was withdrawn at any point

Agency	All		AHPRA		HPCA		HCCC	
	N	%	N	%	N	%	N	%
Total	86	5	30	3	13	5	43	11
Consumer	59	5	21	3	9	5	29	9
Practitioner	22	6	6	3	3	7	13	18
Organisation	5	2	3	2	1	2	1	8

Table A5.4 continued

Practitioner	DR		NMW		PHARM		DENT		PSY	
	N	%	N	%	N	%	N	%	N	%
Total	57	5	17	5	0	0	8	5	4	4
Consumer	47	6	2	3	0	0	7	5	3	4
Practitioner	9	5	11	11	0	0	1	6	1	3
Organisation	1	2	4	3	0	0	0	0	0	0

Table A5.5: Survey 1: how long it took for the complaint/notification to be dealt with and reported delays

Investigation times	All		AHPRA		NSW		HPCA		HCCC		All excl. DR		DR	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
2M or less	431	26	185	19	246	38	76	28	170	45	153	23	278	28
> 2M - < 12M	864	53	513	52	351	54	166	60	185	49	367	56	497	50
12M - < 18M	172	10	149	15	23	4	13	5	10	3	73	11	99	10
18M - < 3Y	129	8	106	11	23	4	15	6	8	2	47	7	82	8
3Y - < 5Y	25	2	17	2	8	1	4	2	4	1	8	1	17	2
5Y or more	14	1	13	1	1	<1	0	0	1	<1	4	1	10	1
Reported delays														
Yes	432	26	288	29	144	22	59	21	85	22	156	24	276	27
No	647	39	332	33	315	48	131	47	184	48	251	38	396	39
Don't know	587	35	383	38	204	31	89	32	115	30	252	37	335	33
Select outcomes when delay reported														
Don't know	90	21	56	20	34	24	19	32	15	18	32	21	58	21
No action	250	58	156	54	94	65	30	51	64	75	88	57	162	59

Table A5.5 continued

	NMW		PHARM		DENT		PSY		IND		PRACT		ORG	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Investigation times														
2M or less	5	6	19	24	1	4	25	22	308	29	87	25	36	16
> 2M - < 12M	44	50	50	62	19	70	59	52	554	52	181	52	129	56
12M - < 18M	19	22	7	9	4	15	13	12	105	10	36	10	31	14
18M - < 3Y	16	18	5	6	2	7	10	9	70	7	30	9	29	13
3Y - < 5Y	3	3	0	0	1	4	2	2	15	1	7	2	3	1
5Y or more	1	1	0	0	0	0	3	3	11	1	3	1	0	0
Reported delays														
Yes	90	28	13	16	27	18	26	23	278	26	98	28	56	24
No	114	36	28	35	66	44	43	38	432	40	130	37	85	36
Don't know	113	35	39	49	56	37	44	39	373	34	121	35	93	39
Outcome where delay														
Don't know	22	25	3	23	2	7	5	19	53	19	18	18	19	35
No action	45	51	6	46	23	85	14	54	181	65	56	57	13	24

Don't know' responses (N=6) not presented
Total may exceed 100% due to rounding

Table A5.6: Survey 1: reported outcomes

	Don't know		No action was taken		Apology given		Explanation given		Information provided		Service provided		Fee, costs waived, reduced		Compensation		Conciliation		Referred to other agency		Retired or surrendered registration	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
ALL	254	15	1032	60	89	5	205	12	121	7	2	<1	27	2	11	1	15	1	39	2	47	3
AHPRA	153	15	599	58	34	3	88	8	54	5	0	0	10	1	6	1	4	<1	26	3	35	3
NSW	101	15	433	63	55	8	117	17	67	10	2	<1	17	3	5	1	11	2	13	2	12	2
HPCA	59	21	142	50	16	6	35	12	26	9	1	<1	3	1	1	<1	1	<1	9	3	10	4
HCCC	42	10	291	72	39	10	82	20	41	10	1	<1	3	1	4	1	10	3	9	3	2	1
DR	136	13	681	66	69	7	156	15	84	8	1	<1	13	1	7	1	11	1	23	2	18	2
NMW	75	23	138	43	11	3	20	6	18	6	0	0	1	<1	0	0	3	1	9	3	23	7
PHARM	12	14	34	42	5	6	6	7	5	6	0	0	3	4	1	1	0	0	1	1	2	2
DENT	14	9	103	67	3	2	15	9	8	5	1	1	8	5	3	2	1	1	3	2	2	2
PSY	17	15	76	66	1	1	8	7	6	5	0	0	2	2	0	0	0	0	3	3	2	2
CONS	141	13	752	67	76	7	172	15	89	8	1	<1	23	2	11	1	13	1	19	2	9	1
PRACT	52	15	197	55	10	3	21	6	16	5	1	<1	3	1	0	0	2	1	12	3	18	5
ORG	61	26	83	35	76	7	12	5	16	7	0	0	1	<1	0	0	0	0	8	3	20	8

Table A5.6 continued

	Fined		Public statement		Conditions on practice		Health, educ. program		Under taking		Prohibition order		Counselled		Caution or reprimand		Registration suspended		Registration cancelled		Other action	
ALL	4	0	5	0	123	7	80	5	83	5	4	0	80	5	107	6	28	2	15	1	19	1
AHPRA	4	<1	1	<1	99	10	66	6	62	6	3	<1	39	4	94	9	24	2	10	1	10	1
NSW	0	0	4	1	24	4	14	2	21	3	1	<1	41	6	13	2	4	<1	5	1	9	1
HPCA	0	0	2	1	21	7	10	4	14	5	0	0	38	13	9	3	3	1	3	1	6	2
HCCC	0	0	2	1	3	1	4	1	7	2	1	<1	3	1	0	0	1	<1	2	1	3	1
DR	1	0	2	0	53	5	36	3	2	2	2	0	42	4	58	6	11	1	5	1	9	1
NMW	2	1	3	1	49	15	27	8	19	6	0	0	17	5	19	6	13	4	9	3	4	1
PHARM	1	1	0	0	7	8	7	8	7	8	0	0	13	16	13	16	3	4	0	0	2	2
DENT	0	0	0	0	7	8	8	5	7	4	1	1	3	2	10	6	0	0	0	0	3	2
PSY	0	0	0	0	6	5	2	2	3	3	1	1	5	4	7	6	1	1	1	1	1	1
CONS	1	<1	3	<1	44	4	40	4	33	3	4	<1	52	5	71	6	5	<1	2	<1	11	1
PRACT	1	<1	0	0	36	10	24	7	32	9	0	0	16	5	25	7	9	3	7	2	1	<1
ORG	2	1	2	1	43	18	16	7	18	8	0	0	12	5	11	5	14	6	6	3	7	3

Table A5.7: Survey 1: reported outcomes by summary outcome categories

	Don't know		No action		Acknowledge communicate fees ¹		Referred ²		Retire or surrender ³		Conditions excl. susp., cancel ⁴		Suspend, cancel ⁵	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
ALL	254	15	1032	60	335	20	53	3	47	3	322	19	38	2
AHPRA	153	15	599	58	152	15	30	3	35	3	234	23	29	3
NSW	101	15	433	64	183	27	23	3	12	2	88	13	9	1
HPCA	59	21	142	50	61	22	10	4	10	4	72	25	6	2
HCCC	42	11	291	73	122	31	13	3	2	1	16	4	3	1
DR	136	13	681	66	239	23	33	3	18	2	159	15	14	1
NMW	75	23	138	43	39	12	12	4	23	7	87	27	19	6
PHARM	12	15	34	42	12	15	1	1	2	2	30	37	3	4
DENT	14	9	103	67	31	20	4	3	3	2	28	18	0	0
PSY	17	15	76	66	14	12	3	3	1	1	18	16	2	2
CONS	141	13	752	67	270	24	31	3	9	1	166	15	7	1
PRACT	52	15	197	55	24	10	14	4	18	5	86	24	15	4
ORG	61	26	83	35	41	12	8	3	20	8	70	29	16	7

[1] Acknowledge, communication, fees = apology, explanation, information or service provided; fees or costs waived, reduced or refunded; received compensation ; [2] Referred = referred to conciliation or to another agency; [3]= Retire or surrender = practitioner retired, did not renew or surrendered registration; [4] = Aggregated conditions excluding suspend/ cancel = conditions placed on practice; required to do a health or education program; caution or reprimand issued; practitioner made undertakings; practitioner counselled; fine imposed ; public statement made; prohibition order issued; [5] Suspend or cancel = registration suspended or cancelled

Table A5.8: Survey 1: extent to which issues were addressed at the point of closure

	Not at all		Partly		Mostly		In full		Don't know	
	N	%	N	%	N	%	N	%	N	%
ALL	958	57	304	18	180	11	177	11	46	3
AHPRA	561	56	185	18	114	11	109	11	32	3
NSW	397	60	119	18	66	10	68	10	14	2
HPCA	134	50	47	18	36	13	38	14	12	5
HCCC	263	66	72	18	30	8	30	8	2	1
DR	623	61	197	19	100	10	67	7	26	3
NMW	136	44	49	16	38	12	71	23	14	5
PHARM	37	45	17	21	14	17	14	17	1	1
DENT	92	61	27	18	11	7	18	12	0	0
PSY	70	62	14	12	17	15	7	6	5	4
CONS	703	64	200	18	98	9	69	6	25	2
PRACT	183	52	63	18	47	13	44	13	12	3
ORG	72	32	41	19	35	16	64	29	9	4

A further 8 cases were reported as being under review relating to medical or dental practitioners
Total may exceed 100% due to rounding

Table A5.9: Survey 2: whether in the respondents' experience agencies used complaints/notifications to identify broader risks or issues in health practice

	Yes		No		Unsure	
AHPRA/National Boards	16		5		43	
AHPRA/National Boards: national sources only [1]	14		4		25	
Population organisation	3	3	2	2	19	11
Consumer organisation	2	2	1	0	7	4
Professional organisation	11	9	2	2	17	10
HPCA/Councils	2		2		56	
HPCA: NSW sources only [2]	2		0		17	
Population organisation	0	0	2	0	22	8
Consumer organisation	0	0	0	0	9	4
Professional organisation	2	2	0	0	25	5
HCCC	12		3		45	
HCCC NSW sources only [2]	9		1		10	
Population organisation	3	3	2	0	19	5
Consumer organisation	4	2	1	1	5	2
Professional organisation	5	4	0	0	21	3
Other jurisdiction health complaint body	14		4		45	
Other jurisdiction: national sources only [3]	19		3		29	
Population organisation	4		3		18	
Consumer organisation	5		1		4	
Professional organisation	5		0		23	

[1] National sources only excludes NSW respondents

[2] NSW sources only excludes responses from organisations outside NSW

Appendix 6: Chapter 6 (experience) additional tables

Whether the agency role and powers were clear

Table A6.1.1: Survey 1: whether the role and powers of the agency were clear: Likert scale responses

	1=Not clear at all		2=Unclear		3=Neutral		4=Clear		5=Very clear	
	N	%	N	%	N	%	N	%	N	%
ALL	441	26	280	17	349	21	380	23	241	14
AHPRA	258	25	166	16	216	21	222	22	155	15
NSW	183	27	114	17	133	20	158	23	86	13
HPCA	59	21	55	20	55	20	71	26	38	14
HCCC	124	31	59	15	78	20	87	22	48	12
DR	305	30	181	18	207	20	212	21	119	12
All excl. DR	136	20	99	15	142	21	168	25	122	18
NMW	61	19	47	15	56	18	98	31	57	18
PHARM	13	16	13	16	21	26	16	20	17	21
DENT	37	24	17	11	42	27	23	15	36	23
PSY	25	22	22	20	23	20	31	27	12	11
CONS	324	29	197	18	249	23	209	19	129	12
CONS AHPRA	186	30	113	18	137	22	100	16	78	13
CONS NSW	138	28	84	17	112	23	109	22	51	10
PRACT	86	25	47	14	64	18	90	26	61	18
ORG	31	13	36	15	36	15	81	35	51	22

Total may not equal 100% due to rounding. Total response rate 98% N=1691; lowest practitioner PHARM (95%)

Table A6.1.2: Survey 1: whether the role and powers of the agency were clear: Likert scale responses for major practitioner groups, AHPRA and NSW

Rank	AHPRA						NSW					
	DR		NMW		Pharm, Dent, Psy		DR		NMW		Pharm, Dent, Psy	
	N	%	N	%	N	%	N	%	N	%	N	%
1=Not clear at all	174	30	39	18	45	21	131	29	22	23	30	23
2=Unclear	101	18	31	14	34	15	80	18	16	17	18	14
3=Neutral	124	22	44	20	48	22	83	19	12	12	38	30
4=Clear	106	18	68	31	48	22	106	24	30	31	22	17
5=Very clear	71	12	40	18	44	20	48	11	17	18	21	16

Total may not equal 100% due to rounding

Table A6.1.3: Survey 1: whether the role and powers of the agency were clear: proportion of comments compared with all ranked responses

Rank	AHPRA		NSW		HPCA		HCCC		Total comment		Ranked responses	
	N	%	N	%	N	%	N	%	N	%	N	%
1=Not clear at all	99	25	68	27	32	32	36	24	167	26	441	26
2=Unclear	73	19	51	21	27	27	24	16	124	19	280	17
3=Neutral	83	21	40	16	12	12	28	19	123	19	349	21
4=Clear	73	19	56	23	19	19	37	25	129	20	380	23
5=Very clear	61	16	33	13	9	9	24	16	94	15	241	14
Total	389		248		99		149		637		1691	

Frequency and proportion prior to thematic coding

Table A6.1.4: Survey 1: whether the role and powers of the agency were clear: thematically coded comments

	Explanation, information, guidelines ¹				Exercise of role & powers ²			Adequacy of role & powers ³			Relationships & accountabilities ⁴			
	1A	1B	1C	Sub.	2A	2B	Sub.	3A	3B	Sub.	4A	4B	4C	Sub.
All	67	284	25	376	147	81	228	23	35	58	25	10	12	49
%	9	40	4	53	21	11	32	3	5	8	4	1	2	7
AHPRA	42	180	14	236	89	49	138	14	18	32	7	5	10	24
%	10	42	3	55	21	11	32	3	4	7	2	1	2	6
HPCA	15	39	4	58	22	9	31	4	6	10	13	4	0	17
%	13	34	3	50	19	8	27	3	5	9	11	3	0	15
HCCC	10	65	7	82	36	23	59	5	11	16	5	1	2	8
%	6	39	4	50	22	14	36	3	7	10	3	1	1	5

[1] Guidelines, explanation, information about role & powers: 1A= comment about general information about the process or level of contact; 1B=general comment about role or powers; 1C= specific comment about role or powers. [2] Exercise of role & powers: 2A= process, actions, reasons, outcome; 2B= attitude and balance (probity or bias). [3] Adequacy of role & powers: 3A= capacity of complaint/notification body; 3B= Power of body, including limits on powers to review or to provide information. [4] Relationships & accountabilities: 4A= complaint/notification bodies; 4B= mandatory reporting or employer related; 4C= other bodies and interface with complaint/notification bodies.

Table A6.1.5: Survey 1: summary comment Theme 1 (explanation, information, guidelines) by raked response

Not clear at all	Unclear	Neither (un/clear)	Clear	Very clear
Sub-theme A: general comment about information provided about the process or level of contact				
No information Never spoke to anyone NO information about the process itself as all that was "PRIVATE" First contact this survey	No information Heard nothing from them; pretty much got told nothing	No information No communication ; kept informed sporadically	Reasonable communication ; kept informed ; outcome remains unclear despite seeking clarification	Clear/ efficient process Communication very clear; kept informed at all times; excellent service [HPCA]
Sub-theme B: generic comment on role or powers				
No guidelines provided ; never defined ; no idea who they are/ if independent of doctors/ of government	No explanation given; ambiguous ; any information I already knew - no details given by agency; stock answer- very general	Not explained ; not clear; in general fashion only; legislation most confusing ; sure they would have told me- but distressed at time so unsure	Somewhat clear ; clear but in no way transparent ; limits explained; very clear ; role and powers explained/ very well- in letters/ calls/ email/ website; aware of bodies and functions through dealing with numerous agencies re similar matters	Role written in the Act (but they denied); very clearly defined roles and powers; very clearly explained the process in call/ letter/ brochure; information sheet; I was already aware
Never explained - given expectations of process but weren't followed; felt blocked when asked for clarification	Understood role and powers but never met my expectations - in fact did not listen to me	I didn't ask - wanted them to fix problem, which they did; encouraged to report- expected more	Investigation undertaken and outcome provided to me	The letter explained the Dr would be interviewed and counselled (appears to have been done)
Sub-theme C: more specific comment about role or powers				
Authorised to introduce standards to protect public (but did not); give impression [there to] uphold standards / protect my welfare (but saw no evidence of this)	Don't know their powers – I know they are supposed to investigate ; discussed role and remit at length beforehand, subsequently showed remit and powers in vastly less powerful light	Called to discuss whether a mandatory notification and to discuss the process	Well described role in assessing suitability to practice ; understand it exists to protect public ; I thought it was to be investigated by an objective body and by inspection; believed had the power to caution or counsel practitioner, possibly to take responsibility to apologise	Ultimate power to register and discipline ; manage professionals with impairment impacting on practice; investigate reports of poor performance ; protect the public ; can refer to Council if think appropriate [HCCC]

Unless otherwise indicated, comments apply to all agencies

Table A6.1.6: Survey 1: summary comment Theme 2 (exercise of role and powers) by ranked response

Not clear at all	Unclear	Neither (un/clear)	Clear	Very clear
Subtheme A: actions reasons, outcomes				
Not investigated/ properly; not consider evidence; didn't assess anything; not done much at all; not given opportunity to respond; long timeframes and lack of communication made a mockery of the process; no outcome and no reason for delay; phoned for explanation and found hadn't received all of the information necessary to make a decision	A more thorough investigation should have taken place; lack of investigation evident; don't think they interviewed anyone involved; not questioned for my side of story (AHPRA); main issue/ concerns not addressed; did not follow up concerns with practitioners who supported my complaint [AHPRA]	Took too long ([HCCC]; very poor feedback [HPCA]; not sure what happened- made a mess and sent to a plastic surgeon to fix his mistake [HPCA]; expected complaint would initiate an investigation but practitioner asked for 'please explain' and nothing further as no rules breached- offered conciliation but felt had been heard and on record [HCCC]; advised by my patient not timely, responsive or impartial and need for further documentation caused additional trauma [HCCC]	Issues handled well and quickly; took a long time thought would be given opportunity to respond; explained role and powers but since going through process just lip service [AHPRA]; felt didn't answer specific questions [HCCC]	AHPRA: But failed to apply normal rules of justice i.e. talk to witnesses and me; clear authority but slow process; each stage of process explained and high level of investigation carried out
Not showed in a clear way how they came to the decision; complaint disregarded and no reasonable explanation; evidence damning and totally refused to implement their policies and procedures to protect the public [AHPRA]; only answer was doctor has nothing to answer for; poor English language skills of nurse resulted in fall and hospitalisation/ failure to retrieve medical records resulted in preventable death – no action or explanation; serious complaint of harm and allowed to surrender registration	Poor outcome; rules/ laws broken yet no result; do not understand how and why action not taken; no clear answer given to simple questions	Not happy with hearing- toothless tiger- felt like a number [AHPRA]; expected Council would see complaint valid and act on it – didn't happen [HPCA]; were told letter of apology would be forwarded but never received it [HCCC];	Investigated complaint- that was enough though an apology would have been good [AHPRA]; response clear but reasons incorrect [HPCA]; HCCC: asked same questions as my lawyer, difference being they got a result; decision clear with response for each of my complaints; made clear wouldn't act	AHPRA: will do nothing; complained of negligence but seemed to decide not worth investigating; told me dealt with and limits placed on practice; HCCC: reply said it all- do nothing; did all they could; professional, efficient
Subtheme B: attitude and balance (probity or bias)				
Bias; only look after/side with/ favour/ protect doctors; cop-out; cover up; corruption; will not listen to truth; accepted practitioner word; did not ask for information; uninterested	Protect/favour doctors/ nurses; immediately believed/accepted practitioner word; did not ask for information; practitioners reviewing practitioners	One sided; clearly took side of nurse; presumption would be unbiased (but not); too much emphasis on nurses' rights rather than competence	Felt would support doctor despite evidence; as a practitioner felt covered up mistakes by dentist; too many supportive and skew outcome to doctors involved	Took a great deal of time and gave sound advice and support; respectful and thorough; fair; understanding and took seriously; work for the doctor and agree with whatever doctor says; protecting members

Unless otherwise indicated, comments apply to all agencies

Table A6.1.7: Survey 1: summary comment Theme 3 (adequacy of role and powers) by ranked response

Not clear at all	Unclear	Neither (un/clear)	Clear	Very clear
Subtheme A: Capacity - skill; knowledge; ability to address, respond; model (system issue, approach)				
AHPRA: Too far away and lack knowledge of regional areas; notified them no longer able to supervise practitioner- found still unreviewed one year later; HCCC: jurisdiction incomplete and inadequate to cover all areas of conduct; my registration obliges me to report poor conduct but the system can only deal with mandatory notification	AHPRA: wanted to know if practice legal/ if I had suffered harm- unanswered; thought I might get new set of dentures but unsure after speaking with [HCE]; HPCA: Only expedited after I responded to a routine email – concerned given threats- can only conclude a problem with prioritising; HCCC: withdrawn as couldn't remain anonymous	AHPRA: Appeared disorganised, changing of staff led to significant confusion, loss of momentum; operate in closed loop, unwilling to provide information, 'archaic rule' unduly delaying investigation	Understand they find it difficult to find an 'expert' to give a concurring opinion while colleagues fall over themselves to defend [HCCC]	But they do nothing about the root cause of the complaint, even after regurgitating slabs of literature from journal articles [AHPRA]
Reasons demonstrate lack of knowledge and competency of appropriate practice [AHPRA]	Not qualified to make judgements on working of psychiatry [AHPRA]	Those investigating lacked necessary expertise to understand, address issue; I had to point out deficiencies, issues [AHPRA; HCCC]	Expected HCCC & Medical Council to have greater cognitive ability [HPCA]	
Subtheme B: Powers- to provide information; to review; other				
AHPRA: Referred to Panel- not explained and not on website that I wouldn't be told outcome; said couldn't tell me, not subject to FOI and don't have review process; not clear there was no review; asked what I could do to appeal-minimal help, told closed; assumed they had more power to actually achieve something; HCCC: read web page- only have few powers – appears for prestige [show]; impotent, crippled by ineptitude and legislation; rang many times to AHPRA and co-regulators per review process- told no	AHPRA: 18 months of providing information and told only 'dealt with'; thought I would be advised outcome; continuously told due to privacy laws and confidentiality could not get responses; role understood- didn't know had no power to compel; web information implied more power than they seemed to have; no one said after all the talking they wouldn't be able to help get money back; HPCA: did not know if responsible person had acknowledged what did and were dealt with; did not want to violate privacy- wanted to be confident independent body assessing – no advice being taken seriously	AHPRA: Unwilling to obtain/ provide information; powerless and a waste of time; relevant party overseas- not sure if any power available; HPCA: limited in what they could do; HCCC: thought I had 28 days to write back but when I was emailed told it was closed; dentist was asked to refund me for the extra work but refused	HCCC: Apart from organising a conciliatory chat or referring it, could not do a great deal at all; understand could not force reimbursement for mediocre service but hoped would have to complete training on how to speak to people with respect- seems no power at all; if all power they have is to ask dentist a question and he denies it- what's the point; issue is hospital not obliged to comply; clear insofar as limitations obvious- powers should be broadened	AHPRA: stressful, no benefit or real understanding of decision; made it clear I may not be appraised of actions taken- stated what could do and possible outcome; HCCC: absolutely no power; if I had written the letter, may not have had effect- more clout with help of HCCC

Unless otherwise indicated, comments apply to all agencies

Table A6.1.8: Survey 1: summary comment Theme 4 (relationships and accountabilities) by ranked response

Not clear at all	Unclear	Not clear- unclear	Clear	Very clear
Subtheme A: regulators and other health complaint entities				
Everyone hand-balled issues; buck passed a number of times- no consultation; passed from one body to another while continued to practice; HCCC and HPCA gave conflicting advice on what would happen next; HCCC and AHPRA had to decide who was going to deal with it; HCCC appears to be middle man for referring matters to the Psychology Council – relationship between these bodies and AHPRA unclear; told by AHPRA to complain to NSW Council who then referred it to AHPRA	AHPRA: Different bodies involved at different stages; don't understand role of AHPRA in complaint to Dental Board when couldn't answer for Board- frustrating; HPCA: a lot of buck passing between HCCC and HPCA; must write to HCCC who then refer to DR Council- don't know who actually decides outcome; wrote to NMW Council who passed it to the HCCC who referred back- unclear why HCCC involved – not explained adequately; HCCC messed it up then handed to DR Council who do nothing	Received letter from organisation I originally complained to saying referred to AHPRA- nothing until finalised 9-10 months later; I understood PH Council dealt with breaches but referred to AHPRA; AHPRA referred to HCCC who referred it back while practitioner remains registered with no restrictions; HCCC influenced by biased DR Council	Told more or less that the process was for them not me and can't help with money and referred it back to the [state] HCE [AHPRA]	Process clear on website and form simplified and assistance is available- original submission made in state 1 and referred to state 2 office – would have preferred for it to be investigated to the standards of state 1 office [AHPRA]
Subtheme B: employers – responsibilities and interface with regulators; mandatory notification (MN)				
Not a complaint- he realised problem, stopped, sought help and was obliged to report [AHPRA]; MN- employer had already taken appropriate action		AHPRA: Several bodies internal and external involved- very protracted; very distant and slow- employer faced with taking action including investigation without advice- seems disconnect given considerable steps to obtain registration; HPCA: initially a little confused about employer obligations in MN; made MN by letter after trying to contact authorities, abused by the practitioner and no one discussed with me the concerns I raised	AHPRA: Investigation took time by regulator and employer in part due to lack of familiarity with requirements, need to be more prompt- too long for employee and employer; no attempt to liaise with employer who is managing difficult situation- would be far better than secrecy method currently employed; having to check unreliable website for conditions is ridiculous and uninformative; HCCC: MN about impaired colleague	MN practitioner with health problem unwilling to disclose or cooperate - only uncertainty was whether any feedback would be provided after terminated services [HPCA]
Subtheme C: other complaint & investigative processes				
AHPRA: No idea why took so long and needed more information when had gone through Coronial inquest; told as Family Court matter unlikely to have resolution soon and were closing; interpretation by Board conflicted with other regulatory body who wrote and advised conduct and advertising illegal' HCCC: not regarded as serious issues although doctor found guilty by two independent health care organisations	AHPRA: misunderstanding of process when Coroner involved and what the HR/professional functions are in the interim; unclear of hierarchy between Health department and commission	AHPRA: confusing to be contacted by both AHPRA and another body of (?) insurers- never clear about their roles; issues referred to AHPRA and Police but insufficient evidence to stand up in Court, concerned practitioner joined agency and were moving around state	Have been dealing with Coroner's office for 18 months- nothing resolved- still under investigation; there are clear guidelines from both AHPRA and other regulator	Referred back to Dental Association that asked me to go to HCCC

Unless otherwise indicated, comments apply to all agencies

Table A6.1.9: Survey 2: respondent understanding of the role of agencies by frequency of response

Perceived role ¹	AHPRA or Board				HPCA ²			HCCC			
	1st	2nd	not role	not sure	1st	not role	not sure	1st	2nd	not role	not sure
Resolve individual issues	5	7	8		1			3		1	1
Peak population	1	1	1		1			1			1
Consumer or consumer health	2							1			
Health professional or defence	2	6	2					1		1	
Represent consumer rights	5	4	8		1			3		1	1
Peak population	1	2			1			1			1
Consumer or consumer health	1	1						1			
Health professional or defence	3	1	8					1		1	
Assist with compensation	1	2	12	2	1					3	2
Peak population		1	1	1	1					1	1
Consumer or consumer health		1	1							1	
Health professional or defence	1		10	1						1	1
Correct treatment, service errors	6	3	6		1			1		4	
Peak population	2	1			1			1		1	
Consumer or consumer health	2									1	
Health professional or defence	2	3	6							2	
Protect the public	15		1		1			4	1		
Peak population	3				1			2			
Consumer or consumer health	1								1		
Health professional or defence	12		1					2			
Set standards- practice and care	10	3	3		1			1	2	2	
Peak population	1	1	1		1			1	1		
Consumer or consumer health	1									1	
Health professional or defence	8	2	2						1	1	
Educate practitioners, the public	9	4	3		1			1	3	1	
Peak population	3				1			1	1		
Consumer or consumer health	1									1	
Health professional or defence	5	4	3						2		
Discipline practitioners	6	5	4	1	1			3		2	
Peak population	1	1	1		1			1		1	
Consumer or consumer health	1							1			
Health professional or defence	4	4	3	1				1		1	
Identify risks in health practice or systems	5	4	5	1	1			2	1	2	
Peak population	1	1	1		1			1		1	
Consumer or consumer health		1								1	
Health professional or defence	4	2	4	1				1	1		

[1] 1st= primary role; 2nd = secondary role

[2] No secondary roles were identified for the HPCA

Table A6.1.10: Survey 2: ranking of agency processes and practices by respondent type and frequency of response

Ranking ¹	AHPRA or Board					HPCA or Council					HCCC				
	1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
This agency is independent	1	1	5	5	3				1		1	1	3		
Peak population			1	2					1				2		
Consumer or consumer health	1										1				
Health professional or defence		1	4	3	3							1	1		
It communicates well to the people involved in a complaint about actions, decisions, outcomes	2	3	7	3	1				1		1		3	1	
Peak population			2	1					1				2		
Consumer or consumer health	1										1				
Health professional or defence	1	3	5	2	1								1	1	
There is adequate opportunity to provide information and respond to issues raised	2	2	3	8	1				1		2		2	1	
Peak population			1	2					1				2		
Consumer or consumer health	1										1				
Health professional or defence	1	2	2	6	1						1			1	
Its processes are fair to both the complainant and the practitioner the complaint is about	2	3	4	6	1			1			2		2	1	
Peak population		1	1	1				1					2		
Consumer or consumer health	1										1				
Health professional or defence	1	2	3	5	1						1			1	
Complaints are dealt with promptly	4	7	3	1	1		1				2		2	1	
Peak population	1	1	1				1						1	1	
Consumer or consumer health	1										1				
Health professional or defence	2	6	2	1	1						1		1		
How complaints are handled appear appropriate to the level of seriousness of the issues raised	1	5	4	4	1		1				1	1	1	2	
Peak population		1	1	1			1						1	1	
Consumer or consumer health	1										1				
Health professional or defence	1	4	3	3	1							1		1	
Results appear commensurate with issues complained about i.e. disciplinary, educative or support outcomes appear appropriate to the issues raised	1	3	5	5	1		1				1		3	1	
Peak population			2	1			1						2		
Consumer or consumer health	1										1				
Health professional or defence		3	3	4	1								1	1	
It communicates well to health providers about trends, risks or issues arising from the complaints it receives	1	4	7	3	1			1					4	1	
Peak population			2	1				1					2		
Consumer or consumer health	1													1	
Health professional or defence		4	5	2	1								2		
It communicates well to the general public about trends, risks or issues arising from the complaints it receives	2	3	9	1	1			1			1		4		
Peak population			2	1				1					2		
Consumer or consumer health	1										1				
Health professional or defence	1	3	7		1								2		

[1] Whether agreed or disagreed with statement. Ranking: 1=Strongly disagree; 2=Disagree; 3= Neutral 4=Agree; 5=Strongly agree

Table A6.1.11: Survey 2: respondent ranking of adequacy of powers available to agencies under law by respondent type and frequency of response

	Not enough or limited powers	Too much power	Adequate powers	Not sure
Ability to refer to other agencies	4	0	13	4
AHPRA	3	0	9	3
NSW	1	0	4	1
Population or consumer	2	0	3	2
Health professional or defence	2	0	10	2
Ability to share information with other agencies	6	0	7	8
AHPRA	4	0	6	5
NSW	2	0	1	3
Population or consumer	3	0	1	3
Health professional or defence	3	0	6	5
Ability to deal with unregistered practitioners	13	0	2	5
AHPRA	12	0	1	1
NSW	1	0	1	4
Population or consumer	4	0	0	3
Health professional or defence	9	0	2	2
Ability to conciliate matters	5	0	8	7
AHPRA	3	0	7	4
NSW	2	0	1	3
Population or consumer	2	0	2	3
Health professional or defence	3	0	6	4
Ability to initiate investigations and inquiries	5	1	11	3
AHPRA	4	1	7	2
NSW	1	0	4	1
Population or consumer	4	0	2	1
Health professional or defence	1	1	9	2
Ability to thoroughly investigate issues	4	1	12	3
AHPRA	2	1	11	
NSW	2	0	1	3
Population or consumer	2	0	3	2
Health professional or defence	2	1	9	1
Ability to apply effective interventions or sanctions	4	3	11	3
AHPRA	2	3	9	1
NSW	2	0	2	2
Population or consumer	3	0	2	2
Health professional or defence	1	3	9	1
Ability to monitor and enforce compliance	3	1	7	9
AHPRA	2	1	6	6
NSW	1	0	1	3
Population or consumer	2	0	2	2
Health professional or defence	1	1	5	7

Whether agreed or disagreed with statement Ranking: [1] = Not enough or limited powers; [2] = Too much power; [3] = Adequate powers; [4] = Not sure (columns excluded if no ranking)

Whether the criteria used to assess the complaint/notification were clear

Table A6.1.12: Survey 1: whether the assessment criteria used by the agency were clear: Likert scale responses

	1=Not clear at all		2=Unclear		3=Neutral		4=Clear		5=Very clear	
	N	%	N	%	N	%	N	%	N	%
ALL	663	40	270	16	332	20	249	15	161	10
AHPRA	412	41	165	16	181	18	157	16	91	9
NSW	251	38	105	16	151	23	92	14	70	11
HPCA	94	34	50	18	60	22	41	15	32	12
HCCC	157	40	55	14	91	23	51	13	38	10
DR	440	44	163	16	187	19	130	13	90	9
All excl. DR	223	34	107	16	145	22	119	18	71	11
NMW	94	30	51	16	69	22	69	22	34	11
PHARM	24	29	14	17	21	26	16	20	7	9
DENT	57	37	23	15	34	22	17	11	22	14
PSY	48	43	19	17	21	19	17	15	8	7
CONS	471	43	170	16	218	20	137	13	100	9
CONS AHPRA	283	47	100	17	102	17	69	11	53	9
CONS NSW	188	38	70	14	116	24	68	14	47	10
PRACT	125	36	66	19	69	20	50	15	34	10
ORG	67	29	34	15	45	19	62	26	27	12

Total may not equal 100% due to rounding. Total response rate 97% N=1675; lowest practitioner DENT (96%)

Table A6.1.13: Survey 1: whether the assessment criteria used by the agency were clear: Likert scale responses for major practitioner groups, AHPRA and NSW

Rank	AHPRA						NSW					
	DR		NMW		Pharm, Dent, Psy		DR		NMW		Pharm, Dent, Psy	
	N	%	N	%	N	%	N	%	N	%	N	%
1=Not clear at all	265	47	64	29	83	38	175	39	30	31	46	36
2=Unclear	90	16	38	17	37	17	73	16	13	14	19	15
3=Neutral	96	17	43	20	42	19	91	21	26	27	34	26
4=Clear	68	12	54	24	35	16	62	14	15	16	15	12
5=Very clear	47	8	22	10	22	10	43	10	12	13	15	12

Total may not equal 100% due to rounding

Table A6.1.14: Survey 1: whether the assessment criteria used by the agency were clear: proportion of comments compared with all ranked responses

Rank [1]	AHPRA		NSW		HPCA		HCCC		Total comment		Ranked responses	
	N	%	N	%	N	%	N	%	N	%	N	%
1=Not clear at all	192	51	93	44	40	46	53	43	285	48	663	40
2=Unclear	54	14	36	17	18	21	18	15	90	15	270	16
3=Neutral	60	16	40	19	15	17	25	20	100	17	332	20
4=Clear	43	11	24	11	10	11	14	11	67	11	249	15
5=Very clear	30	8	18	9	4	5	14	11	48	8	161	10
Sub-total	379		211		87		124		590		1675	
Comment no rank	11		8		3		5		19			
Total	390		219		90		129		609			

[1] Frequency and proportion prior to thematic coding

Table A6.1.15: Survey 1: whether the assessment criteria used by the agency were clear: Thematically coded comments by ranked response

Theme	Explanation [1]		Exercise of role & powers [2]					
	1 = Guidelines, explanation, information about assessment criteria		2 = Exercise of role & powers		2A = evidence, use, reasons, outcome		2B = attitude and balance (fairness)	
	N	%	N	%	N	%	N	%
All	354	57	266	43	199	32	67	11
AHPRA	241	60	162	40	118	29	44	11
HPCA	43	48	47	52	38	42	9	10
HCCC	70	55	57	45	43	34	14	11

Table A6.1.16: Survey 1: summary comment Theme 1 (information, explanation, communication) by ranked response

Rank 1 Very unclear	Rank 2 Unclear	Rank 3 Neutral	Rank 4 Clear	Rank 5 Very clear
Themes: • No information, communication • Criteria not explained, disclosed • Criteria not relevant, appropriate	Themes: • No information, contact • Criteria not explained; disclosed, clear	Themes: • No communication • Criteria not provided; uncertain, unclear • Assumed applied • Understanding of complainant	Themes: • Unsure • Explained, easy to understand • (Very) clear • Cited law	Themes: • Explained, easy to understand • (Very) clear • Mandatory report • What complainant provided was clear
None; not sure; not clear; no idea; nothing explained; no, minimal information; never spoke or contacted; didn't know; never advised of this; no one mentioned/ never made aware any criteria exists; Ambiguous and not fully explained [HPCA]; The complainant has no idea what they think or are investigating [HPCA] Criteria irrelevant; criteria inappropriate; Criteria constantly changing [AHPRA]; conflicted with law, Code of Conduct [AHPRA]; HPCA and HCCC gave conflicting advice about this	Not provided; not told; not communicated; never contacted [AHPRA]; never advised; no transparency on criteria; never made clear; not sure; don't know process; had letters and calls but never explained; HCCC: Written amongst fairly lengthy documents; Gave a good indication of their assessment. I don't recall any criteria other than inappropriate treatment, behaviour	Not sure; don't know; not provided; no communication; wouldn't know as little feedback; not given access to this information; criteria open to interpretation; can't remember; don't recall seeing; legislation is most confusing [HCCC]; Whilst the HCCC was always accessible, and helpful, it kept saying that dental matters were extremely difficult to assess [HCCC] Unknown criteria, but I am not medically trained to know [AHPRA]; Too technical to understand some of letters [HCCC]; I was too upset to clarify all of the reasons given [HPCA]; I wasn't aware in any detail... although I had the idea that it would be against 'standard practice' deemed acceptable by the ethics codes etc. of the professional body [AHPRA]; situation rare-criteria difficult to establish [HPCA]	Not sure [all]; not much detail [AHPRA] Always informed; easy to understand; clear; fully, quite clear AHPRA: Stated the relevant law; Drugs and Poisons Act covered Yes, it is clear a client can register an official complaint. That [the] Dr cannot undermine or intimidate client for complaint [HCCC]	Easy to understand; explained very clearly; made clear; process explained; steps explained; sections of the Act were explained in writing; explained in letters, booklet, phone calls, on website; Mainly the organisation investigates bad practice of doctor [HPCA] AHPRA: They have guidelines; used a Code of Conduct - GPs can refuse to attend; Nursing competency standards clear AHPRA: As defined in National Law for registered health practitioners to report unsafe practice; patient safety; mandatory notification [impairment]
I don't know whether my complaint was assessed as I received no response to it [HPCA]; Nobody discussed the background or facts of the complaint with me or my colleagues at all [HPCA]; Outcome letter was less than one page and gave no information on criteria or process [AHPRA]; No criteria were provided on how the matter was reviewed (no transparency), simply an advice of the decision with no explanation against the detailed questions put	No information provided about the assessment criteria other than "send your papers in" [AHPRA]; Not clear at all because the only feedback I got was the matter was finalised and closed and no explanation of what criteria was used and [or] the outcome [HPCA]; I wasn't given any paperwork or explanation on how the process would go or what exactly would happen [HCCC]; AHPRA sought information,	If you don't know the regulations well or criteria, how can one lodge a well-informed application [AHPRA]; There was no mention of whether they would actually investigate or not, let alone what criteria would be used in such matters [AHPRA]; I was generally poorly informed about this, though I am a medical practitioner who made a mandatory notification about a patient [AHPRA]; I was not aware that the complaint was assessed according to any predetermined criteria [HCCC]; I'm not aware of the criteria used to assess the complaint. When we rang for advice, we were told that notifications, particularly of this nature, are treated as urgent. I'm presuming there would be a ranking applied to the nature of the	The complaint/ notification form outlined on what criteria I could make a notification [AHPRA]; The ambit of their powers is outlined in their first letter of response [AHPRA]; The response letter I received stated the process the investigation would go through [HPCA]	The information in the outcome letter was very clear in letting me know the process will be and how it will take place – such as "action"- response [AHPRA]; I was talked through the process by phone and think every effort was taken to explain all details and procedure [AHPRA]; I was told my complaint to the Dr would be forwarded to the Dr for his reply. They would then assess his reply to my complaint [HCCC]; I was given copies relating to the response of the doctors. I was kept informed about what was happening, at all times [AHPRA]; During a resolution meeting....the

to AHRRA was forthcoming [AHPRA]; They told me nothing of the process and offered no explanation [HCCC]; I was completely excluded from the case, so I am not aware of the criteria that was used [AHPRA]	but at no time indicated what it intended to do with the information or the purpose for which the information was collected	complaint [HPCA]; They mentioned the board had had contact with the psychologist but did not specify how. They did not seek any more information/clarification from the complainant [AHPRA]	resolutions officer had a clear agenda to guide the meeting to ensure all the criteria [issues] was discussed [HCCC]

Unless otherwise indicated, comments apply to all agencies.

Table A6.1.17: Survey 1: summary comment Theme 2A (evidence, investigation, reasons and outcomes) by ranked response

Rank 1 Very unclear	Rank 2 Unclear	Rank 3 Neutral	Rank 4 Clear	Rank 5 Very clear
Themes - Issues unaddressed - Basis of decisions - Assessor qualifications - Role of complainant	Themes - Standards, codes not met - Issues unaddressed - Basis of decisions - Complainant disadvantage	Themes - Issues unaddressed - Basis of decisions - Investigation focus, process - Employer v regulator responsibilities	Themes - Improvements that resulted - Lack transparency in process - Basis of decisions - Complainant disadvantage	Themes - Criteria provided by complainant evidence - Issues unaddressed - Outcome unsatisfactory
Did not address my main complaint [HCCC]; None of the evidence [provided was] investigated [AHPRA]; Based on entirely wrong basis [reading] of the complaint [HPCA]; The way the complaint was investigated it was bound to fail. It was an easy case to prosecute, but the will to do so did not exist [HPCA]; Accurate facts were not a relevant principle in [their] determining [HCCC]; Completely unclear how reached decision [HCCC]; Not expressed in the determination [AHPRA]; I cannot understand how someone can nearly end your life and no consequences to this action [AHPRA]; I don't know what criteria were used, certainly not the ones I expected. At the very least I would have expected an independent inspection of my teeth [AHPRA] No idea... what the qualifications of the assessors are [AHPRA]; Requested the qualifications of the people doing the investigation; the questions that were asked; answers received and how the answers were verified. All of this is secret [HPCA]; Don't know what HCCC said to 'independent clinician' or their qualifications	Treatment [and decision] not consistent with standards or Code of Ethics [AHPRA]; I cannot understand how a decision can be made not to investigate such an incident. The assessment seems to be purely based on the respondent account – absent significant other evidence [HPCA]; The doctors reviewing "side stepped" the wrong medication dosage [issue], causing [the] fall. When I received a phone call from a "contact" person, she said the case would have cost a barrister and she didn't think the HCCC would win (?) [HCCC]; Reason for no action: "not a threat to the general public" whereby [yet] there is a clear risk of psychological impact to previous victims and future victims. Mental health is not addressed at all [AHPRA]; Didn't address the specific areas I identified in my complaint where the practitioner acted unethically [AHPRA]; I don't understand how inaccurate record keeping is an excuse for negligence and a reason not to go forward [AHPRA]; It seems to turn on the subjective and questionable interpretation of the GMP Code by the Medical Council of NSW	The assessment was based on the response of the pharmacist. It is not clear whether the 'panel' relied on independent research of the pharmacist's justification, or any familiarity with current law [HCCC]; There seemed a shift from what I had complained about to focusing on a particular practitioner [AHPRA]; Confusing - reasons given for the matter being HR-surely that would be evident during an initial review of complaint. Who does then monitor clinical practice? [AHPRA]; Feedback was very guarded and the basis for decisions were not clear [HPCA]; The practitioner's opinion, answers or records were given for some aspects of the complaint, but not all issues or responsibilities were addressed [AHPRA]	The Dr was going to have a meeting with the other doctors involved and the administrative staff and try and improve the clinic situation [HPCA] The Commission's reply letter fully explained the reasons for "no further action". Follow-up phone call further reinforced reasoning [HCCC]; AHPRA in general are too secretive and couldn't even provide me with the response that the practitioner made nor did they mention what actions were taken exactly; The criteria seemed narrow enough to not address my main concerns. So the body found an answer that was unsuitable for the problem I brought to their attention [HCCC]; The HCCC did not want to deal with it with the excuse that the original negligence had [not] happened [HCCC]	I sent a signed statement of both episodes. How much clearer can you get [AHPRA]; It was clearly mentioned that the dentist was only interested in making money by hook or crook [HPCA]; My complaint articulated the area of nursing competency not being met and evidence provided to support this [AHPRA] HCCC avoided assessing complaint by stating it related to events too long ago; Definitely [a] Formality. A letter [received] return mail 'No further investigation'. Dead clear- no use whatsoever [AHPRA]

Unless otherwise indicated, comments apply to all agencies

Table A6.1.18: Survey 1: summary comment Theme 2B (balance – fairness and attitude) by ranked response

Rank 1 Very unclear	Rank 2 Unclear	Rank 3 Neutral	Rank 4 Clear	Rank 5 Very clear
Themes: • Lack independence • Bias • Believe practitioner	Themes: • Bias • Believe practitioner • Attitude toward complainant • Complainant disadvantage	Themes: • Bias • Believe practitioner • Indifference	Themes: • Believe practitioner • Too protective of practitioner • Complainant disadvantage	Themes: • Fair to both parties • Law used to benefit practitioner • Took practitioner word
No criteria given except 'the Board' would decide on outcome. One of the clinicians was previously a member of the Board [AHPRA]; Practitioner's claims taken as fact, even though evidence provided to contrary by notifier [AHPRA]; Never really discussed at all. Just a letter. Apparently, a letter from a "doctor" saying "no I didn't" is enough to close a complaint. Excellent use of tax payers' money to protect doctors who use patients as a currency [HCCC]; A bit like lawyers investigating themselves - or politicians looking into politicians [HCCC]; The New South Wales Medical Council is an old boys club [HPCA]; Subjective criteria from prospective of and in the interests of doctors used. No criteria for interference with person and care of patient, protection of person and personal integrity of patient and assurance of proper, necessary and best available care of patient. Criteria used are what doctors need to hide behind, not what patients need for protection [HPCA]	The only criteria [sic] was that doctors wouldn't go against the Dr's!? [AHPRA]; The process chose to take the word of medical staff when they were lying [HCCC]; The investigation process was never defined and the nurses board took the nurses explanation that she did not remember over clear evidence presented [AHPRA] The doctors had the advantage as my medical experience is minimal. And they were able to confer and make their statements together [HPCA] I have no idea other than I was told the minute I opened my mouth that there was no money to be had. I was very offended [AHPRA]; I felt it wasn't taken seriously [HPCA]	The interpretation of events was biased, skewed in favour of him [practitioner] and [name] hospital unit [HCCC]; Accepted comments about...care – seemed disinterested [HCCC]; I understand that the practitioner was asked for a written response to my complaint and they seem to have taken his answers at face value [HPCA] Just went through the motions, that's all [HPCA]; Staff appeared indifferent to the complaint [AHPRA]; I made the complaint just in case my voice might be heard but it seems the system is biased so as not to hear the truth rather to shut people up and pretend to help [AHPRA]	They only took the doctor's opinion [AHPRA]; The criteria used were clear but the process employed was faulty...the agency chose to believe the practitioners without my rebuttal [HCCC] Mostly straightforward. It is a little difficult getting information about a Dr I tend to think they protect them more than they should My word against his – he used so much medical jargon – I didn't understand[HPCA]	I was impressed at the work carried out to be fair to me and the doctors [AHPRA] It was very clear to me that "the Act" (national law) could be biased and used only to benefit the practitioner [AHPRA]; Eventually it was very clear that the investigation simply asked the doctor for her statement and accepted it all, including internal inconsistencies and obviously wrong and incorrect statements of fact [HCCC]

Unless otherwise indicated, comments apply to all agencies.

How well the complainant/notifier was kept informed

Table A6.2.1: Survey 1: how well the complainant/notifier was kept informed: Likert scale responses

	1= Very poorly: no information provided		2= Poorly: minimal information provided		3= Neutral: no opinion either way		4= Well informed: reasonable amount of information provided		5= Very well informed	
	N	%	N	%	N	%	N	%	N	%
ALL	499	29	424	25	318	19	333	19	130	8
AHPRA	306	30	288	28	187	18	184	18	58	6
NSW	193	28	136	20	131	19	149	22	72	11
HPCA	75	27	57	20	53	19	69	25	27	10
HCCC	118	30	79	20	78	20	80	20	45	11
DR	341	33	242	24	182	18	185	18	81	8
<i>All excl. DR</i>	<i>158</i>	<i>23</i>	<i>182</i>	<i>27</i>	<i>136</i>	<i>20</i>	<i>148</i>	<i>22</i>	<i>49</i>	<i>7</i>
NMW	68	21	92	29	66	21	80	25	15	5
PHARM	16	19	25	30	18	22	16	19	8	10
DENT	41	26	35	22	32	21	28	18	20	13
PSY	33	29	30	27	20	18	24	21	6	5
Consumer	360	32	260	23	206	18	202	18	89	8
<i>Cons AHPRA</i>	<i>210</i>	<i>34</i>	<i>168</i>	<i>27</i>	<i>112</i>	<i>18</i>	<i>91</i>	<i>15</i>	<i>40</i>	<i>6</i>
<i>Cons NSW</i>	<i>150</i>	<i>30</i>	<i>92</i>	<i>19</i>	<i>94</i>	<i>19</i>	<i>111</i>	<i>22</i>	<i>49</i>	<i>10</i>
Practitioner	89	25	97	28	67	19	68	19	30	9
Organisation	50	21	67	28	45	19	63	27	11	5

Total may not equal 100% due to rounding

Total response rate for question: 98% N=1704

Table A6.2.2: Survey 1: how well the complainant/notifier was kept informed: Likert scale responses for major practitioner groups, AHPRA and NSW

	AHPRA						NSW					
	DR		NMW		Pharm/ Dent/ Psy		DR		NMW		Pharm/ Dent/ Psy	
	N	%	N	%	N	%	N	%	N	%	N	%
1=No information	196	34	52	23	58	26	145	32	16	17	32	24
2=Minimal information	163	28	62	28	63	29	79	18	30	31	27	21
3=Neutral	97	17	49	22	41	19	85	19	17	18	29	22
4=Reasonable amount of information	90	16	53	24	41	19	95	21	27	28	27	21
5=Very well informed	33	6	8	4	17	8	48	11	7	7	17	13

Total may not equal 100% due to rounding

Table A6.2.3: Survey 1: how well the complainant/notifier was kept informed: Proportion of comments compared with all ranked responses

Rank [1]	AHPRA		NSW		HPCA		HCCC		Total comment		Ranked responses	
	N	%	N	%	N	%	N	%	N	%	N	%
1=No information	140	36	81	35	34	36	47	34	221	36	499	29
2=Minimal information	120	31	41	18	16	17	25	18	161	26	424	25
3=Neutral	62	16	35	15	15	16	20	14	97	16	318	19
4=Reasonable amount of information	47	12	47	20	21	22	26	19	94	15	333	19
5=Very well informed	19	5	29	12	9	9	20	14	48	8	130	8
Total ranked	388	62	233		95	15	138	22	621		1704	
<i>Comment no rank</i>	<i>8</i>		<i>4</i>		<i>3</i>		<i>1</i>		<i>12</i>			
Total	396		237		98		139		633			

[1] Comment frequency prior to thematic coding

Total may not equal 100% due to rounding

Of ranked comments, AHPRA accounted for 62%; HPCA 15%; HCCC 22%

Table A6.2.4: Survey 1: whether the complainant/notifier was kept informed: thematically coded comments by ranked response

	Extent and adequacy of contact and information ²					Process ³				Balance & attitude ⁴			Total
Theme ¹	1A1	1A2	1A3	1B	1C	2A	2B	2C	2D	3A	3B	3C	
All (freq)	305	33	102	50	113	68	9	13	19	16	3	16	747
%	41	4	14	7	15	9	1	2	3	2		2	
AHPRA	178	14	85	36	65	50	6	3	13	9	1	12	472
%	38	3	18	8	14	11	1	1	3	2		3	63
HPCA	51	8	7	11	19	9	1	4	1	1	0	1	113
%	45	7	6	10	17	8	1	4	1	1		1	15
HCCC	76	11	10	3	29	9	2	6	5	6	2	3	162
%	47	7	6	2	18	6	1	4	3	4	1	2	22

1. Ranked comments only included in analysis
2. Adequacy of information, communication: 1A1=No contact, information; 1A2=acknowledgement &/or final letter only; 1A3=Other comment on degree of transparency, contact, engagement; 1B= Complainant/notifier had to initiate contact; 1C= Adequacy/detail of information provided
3. Process: 2A=Timeliness; 2B= Assessment of evidence, understanding of issues; 2C=Able to view, respond to practitioner statement; 2D=management, adequacy of process, powers, outcome, review
4. Balance & attitude: 3A=Level of seriousness, interest, courtesy, helpfulness; 3B=False information from practitioner; 3C= perceived agency probity; assumption practitioner credibility

Table A6.2.5: Survey 1: summary comment Subtheme 1A2 (Acknowledgement and/or final letter only) by ranked response

1=Very poorly: No information	2=Poorly: Minimal information	3=Neutral	4=Well: Reasonable
No communication- just no action would be taken; heard nothing until months later advising no action; generic letter to say closed; letter saying wouldn't be pursued; nothing until final letter; letter saying assessing and letter saying no action/ no investigation; no communication; only initial letter and final letter; two letters- acknowledgement and results unclear- case closed; not kept informed- letter to state would be investigated and letter to state no action would be taken; silence from acknowledgement of the complaint to the "no further action" response	Only letter – 'no action' [HPCA]; only final letter with no explanation [HCCC]; AHPRA: no advice from lodgement to conclusion; information provided was (a) received and (b) resolved; heard nothing until I received a letter stating no further action was required; only contacted me twice. Once to say they accepted the complaint and second to say it was closed; not provided feedback on process- only the outcome with no detail; letter to say they are investigating- letter to say nothing will be done	Letters to confirm receipt and referral only- nothing else; two brief letters at start and end; only final outcome; only when investigation began and when it closed- nothing in between; no discussion entered into; a letter saying that it was "finished" or "resolved" or words to that effect- that was about all; letter to them re complaint, letter returned to me re investigation, letter sent to me: no issue found; only informed at end of process; notified complaint received, notified that dealt with	AHPRA: I complained and received a letter when it had been investigated; I emailed the complaint and then the next response was to receive a letter stating there were no concerns

There was no Rank 5 'very well informed' comments in this subtheme
Unless otherwise indicated, comments apply to all agencies

Table A6.2.6: Survey 1: summary comment Subtheme 1A3 (Other comment on transparency, contact, information) by ranked response

1=No information	2=Minimal information	3=Neutral	4=Reasonable amt.	5=Very well informed
Nomenclature summary				
Nil, no acknowledgement/ information/ contact; secret; hidden; silence; deplorable, disappointing	No information; minimal, infrequent, limited; no communication; insulting, transparency needed	Spasmodic; brief; very little; intermittent; not kept up to date	Reasonably regular; regular; very well; when necessary; occasional; every few months; constant	Constant; very good; regularly; at all times; at every stage; every month or two; kept up to date
1A3=Other comment on degree of transparency, contact, information				
Not kept informed; don't know how conducted investigation; [they made a] vague request for information- not clear what required or why; told what would be done but not how information used; no information on what was being done; no transparency on criteria used to investigate/review complaint; no feedback or follow-up or clarification until final letter [AHPRA]; It appeared that results were going to be kept from me [HPCA]; he only contact I received was a vague request for more information. It is clear they did not even understand the information I provided them [HPCA]; process hidden [HCCC]; I was not consulted prior to decision outcome when communications could not be understood. Decisions were made on assumptions [HCCC]; rang once in the 2 years and 7 months before Dr [name] went to trial [AHPRA]	Communication minimal; one phone call about the issue; very poorly; minor letters advising stage of complaint; template, standard letters, don't provide specific information [AHPRA]; a few form letters; provided extensive documentation, no information about process, little in letters, less when I called; information requested, but little detail on process and procedures, or the progress and timeframes; no information about how the MBA would conduct the review of the conduct of the practitioner complained of; AHPRA: initial letter seemed hopeful but nothing after that, have now called to see what's happening; occasional emails, approximately every four months; a brief note every few months to say "still in progress"; I wasn't kept up to date- vague acknowledgement letters were sent out quite randomly; infrequent communication, multiple investigators over course of complaint, no specific details	Form letters; little information; informed of progress but not details of assessment; no request for contextual or additional information; evidence problems should have been discussed; A brief interim letter only – to say "progressing"; Intermittent communication, months apart and often prompted by my enquiry as to progress; about the process in an administrative sense only; would have preferred more information; I was informed of one stage; clear information, but not very frequently; contact was minimal but may not be necessary; received a couple of letters but hardly contained understandable feedback [HPCA]	Appreciated having the name of a real person to talk to; informed after each process; quite informative; my liaison officer rang several times; kept me up to date with proceedings; very well informed; reasonable, although rating four a little generous; spoke to me when necessary; at intervals- investigation or legal officer gave updates on progress; told what the process was and that my letter and identification would be passed to my colleague for his comments	Very good / excellent communication; kept me updated at all times/ continuously/ always; through phone calls, letters, emails; every month or two would receive letter from Board [AHPRA]; full information provided at every stage; kept in constant communication throughout the whole process; told my complaint to the Dr would be forwarded to the doctor for his reply - they would then assess his reply to my complaint [HCCC]

Table A6.2.7: Survey 1: summary comment Sub-theme 1B: complainant/notifier had to initiate contact by ranked response

1=Very poorly: No information	2=Poorly: Minimal information	3=Neutral	4=Well: Reasonable amt.
Only when I phoned; I had/always had to call; called them <u>every</u> time; always ringing them; wrote multiple times; had to chase them; absolutely no information despite my calls; never informed unless I asked; unless I called was not contacted; heard nothing for months/over a year; had to call, advised in progress then nothing done; felt I was constantly chasing and nothing being done; didn't get back to me at all, only after I rang them; never informed of any stage unless I asked and then only vague time possibility; only way I got contact was to complain [A]	Had to call/email [every/several times/regularly] to find out status/progress/outcome; constantly phoned; unless I called, wasn't kept informed; told would be in mail when ready; my emails/letters were ignored/not answered; no communication as to what would happen; repeatedly unable to contact by phone; had to continually pursue as wouldn't return phone calls or emails; called 5 times over 6 week period before I could speak to anyone in the section who could give me advice; 'pass the buck' or 'we'll call you back' despite repeated requests; only by contacting the Board [A]	Had to chase/prompt/ phone; had to follow up due to lack of contact; communication intermittent/months apart and often prompted by my enquiry about progress; had to call/keep calling for answers; if I contacted the officer, but not always able to get the same one	AHPRA: prompt when I asked for an update; provided I kept emailing; HCCC: when requested; initial contact helpful but I was the initiator in following up

There was no Rank 5 'very well informed' comments in this subtheme
Unless otherwise indicated, comments apply to all agencies

Table A6.2.8: Survey 1: summary comment subtheme 1C: outcome by ranked response

1=No information	2=Minimal information	3=Neutral	4=Reasonable amount
Not informed of any reasons for decisions made; no details of findings [AHPRA] decisions made on assumptions [HCCC]; final letter clinical and unhelpful [HPCA]; no reasons or supporting facts provided [AHPRA]; closed letter with no further action but still not answered any of raised questions [AHPRA]; gave no explanation [AHPRA]	Only informed that the panel decided unsatisfactory conduct and took action [AHPRA]; unclear why the initial reasons provided by HCCC which indicated serious concerns were dismissed by the panel with no explanation [HCCC]; couldn't supply adequate information on the investigation [HPCA]; no explanation- an impersonal letter from Medical Council that said see previous response i.e. doctor had been provided with advice and guidance for future practice	Final letter [said] doctor not at fault, despite impartial opinions finding [significant] permanent damage [AHPRA]; usual perfunctory correspondence, outcome in broad terms [HPCA]; letters saying nothing could be done [AHPRA]	I got some information but was not satisfied with the outcome [HCCC]; final information related to the intern but my complaint was about the pharmacist [AHPRA]; told me what they might do, but gave no promises that anything would be done, or if they would let me know of any decisions made [AHPRA]

There was no Rank 5 'very well informed' comments in this subtheme

Table A6.2.9: Survey 1: summary comment Theme 2: process by ranked response

1=No information	2=Minimal information	3=Neutral	4=Reasonable amount	5=Very well informed
Subtheme A: timeliness				
AHPRA/HCCC: So slow; huge time delays; months with no information; no information after acknowledgement until over a year/ 14 months/18 months later	AHPRA/HPCA: Extraordinarily slow; delays/long delays/don't hear anything for months [6-9months]; took 5-6 months for reply; received a letter months after I reported myself; told 3 months after referred when asked that "nothing happens overnight"; one letter in 12-18 months then flurry of activity asking for information about events years ago; no improvement in timeframes or communication when requested review	A bit slow on doing things; very slow/very long/ drawn out process; months go by and no correspondence; over 12 months waiting for an outcome; too long; timelines at every step were excessive; good information though huge time gaps; timely [HCCC, HPCA]	AHPRA: Slow; long time/ delays; 5 years to assess a long time when all evidence there; not informed that would not be acted on for months; no reason as to why took so long; no timeframes given; kept advised about endless extension times for practitioner, but forwarded responses fairly rapidly once received; HPCA: took a long time; quite a long period waiting for response; HCCC: outcome within 2 months; candid about reasons for delay	Letters prompt and informative [HPCA, HCCC]; answer received in advised timeframe [HCCC]; acknowledged within 5 days of receipt [AHPRA]

Unless otherwise indicated, comments apply to all agencies

Table 6.2.10: Survey 1: summary comment Sub theme 2B (able to view or respond to practitioner response) and Subtheme 2C (process) by ranked response

1=No information	2=Minimal information	3=Neutral	4=Reasonable amount	5=Very well informed
Subtheme 2B: able to view or respond to practitioner response				
	Asked, but not acted on; refused right of reply; refused even though he had access to everything we submitted; AHPRA: given response but when questioned accuracy told 'case closed'	HPCA: Reasonable amount of information though not allowed to know psychologist's responses	Informed initially that practitioner refused access- so it was one sided [HPCA]; letters included practitioner reply [HCCC]; asked to comment on practitioner statement [AHPRA]	HCCC: informed but no access to practitioner's answers; sent copies of doctor's letters; final 'report' a very self-exculpatory letter but contained all the answers I couldn't get directly
Subtheme 2C: Other process comment				
No opportunity to appeal/ contest [AHPRA]; made institutional complaint but continued to contact me despite no longer representing organisation [AHPRA]; legal rights ignored [AHPRA]; tried to stop [interfere with] request for review [HCCC]; suddenly received response directly from practitioner- felt safety could have been in jeopardy as wanted them to stop practising [HCCC]	AHPRA/HPCA: No confidence serious issues [fitness to practice, practitioner and community safety] being prioritised and acted on; poor management of information gathering; multiple investigators; repeat additional information requests	Not confident complaint understood and able to be explained to other parties (HCCC); notifications done [made] over years so information not properly understood [AHPRA]	Advised when they had information, problem was hospital not cooperating (HCCC)	

Unless otherwise indicated, comments apply to all agencies

Table 6.2.11: Survey 1: summary comment Theme 3: attitude and balance by ranked response

1=No information	2=Minimal information	3=Neutral	4=Reasonable amount
Subtheme A: Level of seriousness, interest, courtesy, helpfulness			
'Pass the buck' or no information given or we'll call you back which doesn't eventuate [AHPRA]; brushed under carpet; brusque; rude; self-serving; no empathy; no respect; unfeeling; not given any support	No serious effort by investigators; uneasy feeling not knowing if any action or interest; remote	Felt brushed off; could be more follow up support; not one person to guide through process; communication never open/ honest	Treated with respect- felt they were doing their best
Subtheme 3B: Perceived fairness - agency probity; assumption practitioner credibility			
Cover up; secretive, protects doctors not community; doctor's word means more than mine; looking after their own; one sided; tried to stop request [for review] [HCCC]; no opportunity to appeal, contest [AHPRA], had to go through FOI to find out [AHPRA]; letter based on false information from practitioner, not verified with me	Just told me practitioner did nothing wrong and no further action- in other words I'm a liar [HCCC]; false allegations made but no right of reply [HCCC]; corrupt organisation [AHPRA]	AHPRA: Positives for practitioner when they didn't know full facts- practitioner was presumed right; doctors word gospel; me I'm just a liar; took his word for it; doctor lied	Well informed AHPRA were on the side of doctor's bad diagnosis; seems views of practitioner carried greater weight [HCCC]
Unless otherwise indicated, comments apply to all agencies			

How well reasons for decisions were explained

Table A6.2.12: Survey 1: how well reasons for decisions were explained: Likert scale responses

	Rank 1 Very poorly: Reasons not given at all		Rank 2 Poorly: minimal information for reasons provided		Rank 3 Neutral: no opinion either way		Rank 4 Well: reasonable amount of information about reasons		Rank 5 Very well: reasons very well explained	
	N	%	N	%	N	%	N	%	N	%
ALL	593	35	461	27	267	16	263	16	107	6
AHPRA	377	37	292	29	142	14	156	15	50	5
NSW	216	32	169	25	125	19	107	16	57	8
HPCA	93	34	62	22	50	18	51	18	22	8
HCCC	123	31	107	27	75	19	56	14	35	9
DR	387	38	293	29	140	14	146	14	57	6
All excl. DR	206	31	168	25	127	19	117	18	50	7
NMW	102	32	70	22	63	20	61	19	23	7
PHARM	27	33	22	27	15	18	15	18	4	5
DENT	45	29	40	26	29	19	21	14	18	12
PSY	32	28	36	32	20	18	20	18	5	4
Consumer	414	37	305	28	166	15	150	14	72	6
Cons AHPRA	258	42	183	30	70	11	76	12	29	5
Cons NSW	156	32	122	25	96	20	74	15	43	9
Practitioner	114	33	102	29	52	15	62	18	20	6
Organisation	65	28	54	23	49	21	51	22	15	6

Total may not equal 100% due to rounding

Total response rate for question: 98% N=1691

Table A6.2.13: Survey 1: how well reasons for decisions were explained: Likert scale responses for major practitioner groups, AHPRA and NSW

	AHPRA						NSW					
	DR		NMW		Pharm/ Dent/ Psy		DR		NMW		Pharm/ Dent/ Psy	
	N	%	N	%	N	%	N	%	N	%	N	%
1=Reasons not given	234	41	72	32	71	32	153	34	30	31	33	26
2=Minimal information given for reasons	176	31	52	23	64	29	117	26	18	19	34	26
3=Neutral	69	12	43	19	30	14	71	16	20	21	34	26
4=Reasonable amount of information for reasons	72	13	41	18	43	20	74	17	20	21	13	10
5=Reasons very well explained	23	4	15	7	12	6	34	8	8	8	15	12

Total may not equal 100% due to rounding

Table A6.2.14: Survey 1: how well reasons for decisions were explained: proportion of comments compared with all ranked responses

Rank [1]	AHPRA		NSW		HPCA		HCCC		Total comment		Ranked responses	
	N	%	N	%	N	%	N	%	N	%	N	%
1=Reasons not given	161	43	83	40	36	43	47	38	244	42	593	35
2=Minimal information for reasons	124	33	54	26	19	23	35	28	178	30	461	27
3=Neutral	38	10	20	10	8	10	12	10	58	10	267	16
4=Reasonable amount of information for reasons	40	11	27	13	15	18	12	10	67	11	263	16
5=Reasons very well explained	14	4	24	12	6	7	18	15	38	6	107	6
Total ranked	377		208		84		124		585		1691	
<i>Comment no rank</i>	16		10		5		5		26			
Total	393		218		89		129		611			

[1] Comment frequency prior to thematic coding

Total may not equal 100% due to rounding

Of ranked comments, AHPRA accounted for 64%; HPCA 14%; HCCC 21 %

Table A6.2.15: Survey 1: how well reasons for decisions were explained: thematically coded comments, frequency by ranked response

Comment [1]	Adequacy of explanation [2]					Balance & attitude [3]			Process [4]		Total
Theme	1A	1B	1C	1D	1B-1D	2A	2B	2C	3A	3B	
All.	138	195	78	49	322	8	24	88	11	19	610
%	23	32	13	8	53	1	4	14	2	3	
AHPRA	104	125	57	30	212	0	18	45	5	11	395
	26	32	14	8	54	-	5	11	1	3	
HPCA	24	25	6	7	38	0	1	12	0	5	80
	30	31	8	9	48	-	1	15	-	6	
HCCC	10	45	15	12	72	8	5	31	6	3	135
	7	33	11	9	53	6	4	23	4	2	

1 Ranked comments only included in analysis

2 Adequacy of information, communication: 1A=No reasons given; 1B= Adequacy or detail of explanation; assessment of evidence

3 Balance & attitude: 2A=Level of seriousness, interest, courtesy, helpfulness; 2B=False information from practitioner; 2C= perceived agency probity; assumption practitioner credibility

4 Process: 3A= Able to view, respond to practitioner statement; 3B= Other process comment

Table A6.2.16: Survey 1: summary comment subtheme 1A: reasons for decisions not provided by ranked response

1=Very Poorly Reasons not given at all [79% of comments]	2=Poorly Minimal information about reasons [18%]	3= Neutral	4= Well
Don't know- no communication [HPCA]; would not discuss on phone or answer email [AHPRA]; no reasons; never explained; no discussion; not explained at all; given no information; informed of decision without reasons; 2 line letter saying dismissed [AHPRA]; impersonal generic letter [HPCA]; not required by Act [AHPRA]; repeatedly told 'can't answer' [AHPRA]; can only give information which is publicly available and "an FOI request would be unsuccessful" [AHPRA]; The rationale for decisions were "the board has decided" - as a health professional, I found this demeaning and subversive [AHPRA]; impersonal generic letter, explains absolutely nothing [HPCA]; don't feel explained at all by NMW Council; no reasons- just that matter dismissed [HPCA]; decision made and matter closed [HCCC]; just told dentist cleared of all wrongdoing [HCCC]	No rationale; no reasons; letter informed me closed; called but no information given [HPCA]; letter just said no further investigation would be done [HCCC]; AHPRA: listed possible actions but didn't specify what or why; did not divulge the reasons, however, appreciate some steps taken to remedy practice at that surgery; short sharp letter informing me not proceeding, no explanation; informed of outcome but no reason; was hoping for some understanding of how my complaint would be dealt with but got none	AHPRA: not explained; do not know outcome	HPCA: decision of the nurse requiring retraining/ performance program was not explained

Unless otherwise indicated, comments apply to all agencies. There were no Rank 5 ("Reasons very well explained") comments

Table A6.2.17: Survey 1: summary comment subtheme 1B: adequacy or detail of explanation by ranked response

1=Very Poorly	2=Poorly	3= Neutral	4= Well	5=Very well
Poor; very poor; partial; superficial; contradictory; illogical; vague; unrealistic; not well at all; incomprehensible; fabricated; dismissive; inaccurate; irrelevant to complaint; half answers; puzzled by reasons and didn't comprehend; only told believed the other party [AHPRA]; more detail should have been provided e.g. within normal ranges, proportion of patients experiencing pain [AHPRA]	Limited; minimal; brief; vague; inadequate; lack detail; lack logic; legal reasons did not make sense; jargon; cursory; insufficient; terse short letter, second paragraph inaccurate; less than a page with one paragraph explaining decision made on 200 page complaint [AHPRA]; not given much information about why they came to conclusion [HPCA]; not sufficiently informed of justifiable reasons [AHPRA]; complaint too minor for our workload [HCCC]; investigated and no basis found [AHPRA]; given standard script of response [AHPRA]; had to phone Council for information regarding progress and told registration surrendered [but] no letter advising this development received to date [HPCA]	Not well understood – phone call would have been better [AHPRA]; not explained or why acceptable; no detail; explained but not convincing/ not satisfactory; acceptable; dismissed as irrelevant [HCCC]; in general terms but conditions [on practice] told me what I needed to know [HPCA]	Basic; unclear as outcome unknown; listed possibilities only [AHPRA]; maybe I didn't understand very well; adequate; fully explained; sufficient; clear and understood; in letters; on phone; outlined major points of complaint and practitioner's responses [HPCA]	Through calls, letters, emails; clear; precise; thoroughly; well/ very well informed; explained; lengthy discussion after case closed helpful [AHPRA]; understood it was not a major practice issue [HPCA]; informed no action as registration withdrawn [AHPRA]

Table A6.2.18: Survey 1: summary comment subtheme 1C: assessment of evidence; adequacy of investigation; whether issues addressed by ranked response

1=Very Poorly	2=Poorly	3= Neutral	4= Well	5=Very well
Explanation doesn't take into consideration all aspects of case; didn't address/ understand issues; said no evidence despite providing, not satisfied dealt with correctly; explanation didn't match anything in complaint; misinterpretation of documentation provided; evidence provided dismissed/ignored, some issues not addressed; missed most important aspects of complaint; didn't interview others; no thorough investigation; requested where information was from, told case closed [HCCC]; decision made without mediation or consultation [HCCC]	Misunderstood/ didn't address core issues or assess evidence, no attempt to address any of my complaints, re-versioned events; did not relate to my situation, failed to actually engage with the detail of the arguments in the written complaint; didn't answer questions in complaint, ignored them; identified several issues not addressed; substance of complaint not addressed only that practitioner's treatment "appeared" to be consistent with current practice [AHPRA]; unclear 'may be unsatisfactory and took relevant action' - if took relevant action, why state 'may', why not state 'unsatisfactory [AHPRA]'; reasons demonstrated lack of investigation [AHPRA]; said couldn't substantiate rather than coming to me for more information	Reasons but not explained or why what occurred acceptable; core issue, information ignored; structural part of my complaint pretty much ignored; information I provided overlooked; not all issues addressed; letter from practitioner provided but no proper investigation	Said followed protocol- did not address issue [timing, not whether protocol followed]	Missed whole point of making complaint

Unless otherwise indicated, comments apply to all agencies

Table A6.2.19: Survey 1: summary comment subtheme 1D: outcome by ranked response

1=Very Poorly	2=Poorly	3= Neutral	4= Well	5=Very well
Only advised that had been resolved with no action to be taken and [after review] that [they] had conditions applied [AHPRA]; told totality of evidence doesn't support finding of a departure from professional standards but failed to [name procedure] for nearly a year- is this the standard expected of a specialist? [HCCC]; only told believed other party; breach and cautioned but no explanation why only a caution and no 'flag' on public record in case of reoccurrence [AHPRA]; being advised surgeon would receive a letter of guidance and support is a joke" [HPCA]; despite evidence and inability of practitioner to explain himself, found did nothing wrong; Waste of time lodging complaint as I felt it was in public interest [AHPRA]	Hard to accept 'no action when unprofessional practice basically acknowledged; response directly opposite to that of other regulator [AHPRA]; not sufficient to justify taking no further action; little peeved that he defrauded Medicare, did not treat me and showed a total lack of professionalism and was cautioned [AHPRA]; reasons explained but I disagree with them [HCCC]; decision advises me system improvements have been identified- such as what- identified several which have not been addressed	Poor correlation to medical competency standards; unsatisfactory decision- but explained; decisions reasonably well communicated even if I didn't agree with them; explained but unconvincing; unsure but recall at time of mediation patient advised okay with outcome [HCCC]; outcome reflected evidence and my expectations; not happy with decision; thought a warning at least should have been the outcome [HPCA]; cannot understand how a repeat offender can continue to practice as he does [HPCA]; happy to get money back [HCCC]; they seemed to accept that they had very limited scope, authority or powers to take any real action [HCCC]; thought a warning at least should have been the outcome [HPCA]	Understood brought to practitioner attention and would be supervised and counselled; decision was no significant departure from standard of care- on receipt of this, I requested a review [HCCC]; reasons for not doing anything explained well enough; sufficient information which appeared to also protect privacy of practitioner though don't believe outcome fair; AHPRA: understand why Doctor should attend educational program but can't understand why not on public record or stronger disciplinary action taken; told would inform future notification- reassuring but not fair to me and fear safety of others; didn't want disciplinary action but poor care and over-servicing addressed; reasons explained well enough- toothless tiger	AHPRA/ HCCC: explained and happy with outcome; satisfied to some extent; HCCC: losers here [over-servicing] are the public and the profession; they had explained their powers were limited

Unless otherwise indicated, comments apply to all agencies

Table A6.2.20: Survey 1: summary comment theme 2 (balance and attitude) by subtheme and Likert scale rank

1=Very poorly	2=Poorly	3= Neutral	4= Well	5=Very well
Sub-theme 2A: Level of seriousness, interest, courtesy, helpfulness				
HCCC: Fobbed off, outcome letter to make me go away; made to feel caseworker didn't want to do their job	HCCC: doubt anyone with interest viewed complaint; reviewing doctor didn't take seriously; they'd prefer I go away		HCCC: no help- fobbed off	
Sub-theme 2B: Decision based on false information from practitioner				
HCCC/AHPRA: Reasons based on inaccuracies ; AHPRA: based on lies, false statements (from doctor, nurse, pharmacist, dentist); doctor replied with inaccuracies , would have identified if new practitioner interviewed; didn't explain why they accepted false evidence that was disproved	HCCC/ AHPRA: Lies, false assertions , letter repeated false information from practitioner; practitioner false assertions could have been demonstrated if investigated; lied about observation; accepted as truth	AHPRA: Doctor told so many lies	Gave reasons, but some of the information based on doctor's recollection which was not correct ; decision based on false statement from practitioner; decision based on partly inaccurate information; decision explained but not fair, due to contempt for truth and cover up by doctor	
Sub-theme 2C: Perceived agency probity; assumption practitioner credibility in making decision				
Cover up; corrupt; practitioner disputes and they accept without verifying ; all one sided (doctor, dentist, pharmacist); they are doctors, so believed; distinct impression sole purpose is to protect offending practitioner and make it as difficult as possible to pursue complaint [HCCC, AHPRA]; compounded by poor communication and legal jargon [AHPRA]; doctor/NMW statement taken as fact even though evidence to contrary/no documents to support ; merely quoted statements by dentist/doctor;	Cover up; took (doctor, dentist, nurse) word ; refused to consider lying ; implied I was incompetent or lying; accepted biased explanation ; only took advice from dentist who contradicted us; repeated (psychologist, pharmacist) defence and ordinary member of public has less standing ; paraphrased doctor and didn't address issues; seemed like a 'he said- she said' situation and they believed him over me... both our notes should have had equal veracity; accepted biased explanation by hospital; accepted on face value that practitioner followed guidelines	HCCC/ AHPRA: Biased; based on practitioner submission ; practitioner view only ; doctor word accepted regardless of evidence ; word accepted even if didn't address issue; boys club ; information twisted to suit outcome of investigating body; doctor's letter given a lot of credence and things taken into account even if didn't address complaint; view of practitioner the only view really considered ; no idea why didn't pursue other than take the word of the practitioner over the client ; Final letter unhelpful- didn't feel natural justice observed- felt lazy, biased approach to whole process.	HCCC: explained but felt sided with doctor ; reasons appear rationalisations ; whitewash; defensive	Affront to the intelligence and integrity of complainant; accepted totally what dentist said without evidence from other staff present [HCCC]; practitioner said didn't do it [AHPRA]. Well explained, always taking account all parties points of view [HCCC]

Unless otherwise indicated, comments apply to all agencies

Table A6.2.21: Survey 1: summary comment theme 3 (other process comments) by subtheme and Likert scale rank

1=Very poorly	2=Poorly	3= Neutral	4= Well	5=Very well
Sub-theme 3A: Ability to view, respond to practitioner's statement				
Disappointing national system does not allow obtaining a copy of expert review report outright, had to go through FOI [AHPRA]; practitioner responses 'confidential', a farce [HCCC]	Would have liked to have seen practitioner's response [AHPRA]; just given copy of doctor's reply [HCCC]; explained that doctor requested I not get a copy of his response but he was able to see my complaint ('HCCC rules')- how unfair is this?; sent a copy of the doctor's reply but no explanation on why only a caution issued and why not recorded to 'flag' if this is a recurring practice [AHPRA]	Letter from practitioner provided but no proper investigation [HCCC]		
Sub-theme 3B: Other process comment – timeliness, communication; review				
No decision for >6 months relating to unsafe practice; fitness assessment but no decision and practicing a year later; not contacted for information [impairment, errors matter] and when complained post-decision told decision cannot be reversed but could complain to Ombudsman [AHPRA]; only benefit from process was finding out through FOI what was being said about me; awaiting final answer; had to chase up result myself	Had to call and ask for details, one of the rare occasions call returned [HCCC]; I had to call to seek progress- told nurse had surrendered registration, no letter advising this received to date [HPCA]; given an abbreviation of the Independent Opinion provided- without easy access to the whole submission, I only have minimal information [AHPRA]	AHPRA: took too long- not told of litigation avenue until after option expired; well informed until referred to AHPRA; not aware HCCC was part of process	Necessary to call to know what was going on [AHPRA]; informed at times of process; no complaints about feedback to my calls [AHPRA]; kept updated with emails, letters	Excellent communication [HCCC]
Unless otherwise indicated, comments apply to all agencies				

Whether the complaint/notification process was fair

Table A6.3.1: Survey 1: whether the process was fair: Likert scale responses

	Rank 1 Very unfair		Rank 2 Unfair		Rank 3 Neutral: no opinion either way		Rank 4 Fair		Rank 5 Very fair	
	N	%	N	%	N	%	N	%	N	%
ALL	647	39	315	19	382	23	205	12	122	7
AHPRA	395	39	179	18	234	23	131	13	68	7
NSW	252	38	136	20	148	22	74	11	54	8
HPCA	85	31	42	15	81	29	41	15	27	10
HCCC	167	43	94	24	67	17	33	9	27	7
DR	443	44	224	22	194	19	101	10	50	5
<i>All other practitioners</i>	<i>204</i>	<i>31</i>	<i>91</i>	<i>14</i>	<i>188</i>	<i>29</i>	<i>104</i>	<i>16</i>	<i>72</i>	<i>11</i>
NMW	72	23	32	10	107	34	59	19	42	14
PHARM	26	32	11	13	18	22	19	23	8	10
DENT	70	46	26	17	30	20	12	8	16	10
PSY	36	32	22	20	33	30	14	13	6	5
Consumer	525	48	230	21	195	18	100	9	55	5
<i>Cons AHPRA</i>	<i>313</i>	<i>51</i>	<i>124</i>	<i>20</i>	<i>100</i>	<i>16</i>	<i>54</i>	<i>9</i>	<i>23</i>	<i>4</i>
<i>Cons NSW</i>	<i>212</i>	<i>43</i>	<i>106</i>	<i>22</i>	<i>95</i>	<i>19</i>	<i>46</i>	<i>9</i>	<i>32</i>	<i>7</i>
Practitioner	20	8	28	12	94	39	50	21	34	14
Organisation	102	30	57	17	93	27	55	16	33	10

Table A.6.3.2: Survey 1: whether the process was fair: Likert scale responses for major practitioner groups, AHPRA and NSW

	AHPRA						NSW					
	DR		NMW		Pharm/ Dent/ Psy		DR		NMW		Pharm/ Dent/ Psy	
	N	%	N	%	N	%	N	%	N	%	N	%
1=Very unfair	258	45	48	22	89	41	185	42	24	26	43	33
2=Unfair	124	22	19	9	36	17	100	23	13	14	23	18
3=Neutral	107	19	81	37	46	21	87	20	26	28	35	27
4=Fair	60	11	41	19	30	14	41	9	18	19	15	12
5=Very fair	23	4	29	13	16	7	27	6	13	14	14	11

Total may not equal 100% due to rounding

Table A6.3.3: Survey 1: whether the process was fair: proportion of comments compared with ranked responses

Rank	AHPRA		NSW		HPCA		HCCC		Total comment		Ranked responses	
	N	%	N	%	N	%	N	%	N	%	N	%
1=Very unfair	181	46	111	47	41	43	70	50	292	46	647	39
2=Unfair	95	24	61	26	20	21	41	29	156	25	315	19
3=Neutral	80	20	36	15	22	23	14	10	116	18	382	23
4=Fair	28	7	14	6	9	9	5	4	42	7	205	12
5=Very fair	13	3	15	6	4	4	11	8	28	4	122	7
Total ranked	397		237		96		141		634		1671	97
<i>Comment no rank</i>	<i>23</i>		<i>22</i>		<i>7</i>		<i>15</i>		<i>45</i>			
Total	420		259		103		156		679			

[1] Response comment frequency prior to thematic coding

Table A6.3.4: Survey 1: whether the process was fair: thematically coded comments by ranked response

Comment [1]	Adequacy contact, information [2]		Process & outcome [3]				Balance & Attitude [4]			Total
	1A	1B	2A	2B	2C	2D	3A	3B	3C	
All	124	45	102	140	48	67	46	27	153	752
% total	16	6	14	19	6	9	6	4	20	
% category	73	27	29	39	13	19	20	12	68	
AHPRA	87	34	63	79	36	42	27	15	91	475
% total	18	7	13	17	8	9	6	3	19	
HPCA	15	4	15	30	3	8	8	3	19	105
% total	14	4	14	29	3	8	8	3	18	
HCCC	22	7	24	31	9	17	11	9	43	167
% total	13	4	14	19	5	10	7	5	26	

[1] Ranked comments only included in analysis

[2] Adequacy contact; information: 1A=Level of transparency, contact, engagement about process; 1B= Adequacy or detail of information provided about decisions and reasons

[3] Process & outcome: 2A= Assessment of evidence, understanding of issues; adequacy of investigation; 2B= Outcome; 2C=Able to view, respond to practitioner statement; appeal; 2D= Other process comment

[4] Balance & attitude: 3A=Level of seriousness, interest, courtesy, helpfulness; 3B=Decision based on false information from practitioner; 3C= perceived agency probity; assumption practitioner credibility

Table A6.3.5: Survey 1: summary comment Theme 1 (adequacy of contact and information) by ranked response

1=Very unfair	2=Unfair	3=Neutral	4=Fair	5=Very fair
Sub-theme 1A: Transparency, contact, engagement				
Not fair as I still don't know what really happened; how could I know?; not advised of process; not given any information; this is a process with no feedback , no information sharing, no transparency ; didn't consult me; [I] requested information about case but got no answer [AHPRA]; no contact – faceless treatment. Everything that could be done to keep us at arms-length is done [AHPRA]; we had no visibility of the process. AHPRA appears to have undertaken no process at all	Still unsure of process ; process closed ; secretive ; we were given minimal information ; no consultation; no interview; not contacted to provide further information; they should have contacted me as well; not given a chance to further explain	Not sure what process was used - therefore cannot comment; process secret ; opaque ; difficult to say as so little information provided; no idea what happened; unable to assess as no information ; no information provided despite my request; given no details of the process so unable to answer; still not sure who is on the deciding panel; don't know how the investigation was conducted; don't know how decisions reached	Would have liked to be told outcome before closed; process fair but don't agree with them closing the investigation before obtaining my response; it was ok, but didn't have much input into process after made initial complaint AHPRA: I believe was investigated and both parties given good opportunity to comment ; always able to provide our version of events	HCCC: all parties given opportunity to respond ; procedures clear ; AHPRA: very fair to doctors and myself- responded in writing and informed of responses ; felt consulted and listened to at all times
Sub-theme 1B: Adequacy or level of detail of information provided				
Unfair as no reason given ; no detail of outcome; made little sense; don't even know if he was disciplined; they said "this is the decision, that's it" [AHPRA]; no information to show if the records suggested to be retrieved by the Board were collected or reviewed	AHPRA & HCCC: Still unaware of the precise rationale behind decision; no clear explanation as why no action to be taken	AHPRA & HCCC: no idea how fair without knowing outcome ; still don't have clear explanation ; don't know outcome ; not sure if cautioned; don't really understand the final response [AHPRA]; glad looked into but not sure about action taken [AHPRA]	HPCA: no definitive outcome explained ; it was ok- the letter was clear and outlined why the decision was made	-

Unless otherwise indicated, comments apply to all agencies

Table A6.3.6: Survey 1: summary comment subtheme 2A (assessment, understanding of issues, adequacy of investigation) by ranked response

1=Very unfair	2=Unfair	3=Neutral	4=Fair	5=Very fair
Evidence ignored; ignored evidence in my favour; witness statements ignored; many things not considered; complaint misunderstood; complaint not addressed; ignorance of issues; no interview or follow up for the information I provided in my initial complaint so I had no way to know if my complaint had been understood as intended [AHPRA]; Not investigated; thought would be investigated more thoroughly; not sure practitioner was even questioned in front of Board [AHPRA]; no evidence was sought despite Board stating "issues raised were very serious"; HCCC refused to investigate- arrived with minor injury and left with broken neck	Core issues not addressed; most issues not discussed; illogical response from doctor not fully taken into account; despite all documented proof no action taken; didn't take all concerns into account; have not considered my situation; wrong questions investigated; not robustly investigated; appears little or no independent assessment of the points of complaint or response; I understand that a lot of the assessment is based on records. The doctor had an unfair advantage in that his records were substantial and I only had a record of the incident; If the HCCC had inspected the practitioner's work, they would have seen the issue; the body asked to see the file of the psychiatrist. As if the psychiatrist is going to record her bullying and aggressive tactics? AHPRA]	Told no evidence but provided Don't believe investigated properly; average – no response sought from doctors complained about before the closure of the matter[HPCA]	AHPRA: Dentist has come under scrutiny in past- why couldn't investigators carry on?; good but limited by a missing step- a complainant should have a form to sign to say that they have been adequately heard; my immediate concern was my health and that wasn't addressed; HPCA: they gathered information from both sides	Got all the information and investigated; thorough investigation was carried out

Unless otherwise indicated, comments apply to all agencies

Table A6.3.7: Survey 1: summary comment subtheme 2B: (outcome) by ranked response

1=Very unfair	2=Unfair	3=Neutral	4=Fair	5=Very fair
Outcome didn't reflect evidence; points not addressed; main issue not addressed; I expected some favourable results because my case is so serious; nothing resolved or event attempted to be; with no action, doctor will continue to act in this way; nearly killed me- no penalty; doctor got away with negligence and I am still having problems today	Unsatisfactory outcome; don't feel justice has prevailed- breaking the law deserves a lot more than a 'counselling' phone call; process fair but 'slap on the wrist' for a death [HPCA]; any changes advised by AHPRA were only temporary and partial	Outcome doesn't ensure safe standards of practice; Practitioner replied to the satisfaction investigators – not mine; fair process but outcome not fair; I don't believe the outcome matched the seriousness of the issue	Process was probably fair- the criteria for decision-making is the concern [AHPRA]; the doctor should have been given a professional "smarten up" rap over the knuckles [HCCC]; appropriate outcome; fair in that doctor doesn't work in the [sector] anymore; at least [they] looked into matter	Fair– except the Dr should have been reprimanded; outcome as expected; appeared reasonable and took all matters into consideration; good outcome, happy with outcome; respected AHPRA's professional decision

Unless otherwise indicated, comments apply to all agencies

Table A6.3.8: Survey 1: summary comment subtheme 2C (ability to read and respond to practitioner statement, ability to seek review or appeal) and subtheme 2D (other) by ranked response

1=Very unfair	2=Unfair	3=Neutral	4=Fair	5=Very fair
Subtheme 2C: able to read or respond to practitioner response; seek review or appeal				
No chance to reply; no opportunity to read doctor/ nurse / psychologist response; no right of reply [AHPRA]; not procedurally fair [AHPRA]; AHPRA is not accountable to the extent that its decisions cannot be challenged outside of AHPRA; no avenue for appeal	No chance to review or respond to doctor's responses; they should have given the complainant an opportunity to respond. AHPRA: no independent umpire; no chance of appeal or accountability for the decision or process taken.	AHPRA & HPCA: no chance to respond to practitioner's responses	AHPRA: subject has right to respond to notification; the doctor read my complaint and responded but I could not comment on his response or statement of events; I was invited to respond to comments made by the practitioner I complained about	-
Subtheme 2D1: timeliness				
AHPRA: long delays in responding to my communication and then threatening when requesting response from myself; unreasonable delays; seven and a half months- you call that fair	HPCA: Delays significant hardship for complainant and practitioner. AHPRA: took far too long; practitioner given excessive time to respond; length of process unfair to practitioner; long process. HCCC: prompt response despite unfavourable outcome	AHPRA: took too long; more a matter of taking action before more harm was done; doctor given extra time; major time delays; felt rushed	AHPRA: fair but very protracted; took a long time; a long process but to obtain good result will take time	AHPRA: process just and efficient; HPCA: handled well; HCCC: it was dealt with in good time
Subtheme 2D2: other process comment				
AHPRA: has been no process; safety issues ignored because Family Court [involved]; affected our relationship (negatively) with the doctor; Board reversed the complaint to [one] about me; no opportunity to be present at the Board's review...no legal support provided despite a staff member stating Doctor's often seek legal advice which is why it can take so long for them to respond. HPCA: process didn't adhere to rule of law; denied access to resolution program; HCCC: did not provide alternative solutions; [5 year] time limit unacceptable- medical records are kept for 7 years-too traumatic to address any earlier; happy to be referred elsewhere, but files sent to where practitioner and internal investigator worked	AHPRA: should have been a chance to talk it out in front of Board; unfair that doctors who have illness are treated [as are]- emphasis on complaining- should be an alternative process HCCC: no conciliation; hospital not required to comply and be called to account for doctor's actions; unsatisfactory buck-passing	AHPRA: Still not sure who is on the deciding panel. e.g. peers; practitioner should not just be able to ignore a request; did what it was supposed to but follow up required; HPCA: process seemed ok; reporting a colleague is very intimidating as there is no opportunity for anonymity, preventing worthwhile complaints being made; HCCC: investigation process potentially fair, resolution process not implemented well	appeared fair; however lack of appreciation of the fair and equitable internal processes already undertaken to address the situation prior to reporting [AHPRA]; addressing notification does not address the harm [by violent individuals in the workplace]; conciliation process through HCCC good- got to have my say; both sides had due process [HCCC]	Process handled well [HPCA]; process just and efficient [AHPRA]; gave me an avenue to use, to complain [HCCC]; process both addressed my concerns and gave the practitioner the opportunity to address these in the early stages of the complaint- therefore, fair for both parties [AHPRA]

Unless otherwise indicated, comments apply to all agencies

Table A6.3.9: Survey 1: summary comment Theme 3 (balance & attitude) by subtheme and by ranked response

1=Very unfair	2=Unfair	3=Neutral	4=Fair	5=Very fair
Subtheme A: Level of seriousness, interest, courtesy, helpfulness				
It was like I did not exist ; feared my concerns were simply dismissed ; patient felt no rights to make complaint and no respect given; not interested in what I had to say; appeared to have been ignored ; did not keep me informed [about review] and was cold and uncaring when decision came through- awful; rudely treated; why would anyone bother to complain if they are treated without dignity and respect	Wasn't taken seriously ; not taken seriously as I am a pharmacotherapy client (no rights!); AHPRA: process fair, but result was a slap on the wrist for a death. No consideration for family or pain of the loss ; I feel because it wasn't a very serious complaint (e.g. sexual abuse) that it was brushed off	HCCC: responded, however, they did not care ; AHPRA: I didn't judge fairness- left it to investigators to decide ; this is not for me to judge	Looked at both sides and judged fairly; both sides treated equally and with respect ; felt part of my complaint was treated seriously and pursued; they care [AHPRA]	Took the complaint very seriously and they work hard to try to solve the issues [AHPRA]; both parties treated respectfully and according to the legislation [AHPRA]; overly so [AHPRA]; they went out of their way to accommodate me even though the complaint was outside of their realm [HPCA]; I felt I had control over how to proceed [HCCC]
Subtheme 3B: False information from practitioner				
A pack of lies and fictitious claims; these doctors lied; believed the doctors lies; not given the chance to challenge her lies	He repeatedly gave the Board false and misleading information ; wrote a letter pointing out the lies; the reply by the practitioner was untrue	AHPRA: no one asked if she lied; the dentist lied	AHPRA: the answer he gave was inconsistent with the truth	-
Subtheme 3C: perceived agency probity; assumption practitioner credibility				
Biased ; inbuilt assumption that everything said by doctor was true; one-sided; completely favours the practitioner ; doctor's word taken as the absolute truth over my complaint; doctors all cover each other ; whitewash to protect practitioners ; did not consider my point of view; doctors looking after doctors ; the government pays the wages – one can't win unless they want you to [AHPRA]	Assessors were biased ; process angled to look after the doctor; more on side of midwife; took doctor's word against mine; don't feel Medical Board is completely impartial " old boys club "- HCCC was very fair ; board of doctors protecting doctors; just a cover to protect doctors; main emphasis of the investigation was to protect the practitioner , not to reach an objective assessment of their practice; apologists for medical profession [AHPRA]	Only fairness considered was to the doctor ; very fair to the surgeon concerned; process designed to 'close' complaints with minimal disruption to doctors ; feel practitioner protected and I was not listened to; more inclined to turn a blind eye than fix a problem- it is biased ; doctor's letter given a lot of credence	AHPRA: as fair as could be expected for an organisation that protects the doctors	-

Unless otherwise indicated, comments apply to all agencies

Whether the complainant/notifier was treated with respect

Table A6.3.10: Survey 1: whether respondent was treated with respect: Likert scale responses

	Rank 1= Not shown any respect		Rank 2= Minimal respect		Rank 3= Neutral: no opinion either way		Rank 4= Reasonable amount shown		Rank 5= Treated very respectfully	
	N	%	N	%	N	%	N	%	N	%
ALL	388	23	267	16	330	20	346	21	357	21
AHPRA	249	25	173	17	192	19	206	20	197	19
NSW	139	21	94	14	138	21	140	21	160	24
HPCA	53	19	36	13	63	23	52	19	74	27
HCCC	86	22	58	15	75	19	88	22	86	22
DR	275	27	173	17	181	18	198	20	189	19
<i>All other practitioners¹</i>	<i>113</i>	<i>17</i>	<i>94</i>	<i>14</i>	<i>149</i>	<i>22</i>	<i>148</i>	<i>22</i>	<i>168</i>	<i>25</i>
NMW	40	13	39	12	78	24	73	23	90	28
PHARM	16	19	10	12	19	23	17	21	21	25
DENT	34	22	24	15	34	22	27	17	37	24
PSY	23	20	21	19	18	16	31	27	20	18
Consumer	322	29	191	17	189	17	212	19	191	17
<i>Cons AHPRA</i>	<i>203</i>	<i>33</i>	<i>119</i>	<i>19</i>	<i>100</i>	<i>16</i>	<i>107</i>	<i>17</i>	<i>88</i>	<i>14</i>
<i>Cons NSW</i>	<i>119</i>	<i>24</i>	<i>72</i>	<i>15</i>	<i>89</i>	<i>18%</i>	<i>105</i>	<i>22</i>	<i>103</i>	<i>21</i>
Practitioner	48	14	55	16	80	23	79	23	85	25
Organisation	18	8	21	9	61	26	55	23	81	34

[1] Excluding medical practitioners

Table A6.3.11: Survey 1: whether respondent was treated with respect: Likert scale responses for major practitioner groups, AHPRA and NSW

	AHPRA						NSW					
	DR		NMW		Pharm/ Dent/ Psy		DR		NMW		Pharm/ Dent/ Psy	
	N	%	N	%	N	%	N	%	N	%	N	%
No respect	163	28	31	14	55	25	112	25	9	9	18	14
Minimal	108	19	29	13	36	16	65	15	10	10	19	14
Neutral	107	19	46	21	39	18	74	17	32	33	32	24
Reasonable amt.	105	18	56	25	45	21	93	21	17	18	30	23
Very respectful	91	16	61	27	45	21	98	22	29	30	33	25

Table A6.3.12: Survey 1: whether respondent was treated with respect: proportion of comments compared with ranked responses

Rank ¹	AHPRA		NSW		HPCA		HCCC		Total comment		Ranked responses	
	N	%	N	%	N	%	N	%	N	%	N	%
Very unfair	90	29	61	32	28	39	33	28	151	30	388	23
Unfair	75	24	33	17	11	15	22	18	108	22	267	16
Neutral	56	18	27	14	10	14	17	14	83	17	330	20
Fair	37	12	30	16	10	14	20	17	67	13	346	21
Very fair	49	16	41	21	13	18	28	23	90	18	357	21
Total ranked	307		192		72		120		499	100	1688	98
<i>Comment no rank</i>	<i>20</i>		<i>11</i>		<i>7</i>		<i>4</i>		<i>31</i>		-	
Total	327		203		79		120		530			

[1] Response comment frequency prior to thematic coding

Table A6.3.13: Survey 1: whether treated with respect: thematically coded (ranked) comments

Table 1: Results of survey 2: Whether treated with respect: thematically coded (ranked) comments															
Comment [1]	Adequacy contact; information [2]				Process & outcome [3]						Balance & attitude [4]				Total
Theme ¹	1A		1B		2A		2B		2C		3A		3B		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
All	89	16	39	7	26	5	34	6	46	9	237	44	70	13	541
AHPRA	60	18	31	9	18	5	20	6	32	10	120	36	53	16	334
HPCA	15	20	3	4	5	7	6	8	3	4	38	51	4	5	74
HCCC	14	11	5	4	3	2	8	6	11	8	79	59	13	10	133

1. Ranked comments only included in analysis

2. 1A: Level of transparency, contact, engagement about process; 1B= Adequacy or detail of information provided about reasons, decisions

3. 2A= Assessment of evidence, understanding of issues; adequacy of investigation; 2B= Outcome; 2C=Other process

4. Balance & attitude: 3A=Level of respect, seriousness, interest, courtesy, helpfulness; 3B= Agency probity; whether parties treated equally

5. Percent = row percent, as proportion of all responses

Table A6.3.14: Survey 1: summary comment subtheme 1A (level of transparency, contact, engagement) by ranked response

1=Not shown any respect	2=Minimal respect shown	3=Neutral	4=Reasonable amount of respect shown	5=Treated very respectfully
Dismayed; appalled; insulting; just a number; like complaining to a robot; not notified at all; not consulted; no / very little communication; hardly contacted; not kept in loop; not ever able to establish who was dealing with the problem, let alone how it was dealt with [HPCA]; no one rang to discuss my complaint [HPCA]; case update poor contrary to initial meeting when promised; [AHPRA]; no follow up contact; letters standard content [AHPRA]; no personal interview or phone contact	No/poor communication; no interview/attempt to speak with me; no feedback on process; brick wall- gives no useful information [Medical Council]; wasn't given a chance to explain my side of the story [AHPRA]; mandatory notification- difficult to speak to an officer and twice didn't respond to messages [HPCA]; wouldn't answer phone/ didn't return calls on at least 3 occasions [AHPRA]; not given a chance to meet an investigator and present photos of the damage done [HCCC]; Initial interview – non-existent. In a public area of reception with others who could overhear. Basically expected to drop off the papers and go [AHPRA]	AHPRA/HPCA: No/not much/ minimal contact; no information; had to chase [HPCA]; AHPRA: respect requires a relationship or interaction – there was none; just an email to say received and one to say closed; minimal contact despite seriousness of incident; mandatory report- should have at least been kept informed of process; correspondence a formality- no content communicated; letters technical & brief; letters business-like	Respectful but not comprehensive [AHPRA]; when I was able to contact the officers [HPCA]; through written correspondence only; in this case, but in recent matters – no communication [AHPRA]; returned calls when asked and took time to explain but many experiences [recently] when uncommunicative- feel discriminated against for making complaints about serious code breaches [HCCC]; usually received answers promptly to calls; professional process and verbal communication when requested [AHPRA]; No verbal communication with us about our review and subsequent notification- would have assisted us and AHPRA enormously; contact nice but not able to meet when had further questions [AHPRA]; No one was rude. They accepted and investigated – but never came back to ask my opinion of the expert witness reports [HCCC]	Kept informed [AHPRA]; regular communication and easily contactable [AHPRA]; letters respectful but most are of a generic nature; [but] still a non-transparent investigation [HCCC]; couldn't fault my treatment but no phone interviews [HCCC]; excellent communication [HCCC]; ongoing information by letter as progressed, phone calls helpful and unhurried [HPCA]

Unless otherwise indicated, comments apply to all agencies.

Table A6.3.15: Survey 1: summary comment subtheme 1B (adequacy or detail of information provided) by ranked response

1=Not shown any respect	2=Minimal respect shown	3=Neutral	4=Reasonable amount	5=Very respectful
Not much information; not informed what doctor or Panel said [AHPRA]; blunt [HPCA]; closure letter dismissive 'brush off [AHPRA]; fobbed off with big words [HCCC] no reason for no action; information generic [AHPRA]; We had already taken action. Request for justification why treated as a complaint not well received [HPCA]	HCCC: very limited response to a complex issue that was a comprehensive complaint; HPCA: ended when practitioner resigned- not given any reasons why occurred in the first place; AHPRA: no feedback; on letter 'case closed'; I believe that I should be advised of the outcome and the reasons; If we were respected, full details should have been provided; I had no information; their comment was that "attitude of nurse unprofessional and we have addressed this issue"; to receive letter quoting Act e.g. vexatious, misconceived when issues raised were very serious is disrespectful; I felt my time was wasted and stress of handling the complaint "disregarded" when told only "matter is now closed"	HCCC: paperwork neutral; letter just said nothing was going to happen; AHPRA: staff and Panel respectful- lack of rights e.g. lack of information about outcome were not; never gave any information; difficulty in getting answers over the phone; great difficulty in getting answers; subjective nature of reasons for closing case	AHPRA: But no reasonable information about how it was okay that this practitioner did what he did; All letters were polite, to the point, and to my mind told me everything that a lay person would need to know.	AHPRA: All questions I asked were answered with full explanation and in detail

Unless otherwise indicated, comments apply to all agencies

Table 6.3.16: Survey 1: summary comment Theme 2 (process & outcome) by ranked response

Rank 1 Not shown any respect	Rank 2 Minimal respect	Rank 3 Neutral	Rank 4 Reasonable amt.	Rank 5 Very respectful
Sub-theme 3A: Assessment of evidence; understanding of issues; adequacy of investigation				
AHPRA: Had to push for correct investigation to be done; none of my reasons for complaint properly considered or evidence applied; did not understand/address my concerns; did not read my letter thoroughly; no one asks families or relatives what they know; HPCA: letter not properly read or understood; would have hoped a complaint relating to a criminal offence would have received urgent attention; implied that I was at fault for suffering serious adverse reactions	Respect in sense stuck to guidelines albeit insufficient but not addressing some basic facts in case disrespectful [HCCC]; only some issues addressed [AHPRA]; serious allegations, false information dismissed by Dental Board even though written hard evidence provided	AHPRA: My complaint was investigated; because no more [other] complaints- they wouldn't continue the investigation; HCCC: never addressed all the issues raised- inadequate care and examination, injuries; first [staff member]- no concept of balance of power or circumstances- second understood and limits of HCCC well explained	Suppose it was respectful but didn't feel listened to or understood [AHPRA]	All letters respectful and had full consideration of issues [HPCA]; treated respectfully [but] information given ignored [AHPRA]; [multiple] complaints about staff including myself- investigated and I was treated respectfully [AHPRA & Commission]
Sub-theme 3B: Outcome				
HCCC: Very poorly, considering this doctor almost killed me and has now left me fully disabled; I would have hoped this would have been looked at; HPCA: notification dismissed without any discussion or questioning; just a letter saying did nothing wrong; AHPRA: not at all- complaint dismissed; took no action for serious outcome/ avoidable death; closing notification with no action and no consultation breaches rights (e.g. Mental Health Act)	HCCC: Respectful but didn't get it right; could not expect better; no accountability in the mental health system- designed so everyone can blame someone else; HPCA: don't think requirement for me to see a psychiatrist reasonable [first offence outside work]; AHPRA: complaint completely invalidated; dismissed out of hand; good chance for psychologist to continue to bag me; recommended nothing be done; process long, drawn out, reasons for no action an insult	Respectful until final decision- privacy issues not treated with respect- ignored or dismissed [AHPRA]; outcome of process puzzling and further inquiries not encouraged [HCCC]	Felt complaint taken seriously and opinion respected but very disappointed with outcome [HPCA]; process respectful and listened to but outcome disappointing [HCCC]; left disappointed with decision not to discipline[AHPRA]; dealt with appropriately and undertakings made for practitioner to receive treatment [HPCA]	People nice and listened but waste of time- doctor still rude to patients [AHPRA]; given an empathetic hearing when phoned - but disappointed and dissatisfied with the investigation finding of no further action [HCCC]; treated respectfully on phone- but nothing has happened that I know about [HPCA]
Sub-theme 3C: Other comment on process				
AHPRA: The FOI officer hang up the phone on me; fobbed off without the opportunity to respond to practitioner's version of events/explanation and without reference to evidence provided by notifier; given to right to answer pharmacist's allegations; time taken showed zero respect; long delays; HCCC: no other resolution avenues, mediation or conciliation offered; issues not addressed and refused resolution program; no conciliation or mediation offered; curt refusal to let me see any of the information they used in their investigation	Although most interactions were fine, buck passing lacks respect [HPCA]; AHPRA: complained after I found through FOI what practitioner said- ignored; no attempt at conciliation; treated poorly- asked to respond to unfounded allegations the practitioner [complained about] made about me; complaint made against me by the practitioner I complained against was clearly vexatious. It was solely made in response to my original complaint. This was not acknowledged by AHPRA.	HCCC: was away- not enough time to respond [request review] - 28 days; AHPRA: too ill at times to fully understand some issues; investigators from AHPRA are obviously junior, poorly educated and trained and I don't expect anything of them anymore; long delays disrespectful; always gave excuses for delays; not given opportunity to respond to practitioner comments about my integrity and mental state; colleagues advised me one part of AHPRA does not appear to speak to other parts	Resolution officer respectful but doctors took advantage of my lack of medical knowledge [HCCC]; irony is I ended up being notified about [HCCC]; AHPRA: I was more concerned for vulnerable patients then how I was treated; gave impression that complaint would be addressed and that appropriate actions would result following investigation; phone communication professional and written received in good timeframe	AHPRA: Did a good job; acted in professional capacity; when I was finally contacted-delay unacceptable; HCCC: always polite, courteous and helpful. I just think that it is a bureaucracy that doesn't have any real power and doesn't want to upset the status quo; staff respectful and understood complaint factually based and guided by National Standards

Unless otherwise indicated, comments apply to all agencies

Table A6.3.17: Survey 1: summary comment subtheme 2A (level of seriousness, interest, courtesy, helpfulness) by ranked response

1= No respect	2= Minimal respect	3= Neutral	4=Reasonable amount	5=Very respectful
HCCC: treated politely, not respectfully; no respect, no empathy, no consideration; ignored; told to suck it up; infantilised; treated like I was bothering the HCCC; person giving feedback rude; belittled- not believed; HPCA: not at all; ignored; interactions left me feeling like a pest; talked at; didn't want to listen to my points; talked down to; fobbed off; only receptionist at Council and resolution officer at HCCC [was honest, caring]- the rest should be sacked; AHPRA: dismissed; ignored; not taken seriously; from my first contact felt I was interrupting; disbelieved my experience; taken aback by rudeness of staff; treated like an imposition; I was humiliated, confused and intimidated at the panel presentation; the communication was harsh and did not consider my thoughts and feelings; not from practitioner but was by the investigator	HCCC: Not taken seriously; polite but no urgency or empathy; dismissed; some interested in listening-others not at all; ok; HPCA: talked down to; talked at; said I was emotional; girl on phone ok; After I said I worked in health care, they were very cautious about what was explained'; AHPRA: stress of complaint disregarded; treated like an old fool; Investigators obviously had no understanding or interest in clinical practice issues; felt fobbed off 'don't call us we'll call you'; were ok; superficially professional; rude and unprofessional- basically indicated that she thought I was a nonsense complainer and kept sighing when I asked questions about the process; treated as if my feelings and opinions were not important and did not need to be addressed. I felt like my concerns were trivialised then dismissed or ignored.	HCCC: courteous but not 'respectful'; polite but disrespectful that taxpayers dollars going to fund them; informative but didn't seem interested; patient advised did not feel 'anything was happening' – may have meant didn't feel was being respected; not friendly or patient- a bit officious and short; average; HPCA: fairly though not taken seriously enough; ignored; depended on the individual; felt reluctant to deal with nurses and issues involved; AHPRA: felt no one was concerned; treated neutrally; 'clinically'; just another complaint to be dealt with; treated as a nuisance; ticking boxes	Friendly; polite; courteous; respectful; professional; listened to me; showed consideration [AHPRA]; sensitive to my distress [HCCC]; helpful, didn't immediately dismiss my concerns [HCCC]; very nice and sent me copies of the doctor's response [AHPRA]; people not involved in the decision-making process were [AHPRA]	Treated professionally; spoken to politely/ courteously; understanding; treated well/ very well; respectfully; felt heard and validated [HCCC]; felt understood [HCCC]; letters polite and considerate [HCCC]; addressed with respect and fairness [HPCA]; Very, very helpful in stressful circumstances [HPCA]; all phone calls showed concern [AHPRA]; doctor declined mediation but offered financial settlement - officer supportive throughout [AHPRA]

Unless otherwise indicated, comments apply to all agencies

Table A6.3.18: Survey 1: summary comment subtheme 2B (perceived agency probity; assumption practitioner credibility in making decision) by ranked response

1 No respect	2 Minimal respect	3 Neutral	4 Reasonable amount	5 Very respectful
Closed club; doctors believed- I'm not no proof; they just listen to doctors lies; always knew that nothing would happen because he's the Dr and I am the patient on disability pension; Witness of patient given no value or credence. False and lame rebuttal of doctors treated preferentially by the HCCC and the Medical Council; the system protects the system; I believe I was discriminated against as I am merely the 'general public' and of no significance; not even asked about the discrepancies between my version of events and those of the pharmacist; the nurse was interviewed, called me a liar and the case was closed.	AHPRA & HCCC: My word against the doctors... Wow!!! Dr lied in his reply as well as did not address all of the complaint. His word seems to hold more importance than mine; doctor is correct, simply because he has a "right" – which should never be questioned; Just feel like medical board sided with doctor; The medical board did not even ask [name] to produce his evidence; were too mindful not to upset the doctors; felt that AHPRA was representing the dentist; despite this issue being investigated excuses were made for the practitioner's actions.	AHPRA: felt exercise was solely to disprove the complaint to the benefit of the Dr complained about; In words I was shown respect, but in reality I got the impression that the board did not think that the "issue" was important – and easily sided with the doctor; Yes, but I would have been better pleased if they had been more honest about what I was saying and what was going on; I feel I was made to look like an idiot and he looked like such a "good bloke"; HPCA: no consideration was given to my [child]-more concern for the corrupt doctor; one sided process [HCCC]	AHPRA: reasonable amount of respect however I think more respect is given to the practitioner. i.e. allowing him to have lawyers 'defending' him. If I had people arguing my 'case' for me I believe there would have been a different outcome. HPCA: respectfully by the Pharmacy Council but HCCC implied I should have checked dosage instructions on the internet	People do lie even though they treat you respectfully

Unless otherwise indicated, comments apply to all agencies

Whether the complaint/notification process affected health

Table A6.4.1: Survey 1: whether the process had an effect (impact) on health: Likert scale responses

	Very significant impact on health		Significant impact on health		Some impact on health		Slight impact on health		Health not affected at all		Not applicable organisation	
	N	%	N	%	N	%	N	%	N	%	N	%
ALL	362	22	236	14	282	17	199	12	570	34	23	1
<i>CONS & PRACT [1]</i>	<i>360</i>	<i>25</i>	<i>231</i>	<i>16</i>	<i>272</i>	<i>19</i>	<i>181</i>	<i>13</i>	<i>401</i>	<i>28</i>	<i>NA</i>	<i>NA</i>
AHPRA	208	21	140	14	166	17	118	12	354	35	16	2
NSW	229	21	162	15	183	16	131	12	390	35	18	2
HPCA	54	20	34	12	40	15	31	11	110	40	6	2
HCCC	100	25	62	16	76	19	50	13	106	27	1	<1
DR	268	26	161	16	191	19	122	12	266	26	7	1
<i>All other practitioners</i>	<i>94</i>	<i>14</i>	<i>75</i>	<i>11</i>	<i>91</i>	<i>14</i>	<i>77</i>	<i>12</i>	<i>304</i>	<i>46</i>	<i>16</i>	<i>2</i>
NMW	38	12	20	6	39	12	34	11	170	54	13	4
PHARM	3	4	9	11	7	9	12	15	47	60	1	1
DENT	32	21	24	16	28	18	18	12	51	33	0	0
PSY	21	19	22	20	17	15	13	12	36	32	2	2
Consumer	316	29	191	17	223	20	131	12	245	22	NA	NA
<i>Cons AHPRA</i>	<i>175</i>	<i>29</i>	<i>109</i>	<i>18</i>	<i>125</i>	<i>20</i>	<i>74</i>	<i>12</i>	<i>130</i>	<i>21</i>	<i>NA</i>	<i>NA</i>
<i>Cons NSW</i>	<i>141</i>	<i>29</i>	<i>82</i>	<i>17</i>	<i>98</i>	<i>20</i>	<i>57</i>	<i>12</i>	<i>115</i>	<i>23</i>	<i>NA</i>	<i>NA</i>
Practitioner	44	13	40	12	49	15	50	15	156	46	NA	NA
Organisation	2	1	5	2	10	4	18	8	169	74	23	10

[1] Consumer and practitioner respondents only

Table A6.4.2: Survey 1: whether the process had an effect (impact) on health: Likert scale responses for major practitioner groups, AHPRA and NSW

	AHPRA						NSW					
	DR		NMW		Pharm/ Dent/ Psy		DR		NMW		Pharm/ Dent/ Psy	
	N	%	N	%	N	%	N	%	N	%	N	%
1=Very significant impact on health	151	27	25	11	32	15	117	26	13	14	24	19
2=Significant impact	89	16	13	6	38	18	72	16	7	7	17	13
3=Some impact	103	18	30	14	33	15	88	20	9	10	19	15
4=Slight impact	68	12	23	11	27	13	54	12	11	12	16	13
5=No impact	150	27	120	55	84	39	116	26	50	53	50	39
Not applicable	6	1	8	4	2	1	1	<1	5	5	1	1

Table A6.4.3: Survey 1: Summary outcome categories by those reporting health impacts

Outcome [1]	Don't know		No action		Acknowledge communicate fees		Referred		Retire surrender		Conditions excluding suspend or cancel		Suspend cancel	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
All responses	254	15	1032	60	335	20	53	3	47	3	322	19	38	2
<i>All resp. DR only</i>	<i>136</i>	<i>13</i>	<i>681</i>	<i>66</i>	<i>239</i>	<i>23</i>	<i>33</i>	<i>3</i>	<i>18</i>	<i>2</i>	<i>159</i>	<i>15</i>	<i>14</i>	<i>1</i>
Very sig impact [2]	43	12	278	77	60	17	8	3	4	1	42	12	4	1
Sig impact [3]	24	10	168	72	43	19	6	3	1	-	31	13	1	-
Slight, some impact [4]	68	14	299	62	11	23	18	4	11	2	88	18	10	2

[1] Outcome:

[2] Very significant impact on health

[3] Significant impact on health

[4] Some and slight impact on health

Table A6.4.4: Survey 1: Whether the process had an effect (impact) on health: proportion of comments relating to complaint bodies compared with ranked responses

Rank	AHPRA comment		NSW comment		HPCA comment		HCCC comment		Total comment		Ranked responses	
	N	%	N	%	N	%	N	%	N	%	N	%
1=Very significant impact on health	89	30	57	32	20	32	37	32	146	31	362	22
2=Significant impact	52	17	36	20	10	16	26	23	88	19	236	14
3=Some impact	74	25	46	26	16	25	30	26	120	25	282	17
4=Slight impact	58	19	30	17	14	22	16	14	88	19	199	12
5=No impact	25	8	8	5	3	5	5	4	33	7	570	34
Not applicable	-	-	-	-	-	-	-	-	-	-	23	1
Total ranked	298		177		63		114		475		1672	97
Comment no rank	11	4	10		4		6		21			
Total	309		187		67		120		496			

Table A6.4.5: Survey 1: whether the process had an effect (impact) on health: thematically coded comments relating to complaint/notification agencies

Comments relating to complaint/notification agencies										
Theme ¹	Affected self or other						Process & outcome			
	Acting for or impact on other		Physical, psychological symptoms		Aggravated existing condition; reminder of events		Process		Outcome	
	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
All	22	4	217	44	51	10	169	34	37	7
AHPRA	15	5	130	42	33	11	104	34	27	9
HPCA	1		30	45	7	10	25	37	4	6
HCCC	6	5	57	58	11	9	40	33	6	5

[1] Excludes comments relating to practitioner subject of complaint or to the original events giving rise to the complaint [N=333]

Table A6.4.6: Survey 1: very significant impact on health

	AHPRA	NSW	HPCA	HCCC	Total
Very significant impact' comments relating to agencies (%)	30	32	32	32	31
Very significant impact' all comments ranked responses (%)	21	23	19	25	21

Table A6.4.6: Survey 1: summary comments sub-theme 1A (physical or mental symptoms) and subtheme 1B (exacerbated condition) by ranked response

1=No impact	2=Slight	3=Some	4=Significant	5=Very significant
Sub-theme 1A: Physical or mental symptoms reported				
AHPRA: Exposed me to ridicule- resulting in anxiety, stress and low self-esteem; no other than blood pressure going up; slight spike in blood pressure; emotional stress; endured worse when first raised with [state commission]; HCCC: not process per se; Helped me move on emotionally [AHPRA]	Stress; emotional stress; mild increase in stress; some distress; very stressful; emotional impact; anxiety; anger; frustration; frustrated and angry on behalf of injured party; preoccupied my thoughts; affected sleep; affected family and business [AHPRA]; affected my happiness a great deal [AHPRA]; made me feel very unworthy; stress-concern practitioner would harm self or others [HPCA]; Made an already difficult time for me even worse. Making complaint helped [HPCA]	Very stressful; upsetting; sleepless nights; disturbed appetite; high blood pressure; asthma; drained; frustration; considerable stress; depressed; skin rashes; chest pain; constant worry; now take night sedation [AHPRA]; added to grief and stress- left me reluctant to trust healthcare people [HPCA]; Initially the decision to make the complaint - felt better after making [HCCC]	Stress; worry; emotional stress; extremely distressed for a few weeks; depression; severe depression; considered suicide; anxiety; anxiety provoking; ongoing stress; psychologically; huge weight loss; self-esteem; insomnia; agitation; trauma; blood pressure went up every time I received a letter from AHPRA; health deteriorated as a result of the stress; psychological and emotional suffering; emotionally disruptive;	Very / major / extremely stressful; depression; major depression; anxiety; anger; seeing counsellor nightmares; loss of confidence; fear; very stressed and don't know who to turn to; exhausted and weight loss; mental health- suicide; suffering panic attacks and chest pain; very nervous, felt withdrawn and could not sleep; nightmares; post-traumatic stress disorder symptoms; started suffering chest pain and required surgery- what I went through with AHPRA is appalling; placed on stress leave by specialist until matter had been dealt with [AHPRA]; suicidal ideation and now living day to day-hopeless [self-notification]; both of us stressed- my relative in hospital as a result; suffered a stroke two weeks after hearing; Allowed me to get the complaint "off my chest" and concentrate on getting healthy again [HPCA]

Sub-theme 1B: Process or recalling original events affected health

HPCA: Made me more unwell, lowered mood and self-worth;	Emotional impact recalling events/ going over and over it; brought up stressful and painful experiences; worsened depression and anxiety; disillusioned and not helped potential recovery;	Writing complaint mentally taxing to recall event; depression and anxiety worsened; affected my mental recovery; relative died and reliving it for the complaint; upsetting – brought back memories; become distressed and emotional; psoriasis flared up again as a result of the stress	Suffer social phobias and nerves worse; added to the stress already incurred; highly anxious throughout [as a result] and extremely emotional and anxious for a result to my complaint; added to depression and anxiety; delayed treatment which prolonged pain; increase in depression; contributed to my taking anti-depressants	Huge amount of stress when already unwell; anxiety went through roof - had to increase medication; became five times more unwell; severe onset longstanding PTSD; anxiety to point of nervous breakdown; aggravated injury/ disease; added to high blood pressure; have autoimmune illnesses exacerbated by stress; process of complaining required me to relive trauma and go through very stressful process; health already significantly affected by practitioner's actions and process stressful

Unless otherwise indicated, comments apply to all agencies

Table 6.4.7: Survey 1: summary comment subtheme 1C (acting for others and impact on others) by ranked response

1=No impact	2=Slight	3=Some	4=Significant	5=Very significant
AHPRA/HCCC: not affected; [as] acting for relative/ patient/ client/ organisation [but] HCCC: we were all very upset; AHPRA: doctors looking after affected patients found process made them anxious and had slight impact on health; patient anxious about future repetition; person I made for slightly affected	HPCA: client was affected- depression; HCCC: family found this a very stressful time	AHPRA: my health not affected but concerned for my children; anxiety for myself and anxiety and fear of seeing that doctor again for my child	-	AHPRA: not mine, but other's health greatly affected; HCCC: affected health of our client in a massive way; particularly affected my parent who is elderly and in poor health

Unless otherwise indicated, comments apply to all agencies

Table A6.4.8: Survey 1: summary comment subtheme 2A1 (fear or experience of repercussions) and 2A2 (mandatory reports) by ranked response

1=No impact	2=Slight	3=Some	4=Significant	5=Very significant
Slight anxiety now regards counter-suing [HCCC]; staff worry about repercussions and constantly question what they can do better- take seriously as should [AHPRA]	HCCC: stressed about complaint and warned 'doctors stick together' and could have negative repercussions in future; HPCA: harassed at work because of complaint; stressed even though I am the employer; witnesses very stressed as concerned about repercussions	AHPRA: Increased anxiety, hyper vigilance and concerns regarding reprisal; upset- threatened with legal action by practitioner; very stressful and was worried I would be not treated well by the hospital again	AHPRA: very stressful in work environment, practitioner under supervision since incident [but] undermining leadership, dividing staff, now put in a bullying complaint against me	AHPRA: I am really wondering if the staff of the hospital didn't act out against me when I had to go back there, in a similar fashion to group members acting against a whistle-blower
AHPRA: mandatory/ my role/ professional obligation/ employer so not emotionally involved/ personal/ health not affected; part of my role; explained to practitioner that required; very clear on referral reason and priority for maintaining patient safety	AHPRA: annoyed at [counter-complaint] just because I was complying with my legal obligation and AHPRA did nothing to protect me- created a level of unwelcome stress	AHPRA: upset that I was required by law to complain against my colleague; very stressful to report patient – I sought medico-legal advice- process damaged (doctor-patient) relationship - I was not supported in any way by AHPRA in this	-	AHPRA: very anxious about having to notify about this matter when it had nothing to do with my clinical practice and it significantly caused me stress [self-notification]; attempted suicide when I became aware they had been mediatory reported and I would have to give evidence

Unless otherwise indicated, comments apply to all agencies

Table A6.4.9: Survey 1: summary comment subtheme 2A2 (other process comment) by ranked response

1=No impact	2=Slight impact	3=Some impact	4=Significant impact	5=Very significant impact
AHPRA: Continually frustrated by the inefficiencies and lack of accountability of our national body; just disappointing that a body like this is not interested in patient safety; HPCA: gave up thinking about it- process pro-doctor and waste of time; very distressing- state government cover up; HCCC: have thick skin after dealing with HCCC for over a year	Anxious about process; worried about it a lot – not sure what I will do next time; stress, feel not listened to; insufficient information or communication about process causes stress; repeatedly asked for information; occasional sleep disturbance when contacted, or if made aware of another poor outcome from the same practitioner; anxiety and annoyance with the whole process given the effort to reasonably represent the issues but it passed [AHPRA]; stress related to providing responses; very anxious about the length of time for negotiations to be completed [HCCC]; frustration but to their credit HCCC didn't deny there was an issue; mild stress while awaiting outcome; anxious about review I had to go to- I had already been dealt with through the court system HPCA]	Any lengthy process like this with partial resolution is stressful; I was more upset that HCCC believed him and obviously just dismissed what I told them; impact on mental health; whole process stressful and little support available; drained me dry, filling in papers and writing letters; felt they were protecting the practitioner [HCCC]; frustration of dealing with a very unprofessional [complaint] procedure has been more disappointing than the practitioner ; mentally and emotionally draining process; matter is very time-consuming, interfering with my work commitments as well as affecting my feeling of wellbeing; drawn out process that left me feeling anguished and frustrated, with no real sense of timeline or outcome.[AHPRA]	Very upset, stress and anxiety that complaint not investigated; lack of trust in a fair process; very distressed that I have little option but to sue; matter ongoing and seemed to stall for a great period of time; [event] caused enormous stress and further treatment over nine months- I struggle with trying not to be angry with it, then worry I've caused him trouble also; delays in process contributed to mental stress; stress and made to feel not listened to as not doctors; process made me feel very depressed as I cannot wear the dentures; significant health issues including anxiety and depression about the situation; spent [weeks] preparing the notification, affecting family and clinical practice; spent a long time writing and documenting complaint, with significant anxiety and stress related to finding and contacting witnesses;	Trying to get facts – near impossible due to deceit and cover-up - weight loss, angina; making the complaint in the first place took courage- to be ignored further is just more abuse; very stressful and ongoing- waiting for an ending, having to relive the event and chase up records to prove the doctor failed us; added distress and waste of energy I needed to use for resolution of ongoing symptoms caused by bad work; waiting so long trying to wear a worn old denture, had to get two doctors letters to forward on to [investigation]; health was severely affected- they didn't even care about my point of view it infuriated me; stresses of non-transparent, unfair, non-reviewable process resulting in anxiety over the true cause of my [health] problems; mental health significantly affected by initial incident and subsequently by the complaint process taking so long, ultimately with its unfair outcome; affected me more because of the lack of information provided

Table A6.4.10: Survey 1: summary comment subtheme 2B (outcome) by ranked response

1=No impact	2=Slight	3=Some	4=Significant	5=Very significant
Very distressing. It's a state government cover up. My [practitioner] tried to [harm] me	Distressed concerns not addressed; distressing to see patient recover from procedure and wait almost 12 months to find no action will be taken; anxious about outcome; made me angry, stressed and sleepless that I was not taken seriously and my complaint was dismissed; some anxiety, stress and anger at wrong decision being upheld; the lack of "real" outcome is deflating and disappointing somewhat; I felt sick on receiving the closure letter and had to work at managing my thoughts; extreme frustration, anxiety and stress that practitioners can damage a patient's self-esteem and incur no penalty or even accountability; waiting 2 years for a decision that didn't permit closure for family; anger at refusal to be accountable; felt very let down that my situation was nullified	AHPRA: emotionally difficult when I learnt the doctor was to keep practising; stress and frustration of nothing being done affected me; uncertain about outcome; because there was no communication, I was worried the matter would be covered up- since the decision, I have been left with a feeling of anger I can't get past; very angry and depressed about the lack of information and eventual outcome; HCCC: It drained me dry, filling in papers and writing letters. I knew from the beginning when I got the run around that I wouldn't get a satisfactory result.	AHPRA: uncertain about the outcome; anxiety, depression and a lack of trust in a fair outcome or process; the decision to take no action caused immense rage, anger, disbelief, chest pain, insomnia, crisis of faith in the complaints system; HCCC: angry about outcome; just empty inside, disappointed, still feeling disdain for this man; I was despondent, depressed and disappointed. I cried a lot. I felt very let down.	AHPRA: I had faith it would be dealt with professionally. My depression returned ten-fold when it was washed under the carpet; extreme anxiety; sleeplessness; sense of hopelessness in obtaining answers to questions regarding my [parent's] medical treatment and lack of communication between nursing staff, the doctor concerned in our family. AHPRA considered the matter closed, but there is no closure for our family; took nearly 2 years to investigate and the final verdict was most unsatisfactory at every level; very traumatic for me to know that [doctor] has gone scot free- I have lost my [partner], knowing that there is no further recourse is mentally shattering; took no action and no reason given [following death] - a complete nightmare. Stressful.

Satisfaction with the complaint/notification process

Table A6.5.1: Survey 1: satisfaction with the complaint/notification process

	Rank 1= Very dissatisfied		Rank 2= Dissatisfied		Rank 3= Neutral		Rank 4= Satisfied		Rank 5= Very satisfied	
	N	%	N	%	N	%	N	%	N	%
ALL	783	46	339	20	255	15	219	13	108	6
AHPRA	484	47	198	19	147	14	139	14	58	6
NSW	299	44	141	21	108	16	80	12	50	7
HPCA	100	36	53	19	59	21	47	17	22	8
HCCC	199	50	88	22	49	12	33	8	28	7
DR	525	51	213	21	138	13	105	10	50	5
<i>All other practitioners</i>	258	38	126	19	117	17	114	17	58	9
NMW	98	31	54	17	67	21	71	22	30	9
PHARM	33	40	15	18	12	15	15	18	8	10
DENT	78	50	29	19	22	14	12	8	14	9
PSY	49	43	28	24	16	14	16	14	6	5
Consumer	605	54	207	19	144	13	97	9	65	6
<i>Cons AHPRA</i>	368	59	106	17	68	11	49	8	31	5
<i>Cons NSW</i>	237	48	101	20	76	15	48	10	34	7
Practitioner	132	38	85	24	57	16	56	16	22	6
Organisation	46	20	47	20	54	23	66	28	21	9

Total response rate 98% N=1704; AHPRA & HCCA 99% HCCC 98%; practitioner highest PSY (100%)

Table A6.5.2: Survey 1: satisfaction with the complaint/notification process: Likert scale responses for major practitioner groups, AHPRA and NSW

	AHPRA						NSW					
	DR		NMW		PHARM, DENT, PSY		DR		NMW		PHARM, DENT, PSY	
	N	%	N	%	N	%	N	%	N	%	N	%
1=Very dissatisfied	314	54	66	30	104	47	211	47	32	33	56	42
2=Dissatisfied	115	20	41	18	42	19	98	22	13	13	30	23
3=Neutral	71	12	46	21	30	14	67	15	21	22	20	15
4=Satisfied	60	10	51	23	28	13	45	10	20	21	15	11
5=Very satisfied	22	4	19	9	17	8	28	6	11	11	11	8

Total may not equal 100% due to rounding

Table A6.5.3: Survey 1: whether satisfied with process: proportion of comments compared with all ranked responses

	AHPRA		NSW		HPCA		HCCC		Total comment		Ranked responses	
	N	%	N	%	N	%	N	%	N	%	N	%
1=Very dissatisfied	252	56	131	51	47	46	84	54	383	54	783	46
2=Dissatisfied	90	20	685	26	24	23	44	28	158	22	339	20
3=Neutral	55	12	25	10	15	15	10	6	80	11	255	15
4=Satisfied	42	9	18	7	11	11	7	4	60	8	219	13
5=Very satisfied	14	3	17	7	6	6	11	7	31	4	108	6
Total Ranked	453		259		103		156		712		1704	98
<i>Comment no rank</i>	5		5		2		3		10			
Total	458		264		105		159		722			

Comment frequency prior to thematic coding

Total may not equal 100% due to rounding

Of ranked comments, AHPRA accounted for 63%; HPCA 15%; HCCC 22%, %, which is proportionate with survey returns for each body

Table A6.5.4: Survey 1: satisfaction with the complaint/notification process: thematically coded comments by ranked response

	Reasoning, outcome ¹		Balance, attitude ²		Engaged, informed ³		Adequacy ⁴		Timely ⁵	
	N	%	N	%	N	%	N	%	N	%
ALL	264	24	211	19	199	18	168	15	100	9
AHPRA	164	23	127	18	145	20	107	15	80	11
HPCA	45	30	32	21	27	18	16	11	8	5
HCCC	55	25	52	24	27	12	45	20	12	5
Rank 1	137	52	147	70	102	51	113	67	36	36
Rank 2	60	23	38	18	45	23	30	18	27	
Rank 3	35	13	8	4	24	12	16	10	15	
Rank 4	22	8	8	4	19	10	6	4	15	
Rank 5	10	4	10	5	9	5	3	2	7	

Table 6.5.4 continued

	Impact ⁶		Review ⁷		Other ⁸		Total	
	N	%	N	%	N	%	N	%
ALL	60	6	16	1	72	7	1090	
AHPRA	40	6	13	2	43	6	719	
HPCA	12	8	0	0	10	7	150	
HCCC	8	4	3	1	19	9	221	
Rank 1	38	63	9		52	72	634	58
Rank 2	14		3		10		227	21
Rank 3	6		3		3		110	10
Rank 4	1		1		5		77	7
Rank 5	1		0		2		42	4

Ranked comments only included in analysis. Rank 1= most negative; Rank 5 = most positive response

[1] **Reasoning, outcome:** Issues addressed or not, adequacy of reasons, comment on outcome.

[2] **Balance, attitude:** perceived fairness of process (e.g. parties treated equally or perception of bias); perceived attitude (e.g. taken seriously, believed).

[3] **Engaged, informed:** level of engagement; information; communication.

[4] **Adequacy:** of process [excluding engagement and timeliness] including assessment of evidence, understanding of issues; follow up or investigation, experts used; support

[5] **Timely:** efficiency of process, delays, impact on other processes.

[6] **Impact:** impact on complainant, including retaliation (N=41, 4%) or impact of process on risk to public, safety (N=19, 2%).

[7] **Review:** availability of review or appeal rights; use of Freedom of Information or similar to access information.

[8] **Other:** general positive comment (N=8, 1%) or negative comment (N=64, 6%)

Table A6.5.5: Survey 1: sample of timeliness comments associated with overall process satisfaction rating

R1	"Appears to have been a very significant delay in investigating a medical practitioner who demonstrated several examples of very poor/ dangerous care delivery" (Ref 1378)
R2	"Time taken for process- Initial complaint made in [date over 2 years prior]." (Ref 795) "Difficult to find out how to make a complaint. Long time between contact. It took over 18 months to complete. Do not believe the responsible practitioner was held to account." (Ref 1225) "The process took too long and the practitioner was practicing during this time" (Ref 226) "Took too long and lack of communications and result not as expected" (Ref 1484)
R3	"Process took too long and client I was complaining on behalf of lost interest. Client was young and vulnerable and disengaged with worker during the time the process took." (Ref 1209)
R4	"My complaint was taken seriously. The investigation proceeded, and was completed in a reasonable period of time. The regular updates/notice of ongoing investigation were reassuring." (Ref 1125) "I felt the HCCC were very prompt and dealt with the complaint well" (Ref 1491) "Adequate but not timely" (Ref 197) "Took a very long time and progress appeared to be inconsistent" (Ref 38) "Took too long" (Ref 705) "Happy with process, just frustrated with the time taken for final decision to be made" (Ref 1502)
R5	"Incredibly quickly handled (within a week the issue was completely resolved)! I felt listened to and no longer dismissed." (Ref 938) "On request given information re the process, advised of time line and received outcome in a timely manner" (Ref 1368) "Quick action taken, process was simple and straight to the point. Processes short." (Ref 52) "Dealt with in a timely, efficient and kind manner" (Ref 812)

R= Ranking: Rank 1= most negative; Rank 3= neutral; Rank 5= most positive

Table 6.5.6: Survey 1: sample of comments associated with overall process satisfaction rating

Rank 1: very dissatisfied	My concerns were not addressed. The public is still at risk as the practitioner will continue to practice in a similar manner." (Ref 96) "No information given, no explanation for the lack of action, given serious nature of complaints" (Ref 564) "My comprehensive submissions were reciprocated with thin responses and "standard" response letters. Lack of detail behind decision." (Ref 1104) "AHPRA's decision in fact "emboldens" the doctor rather than warning the doctor of his behaviour - that he can get away with his actions" (Ref 709) "For all the effort and strength it took to prepare and relive the experience came down to a letter being sent for guidance and support to the surgeon!" (Ref 287) "Not happy with the lack of discipline for the nurses involved; [and] with the lack of feedback from the Nursing and Midwifery Council" (Ref 873) "...it is evident in these decisions that the Board has either not taken the time to read the evidence submitted, or they were complicit in 'not adequately respond[ing] to the substance of complaints' or 'too readily find[ing] complaints against doctors unsubstantiated... I have lost all faith in their ability to protect public health against negligent doctors by disciplining them accordingly" (Ref 1289) "Result did not satisfy effort to make the notification. Onus is on the notifier to provide evidence yet no evidence required to support practitioner's statements." (Ref 551) "I felt the complaint was completely minimised. I provided significant supporting evidence to collaborate my complaint and this does not appear to have been taken into consideration. The evidence was not addressed with the health professional or even acknowledged in the outcomes. My complaint was essentially treated as "he said versus she said", which was not the case as I had significant supporting evidence..." (Ref 1099) "The major effort taken to write with lucidity, research and substantiate evidence involved significant output. The pathetic response from the Medical Council was unworthy." (Ref 1372) "I was not provided with what I think is sufficient information. That the complaint process was just a standard investigation regarding his [the doctor's] current position and that did not take into consideration previous complaints or follow up with these complainants." (Ref 930)
Rank 2: dissatisfied	"I find it difficult to understand - if you do not complete your CPD... your registration is cancelled. However if you are not practicing safely and employment terminated and notification sent to AHPRA, your registration is not suspended; and even though you don't pass the practical and theoretical test, you still have the opportunity to practice...this staff member is still practising in our region at other facilities - how can you even renew your registration if you are being investigated?... AHPRA is supposed to be a governing body to protect our patients and our health care system. I do not believe it has done so in this case." (Ref 944, Rank 1 organisation complainant; outcome: don't know) "Poor communication. No indication that public safety is ensured" (Ref 204) "Communication was prompt and appropriate. However I am unsatisfied with the investigation of the complaint and the lack of transparency about how the determination was made." (Ref 785) "I don't think adequate action was taken against the doctors for their obvious lack of care" (Ref 149) "Not rigorous enough. Onus entirely on me [the complainant]." (Ref 519) "The process does not seem to involve enquiry or debate, but rather relies on the limited "he said-she said" basis" (Ref 292) "As previously outlined I feel the medical records were not fully examined. Doctor identified to provide a report gave a lame excuse... [and did not provide a report] - this was accepted. The other doctor decided to retire and therefore was not available to offer explanations or answer questions." (Ref 937) "Feedback from the surgeon was only what he had done, not what should have been done (investigations). My question why a [diagnostic test] was not carried out was not answered..." (Ref 518) "Although a breach was found to have occurred and the doctor was cautioned, this resolution does not necessarily mean the doctor will be further reviewed or his practices scrutinised to ensure he is delivering a quality health service to his patients. Therefore the onus is on patients that are dissatisfied to lodge a complaint - but really this does nothing either, as it is not recorded and therefore not monitored and performance not managed." (Ref 1490 Rank 2 consumer complainant; outcome caution)
Rank 3: neutral	"It was just okay. I wish I knew exactly what action was taken with the practitioner – was he just spoken to, is there any change in how he practices." (Ref 319) "Satisfied that it was investigated. Dissatisfied that I don't know the outcome/recommendations with any practice changes made." (Ref 1036) "My main concern is with the whole process, not just the AHPRA component. The practitioner does not believe she did anything wrong. I feel that if there was some limitation on her practice she may have gained some insight." (Ref 1066) "I don't feel like it had much effect except for me to feel like I had stated my concerns, and hopefully that because of the process of the complaint, the GP will be more aware of his obligations. The fact that there was no particular outcome requiring him to do anything different is probably not unexpected, it was more about me being able to say that I thought he'd done the wrong thing and him hopefully reading that and getting the feedback." (Ref 1351) "Don't know the outcome but if he hasn't been disciplined... if he has weaselled his way out of this I will be very disappointed in the system" (Ref 1355) The practitioner was disciplined adequately." (Ref 441) "I believe that I did the right thing professionally. It is unclear to me whether the practice that she works at was notified about the significant concerns (or whether they care). The practitioner continues to practice there – I have no idea whether they have increased their oversight of her practice." (Ref 1080 Rank 3 practitioner complainant; outcome conditions)

Rank 4: satisfied	<i>"I was kept informed. I felt that their intervention would decrease the likelihood of others suffering the same fate."</i> (Ref 698) <i>"Satisfied with the process but not the outcome...he is now practicing in another area"</i> (Ref 1135) <i>"I am satisfied that the particular practitioner has been cautioned. I am not satisfied that this complaint process is capable of dealing with any more systemic issues."</i> (Ref 47) <i>"Process followed it steps but did not resolve anything. I wonder if this doctor has the complaint noted on his file."</i> (Ref 733) <i>"Although well managed, the consumer is only helped to a degree. No advice or recommendations are given. It seems like just another bureaucratic process to give consumer s the feeling they are being heard, but no real advice is given beyond their immediate scope. Perhaps I'm expecting too much, but I do not deal with this regularly and I was hoping not to have to engage with lawyers. It seems any complaint in healthcare requires lawyers to be involved, which is both ridiculous and expensive."</i> (Ref 1519) <i>"I would have been more satisfied had AHPRA notified me of the substantive outcome of the complaint rather than a finalisation letter that stated there were grounds for a complaint and they had referred the matter to the relevant professional body"</i> (Ref 1) <i>"With the process itself, it was handled in an efficient and seemingly capable manner"</i> (Ref 1497)
Rank 5: very satisfied	<i>"I feel everyone that I dealt with listened to my concerns"</i> (Ref 242) <i>"My complaint was fully addressed"</i> (Ref 1554) <i>"Professional, courteous - both HCCC staff and MCA [Medical Council]"</i> (Ref 1344) <i>"They explained everything well"</i> (Ref 662) <i>"I was treated with respect and kept informed and therefore I am very happy with the process"</i> (Ref 1534) <i>"The matter was handled in an expert manner and the person involved would be aware of the mistake and improve his/her practice"</i> (Ref 640) <i>"I think the overall result after in-depth investigations was fair to both parties and makes it safer for the large number of elderly people in this are."</i> (Ref 192) <i>Practitioner has conditions applied to their registration and must not work as a registered nurse until cleared to do so"</i> (Ref 1381)

Satisfaction with the complaint/notification outcome

Table A6.5.7: Survey 1: satisfaction with the complaint/notification outcome

	Rank 1= Very dissatisfied		Rank 2= Dissatisfied		Rank 3= Neutral		Rank 4= Satisfied		Rank 5= Very satisfied	
	N	%	N	%	N	%	N	%	N	%
ALL	897	53	308	18	200	12	186	11	92	6
AHPRA	361	54	133	20	78	12	60	9	36	5
NSW	536	53	175	17	122	12	126	12	56	6
HPCA	122	44	58	21	43	16	34	12	19	7
HCCC	239	61	75	19	35	9	26	7	17	4
DR	603	59	187	18	109	11	80	8	41	4
<i>All other practitioners</i>	294	44	121	18	91	14	106	16	51	8
NMW	112	36	49	16	54	17	64	20	35	11
PHARM	36	44	16	20	11	13	15	18	4	5
DENT	87	57	30	20	15	10	13	9	8	5
PSY	59	52	26	23	11	10	14	12	4	4
Consumer	688	62	197	18	95	9	84	8	42	4
<i>Cons AHPRA</i>	401	65	97	16	46	8	49	8	23	4
<i>Cons NSW</i>	287	59	100	20	49	10	35	7	19	4
Practitioner	152	44	73	21	57	16	43	12	22	6
Organisation	57	25	38	17	48	21	59	26	28	12

Total response rate 97% N=1683; all bodies 97%; practitioner lowest DENT (96%) highest PSY (99%)

Table A6.5.8: Survey 1: satisfaction with the complaint/notification outcome: Likert scale responses for major practitioner groups, AHPRA and NSW

	AHPRA						NSW					
	DR		NMW		PHARM, DENT, PSY		DR		NMW		PHARM, DENT, PSY	
	N	%	N	%	N	%	N	%	N	%	N	%
1=Very dissatisfied	349	60	77	35	110	51	254	58	35	37	72	55
2=Dissatisfied	94	16	36	16	45	21	93	21	13	14	27	21
3=Neutral	60	10	40	18	22	10	49	11	14	15	15	12
4=Satisfied	51	9	44	20	31	14	29	7	20	21	11	8
5=Very satisfied	24	4	22	10	10	5	17	4	13	14	6	5

Total may not equal 100% due to rounding

Table A6.5.9: Survey 1: whether satisfied with outcome: proportion of comments compared with all ranked responses

	AHPRA		NSW		HPCA		HCCC		Total comment		Ranked responses	
	N	%	N	%	N	%	N	%	N	%	N	%
1=Very dissatisfied	258	59	157	59	52	50	105	66	415	59	897	53
2=Dissatisfied	89	20	65	25	34	32	31	19	154	22	308	18
3=Neutral	38	9	19	7	10	10	9	6	57	8	200	12
4=Satisfied	35	8	13	5	6	6	7	4	48	7	186	11
5=Very satisfied	17	4	11	4	3	3	8	5	28	4	92	6
Total Ranked	435		265		105		160		702		1683	
<i>Comment no rank</i>	15		14		7		7		29			
Total	452		279		112		167		731			

Comment frequency prior to thematic coding

Total may not equal 100% due to rounding

Of ranked comments, AHPRA accounted for 62%; HPCA 15%; HCCC 22%, %, which is proportionate with survey returns for each body

Table A6.5.10: Survey 1: thematic analysis of comments for satisfaction with outcome

	General		Engaged informed		Balance attitude		Timely		Managed		Addressed, reasoning		Impact		Total
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total	60	6	108	12	140	15	22	2	58	6	394	42	156	17	938
Rank 1 %	83		51		77		27		24		53		61		

Rank 1%= proportion of responses within the thematic category that are ranked 1(very dissatisfied)

[1] **General**: general positive [N=2] or negative [N=58] comment

[2] **Engaged, informed**: level of engagement; information; communication, transparency

[3] **Balance, attitude**: perceived fairness of process (e.g. parties treated equally or perception of bias); perceived attitude (e.g. taken seriously, believed).

[4] **Timely**: efficiency of process, delays, impact on other processes

[5] **Managed**: process comment including assessment of evidence, understanding of issues; follow up or investigation,

[6] **Addressed, Reasoning**: whether issues were addressed or not, adequacy of reasons, comment on outcome

[7] **Impact**: impact on complainant or risk to public, safety

Table A6.5.11: Survey 1: sample of comments about satisfaction with outcome by ranked response

Rank 1	Rank 2	Rank 3	Rank 4	Rank 5
Got away with it No justice If I did this Not called to account	Got / allowed to get away with it Lack responsibility Disappointed, will never complain again	Disheartened Limits, did best can achieve Limits, but pleased cplt. justified On record for future	Partially satisfied At least investigated More just outcome after review	Fair, good, appropriate
Practitioner: No impact on them, we live with loss	Practitioner: Would rank higher if believed would change	Practitioner: Unsure learned anything	Practitioner: Apology missing Education: aware of what needs to change	Practitioner: May/ hope will change
Not consistent with standards Nothing done Unsafe	Didn't get help needed as not upheld No responsible outcome Stronger sanctions Unsafe Standards not being monitored	Employer acted, not regulator Working elsewhere – new employer unaware Conditions +ive Caution, prefer > sanction Nothing re improving standards	Correct decision Met expectations Should have suspended Suspension reasonable Would prefer > sanction	Getting treatment Warning-what wanted Can't practice

Table A6.5.11 continued

Rank 1 very dissatisfied	No action taken against practitioner and no recommendations able to be implemented. If I did anything like this, I'd be hauled over the coals Dissatisfied as the doctor does not get any disciplinary action taken against her. If I spoke like that to someone in my job. I'd be fired. He got away with incapable [incompetent] practice Am disgusted by the outcome. Heard through the grapevine that she referred to the outcome as "I knew I'd get away with it" There were [number] mistakes in a medical report. There were untruths/lies in the same report and nothing was done about it. The whole thing was despicable and the practitioner was not held accountable Yes I am very dissatisfied because yet again I feel there is no justice being done and she continues talking about my health condition and enjoying her life and I continue living a stressful, unhappy and fearful, unsafe life Even though all three practitioners were found negligent and causing my [child's] death, they are all still practising Mandatory Notification was not an easy decision that took a lot of peer consultation; Pharmaceutical Board whitewashed a very serious issue The outcome is not consistent with all recognised medical expectations
	Not all issues were addressed and, of those which were addressed, an 'easy way out' approach was used To let him exonerate himself and make glib promises, is not worth the paper it is written on The doctor was able to write a polite letter and it made the treatment or lack of treatment I received irrelevant No repercussions for the GP who has caused/contributed to this lifelong condition Having received the Board's approval, the doctor will continue to be wrong and "uncaring" Felt [response] was dis-ingenuine [sic]. I am glad it has been recorded somewhere. After reading their responses, I feel there is a lack of taking responsibility and in covering themselves Although the Doctor was counselled, my other requests were ignored and never addressed. When I questioned this the buck passing started. Also the representative appeared to be defensive and withholding basic information. When I pointed out that Doctor [name] had twice previously [been] reprimanded she feigned surprise and even claimed she didn't know this was unusual. In short she appears to be living up to the worst suspicions people have about the medical board; i.e. it's doctors investigating other doctors and thus on the side of doctors and not patients. I would say satisfied if I knew the complaint would make her think twice the next time before she acts The outcome doesn't seem to me to have the public safety consideration in centre stage at all The final outcome in my opinion, does little to satisfy my main objective – to ensure safe and "good" standards of care to patients of this practice Concerns continue regarding the clinicians ongoing capacity to practice in clinical psychology despite demonstrated incompetency in key skill sets The practitioner was practising outside of his medical restrictions...When the supervisor [was contacted] she lied The HCCC took her for her word and no further action has been taken. This is unsafe and unacceptable Expectation that professional standards are not being monitored At a minimum the doctor should be reviewed for his capacity to act with competence

Rank 3: neutral	<i>He changed his practice but not sure he learnt anything. He now doesn't refer patients to palliative care service when he should.</i> <i>They went through the process – very little recommendations about improving standards</i> <i>I have accepted that it is the best that can be achieved</i> <i>There is no satisfaction to be gained by finding that a colleague is no longer able to competently practice.</i> <i>I believe the doctor should have received a greater sanction than just a caution, but was pleased that the conclusion justified my complaint</i> <i>I am happy I made a formal complaint and that this is on record for future reference if another complaint arises about the same doctor</i> <i>Happy he is being put on (conditions)</i> <i>This Registered Nurse resigned - is now working locally - site she is now working at is unaware of incident</i> <i>Satisfied employment was terminated by employer. Not satisfied with AHPRA outcome</i> <i>Satisfied with outcome (no longer registered)</i>
Rank 4: satisfied	<i>I was surprised and unhappy to learn that both practitioners were still working, and that though they were given warnings/suspended for an amount of time, this was not public knowledge and they were able to work elsewhere without any repercussions</i> <i>I am only partially satisfied but worn out by the lengthy delays and the inability of the process to deal with deeper issues</i> <i>At least as a result of my request for review I feel a more just outcome has been reached</i> <i>Resulted in review of practice although communication issues were not addressed</i> <i>The matter was investigated and a breach identified - so satisfied with this. Just not satisfied with the lack of recording or follow up.</i> <i>Education was put in place, practitioner made fully aware of his shortcomings</i> <i>Achieved what was needed for public protection whilst this person was treated for mental health condition</i> <i>Fairly satisfied – nothing can now undo what's already happened. I would just like to know that is much more careful in future!</i> <i>An apology from the practitioner was the only thing missing</i> <i>There were two parts to my complaint- costs I hadn't consented to, and the poor communication from the dentist. I was promptly reimbursed all costs, but I never heard an apology from the dentist acknowledging the poor conduct and a commitment to change.</i> <i>I gained the documents requested. No explanation or apology from the doctor.</i> <i>Would have appreciated acknowledgement of errors from the offending pharmacy in writing and an apology.</i> <i>Would have preferred a stronger approach to her extremely poor practice</i> <i>A suspension period should have been implemented</i> <i>I think being suspended pending further investigation was reasonable</i>
Rank 5	<i>I was pleased to see letter sent to doctor, to read his reply and defence, this may have been enough to get him to rethink his behaviour towards his patients. I rattled his cage</i> <i>I would hope the doctors in my complaint, would now improve their treatment of patients.</i> <i>I now hope with education he can now make better choices in giving prescriptions to people</i> <i>Registration suspended</i> <i>Dr no longer allowed to practice.</i> <i>Staff member has support and a plan in place to get treatment going</i> <i>Outcome [was] what I wanted (practitioner issued a warning), but the process was stressful and opaque</i> <i>Appropriate discipline against the practitioner.</i> <i>Outcome good for me</i> <i>I think the action taken was all that was needed. I don't want to know if it 'worked'! I'm never going back to him.</i>

Whether the respondent would recommend the complaint/notification process to others

Table A6.5.12: Survey 1: preparedness to recommend the process to others

	Rank 1= Definitely wouldn't		Rank 2= Probably wouldn't		Rank 3= Neutral		Rank 4= Probably would		Rank 5= Definitely would	
	N	%	N	%	N	%	N	%	N	%
ALL	555	33	229	14	213	13	279	17	398	24
AHPRA	336	34	140	14	104	10	174	17	249	25
NSW	219	33	89	13	109	16	105	16	149	22
HPCA	75	27	36	13	43	16	48	17	76	27
HCCC	144	37	53	14	66	17	57	15	73	19
DR	362	36	154	15	147	15	147	15	201	20
All other practitioners	193	29	75	12	66	10	132	20	197	30
NMW	70	22	25	8	34	11	71	23	116	37
PHARM	25	31	12	15	3	4	14	18	26	33
DENT	62	40	22	14	17	11	23	15	30	20
PSY	36	32	16	14	12	11	24	21	25	22
Consumer	434	40	164	15	137	13	154	14	209	19
Cons AHPRA	263	44	90	15	58	10	79	13	115	19
Cons NSW	171	35	74	15	79	16	75	15	94	19
Practitioner	93	27	51	15	50	14	65	19	88	25
Organisation	28	12	14	6	26	11	60	26	101	44

Total response rate 97% N=1674; AHPRA 96% HCCC 98%; practitioner lowest PHARM (95%) highest PSY (98%)

Table A6.5.13: Survey 1: preparedness to recommend the process to others: Likert scale responses for major practitioner groups, AHPRA and NSW

	AHPRA						NSW					
	DR		NMW		PHARM, DENT, PSY		DR		NMW		PHARM, DENT, PSY	
	N	%	N	%	N	%	N	%	N	%	N	%
1=Definitely wouldn't	213	38	42	19	81	37	149	34	28	29	42	33
2=Probably wouldn't	96	17	18	8	26	12	58	14	7	7	24	19
3=Neutral	64	11	25	11	15	7	83	19	9	9	17	13
4=Probably would	82	15	52	24	40	18	65	15	19	20	21	16
5=Definitely would	111	20	82	37	56	26	90	20	34	35	25	19

Total may not equal 100% due to rounding

Table A6.5.14: Survey 1: whether would recommend the process to others: Proportion of comments compared with all ranked responses

Rank [1]	AHPRA		NSW		HPCA [2]		HCCC		Total comment		Ranked responses	
	N	%	N	%	N	%	N	%	N	%	N	%
1=Definitely wouldn't	159	35	98	36	33	29	65	39	257	33	555	33
2=Probably wouldn't	58	13	38	14	12	12	26	15	96	14	229	14
3=Neutral	54	12	50	18	22	21	28	17	104	13	213	13
4=Probably would	75	17	41	15	16	16	25	15	116	17	279	17
5=Definitely would	108	24	49	18	25	22	24	14	157	24	398	24
Total Ranked	454		276		108		168		730		1674	
Comment no rank	12		6		4		2		18			
Total	466		282		112		170		748			

[1] Comment frequency prior to thematic coding

[2] Rank 1: Six HPCA matters reference HCCC, one of which refers to a review process; two comment on both bodies; Rank 5: One HPCA matter references the HCCC; one refers to both

Total may not equal 100% due to rounding

Of ranked comments, AHPRA accounted for 62%; HPCA 15%; and the HCCC 23%, which is proportionate with survey returns for each body

Table 6.5.15: Survey 1: summary comments Themes 1-4: preparedness to recommend the process to others by ranked response

1=Definitely wouldn't	2=Probably wouldn't	3=Neutral	4=Probably would	5=Definitely would
Theme 1: Recommend out of legal obligation, required				
1= Not recommend; if not for mandate would never do again- harmed patient, created problems for us both [AHPRA]	2=Feel conflicted as mandatory [AHPRA]	3=Only because legally required; professional responsibility; but no confidence in outcome PROCESS: warn onerous, track requests and document closely, will be asked repeatedly for same information [AHPRA]	4=Only because legally required; out of professional obligation PROCESS: Would regardless [even if not required] as process fair and transparent [AHPRA]	5=Only because, or if, legally required, personal view – probably wouldn't; obliged notwithstanding dissatisfaction PROCESS: don't expect timeliness or much information; with some reservation; some concern non-health professionals making complaint without 'expert' opinion as may just be a misunderstanding
Theme 2: Recommend due to lack of alternatives or cost of other options				
Lack alternatives PROCESS: inadequate process, biased against citizens LAW: Legal action inaccessible (cost) so practitioner 'gets away with it'	Lack alternatives PROCESS: poorly organised, opaque, ineffectual, system broken; they don't consider impact on people	Lack alternatives PROCESS: slow, opaque OUTCOME: don't expect anything LAW: Legal action if can afford it	Lack alternatives; would if had no other options PROCESS: lengthy, frustrating, improve timeliness, accountability communication OUTCOME: unlikely to work, expect they'll get away with it, if person has other treatment options LAW: Pursue legal or other action if can, legal too expensive	Lack alternatives to hold accountable; only process to help practitioner with a problem or impairment PROCESS: but prepare them; need to use process to improve it; develop independence OUTCOME: toothless tiger but only way may be disciplined [AHPRA] LAW: Legal action costly
Theme 3: On record for the future				
If enough complaints may eventually act to protect public; tip scales if recurs [AHPRA]	If enough complaints may eventually act to protect public; tip scales in another case OUTCOME: Don't expect much; waste of time except may be on record	3=Nil	If enough complaints may act; clearer picture of dissatisfaction; on their record for future; highlight practitioner who may need monitoring PROCESS: a lot of effort and stressful OUTCOME: Better than nothing; don't expect action / positive results	If enough complaints may act; may take seriously, harder to ignore; puts practitioner on notice; hope it prompts a look at systems and processes; may result in different outcome
Theme 4: In principle, to protect the public				
Important system is used; speak up for future improvement; would advise to make even if not recommend	Need to report though didn't work for me; have to try and effect change [AHPRA]	Right thing; protect elderly; stand up for underdog; to improve care delivery; our expectations of substandard work and response to it should be high; make practitioner accountable PROCESS: Worth trying; takes a lot of courage and grief; process needs to be more transparent	For future improvement and change; to maintain standards; blind faith put in practitioners- must make them accountable; for others health and safety; to prevent recurrence; hate to see them get away with it; better to draw attention to bad practice and not just ignore it; lost faith but hopefully still advise them of process PROCESS: time consuming and draining; it's not for all; any process better than no process	For future improvement; public duty; prevent recurrence; protect public; make accountable; set or clarify standards/ issues not resolvable at individual level, despite concerns about my matter- responsibility to report; only in principle not for faith in process; vital- 'discipline and resign' insufficient as practitioner can move PROCESS: hope process will improve; don't expect satisfying result; supposed to deal with complaints and fairly- seem to have to force them to be accountable and reach correct decision [HCCC]; not transparent including information about how managed and impact [if any] on future practice; needs more powers to keep doctors accountable [AHPRA]

Categorised in order e.g. if indicated would recommend 'in principle' and added other process remark, would show process remark in same place

Unless otherwise indicated, comments apply to all agencies

Table A6.5.16: Survey 1: summary comments Themes 5-7 (positive, equivocal & negative comment): preparedness to recommend the process to others by ranked response

Theme 5: Positive experience				
1= Nil	2= Nil	3= Nil	4= Probably would	5= Definitely would
			PROCESS: effective; more effective than workplace systems; efficient; fair; transparent; timely IMPACT: for peace of mind and answers; feel less victimised; probably help; highlights issues; important that available ATTITUDE: kind and supportive during process	PROCESS: taken seriously; unbiased; efficient; handled well; no cover-ups; explained [things]; have confidence in the process IMPACT: wouldn't have achieved outcome without their help ATTITUDE: seem to want to help; will do what needs to be done insofar as possible; respectful; care; understand; best customer service; listened to; felt on my side
Theme 6: Equivocal, other				
1= Definitely Wouldn't try directly first [AHPRA]	2= Nil	3= Neutral	4=Probably would	5=Definitely would
		PROCESS: official channel but process flawed, frustrating; slow; hope better in future; need better feedback; need to push; professions needs to assist with 'prosecution' as well as defence [of fellow practitioners] IMPACT: think twice if worth it OTHER: depends on circumstances; on quality of assessing officer; on seriousness of matter; on extent may affect others; if had direct evidence; solicitor advised process to obtain report OUTCOME: slim chance; would like better outcomes for over-servicing problems; power of medical profession means 'standard practice' (even if inappropriate) won't be questioned; process works for clearly unethical or illegal behaviour but not for 'standards of care' unless egregious	PROCESS: no information about what achieved due to current law; lack transparency; lengthy; process works for patients, not fellow practitioners IMPACT: stressful; don't take lightly, especially regional areas; only do if mentally strong; get support before act OTHER: with reservation; depends; better than nothing; research alternatives; take legal action; use caution, formal complaints not always effective; useless unless very serious OUTCOME: worth trying but lack of action well documented; lack confidence that action will be taken inhibits complaints; don't expect much [serious breaches no action]	PROCESS: insist on support person; necessary, not optimal; need to better advertise process IMPACT: process fair but too long; stress; need to be demanding; horrible experience OTHER: forces practitioner to provide information they would otherwise with-hold; might help others; also take legal action
Theme 7: Negative, experience				
1=Definitely wouldn't	2= Probably wouldn't	3=Neutral	4= Nil	5=Definitely would
DESCRIPTOR: bias [49]; boys club; waste time [16]; no action [18]; take legal action [21] or go to media or other; no point [11]; no help; cover up; farce; can't trust; frustrating; whitewash; obstacles at every point; don't care; no desire to hold accountable; unhelpful; no interest; need to chase PROCESS: poor investigation; no process; no accountability; opaque-no transparency; no information; no explanation; lack ability to investigate all issues; serious issues trivialised; incompetent; inefficient, lengthy; lack review or appeal; evidence not considered IMPACT: disempowering; failed me and others; no confidence in body or system; heartache; worry; compounded issues rather than helped work through; victim further victimised; caused upset; had hoped something positive would result OTHER: would never use this process again and would recommend my employer go through HR and dismissal instead OUTCOME: no consequence; condone unprofessional behaviour; no action on systemic issues; incapacity-need to regularly assess and review practitioners; failed practitioner [needed assistance] and patient care; public risk	DESCRIPTOR: bias [44]; toothless tiger; waste time [9]; take legal action, police; not taken seriously; no confidence protect public PROCESS: no power to compel answers; poor process for mandatory complaint- standards need revision; slow; ineffective; lack proper investigation; no action; not interested in systemic reform IMPACT: stress; need to support, including people making mandatory report; patients fear retaliation; disheartening; no faith in system to be just, fair or thorough; frustration; disappointment; no closure for family OTHER: shouldn't have to take separate action for compensation OUTCOME: no recommendations for improvement despite deficits identified; poor practice and harm- no action; don't believe will result in change in practice	DESCRIPTOR: unsatisfactory; not designed for patients or vulnerable groups; people won't complain- not believed; retribution; bias [3]; no point [3]; take legal or union action; a lot of time, no result PROCESS: poor process; staff under-developed; provide evidence- told none; no action on serious harm; issues not addressed; whitewash some practitioners and target others; don't appear to act unless death or catastrophic harm; should protect vulnerable but don't IMPACT: stress OTHER: should be independently investigated themselves OUTCOME: [practitioner] will keep doing- got away with it; incompetent but still practising		DESCRIPTOR: corrupt; appalling service PROCESS: [they] put onus back on employer to manage incompetent, unsafe employees; fail to act; endorse illegal conduct

Table A6.6.1 Survey 1: most positive responses (Rank 5) for process and outcome by agency, source (respondent) type and subject profession

	All returns	Process			Outcome			Process & Outcome		
	row %	N	%	row %	N	%	row %	N	%	row %
Total		108	6		92	5		67	4	
Agency										
AHPRA	60	58	6	54	56	5	61	37	4	55
NSW		50	7		36	5		30	4	
HPCA	17	22	8	21	19	7	21	14	4	21
HCCC	23	28	7	26	17	4	19	16	4	24
Subject profession										
DR	60	60	5	46	41	4	45	31	3	46
NMW	19	19	9	28	35	11	38	23	7	34
PHARM	5	5	10	7	4	5	4	3	4	5
DENT	9	9	9	13	8	5	9	7	4	10
PSY	7	7	5	6	4	3	4	3	3	5
Respondent source										
Consumer	66	65	6	60	42	4	46	35	3	52
Practitioner	21	22	6	20	22	6	24	15	4	22
Organisation	14	21	9	19	28	12	30	17	7	25

Appendix 7: Study materials

Human Research Ethics Committee

Letter of approval
Letters of approval (variation)

Survey 1

Researcher cover letter
Agency cover letter (proforma for x3 agencies)
Participant Information Sheet
Survey questionnaire
Supplementary information sheet
Expression of Interest and consent to interview form
Website notice for agency websites
Researcher follow-up cover letter
Agency follow-up cover letter (proforma for x3 agencies)
Protocol

Survey 2

Researcher cover letters (x3 respondent types)
Survey questionnaire (page 1 varies for each of x3 respondent types)
Participant Information Sheet