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LAW REFORM COMMITTEE

Inquiry into alternative dispute resolution

Melbourne — 11 February 2008

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Ms B. Wilson, health services commissioner, Office of the Health Services Commissioner.

The CHAIR — Welcome, Beth Wilson. You understand that this hearing is covered by the Parliamentary Committees Act and it is covered by privilege, so the things that you say will be protected, but if you say them outside they will not be.

Ms WILSON — What is the last bit?

The CHAIR — If you say it outside, the same thing, beyond the purview of this hearing, then you will not have the parliamentary privilege to protect you against litigation. We have got about half an hour, so we will throw it open to you. Thank you very much for the submission that you sent in. We will throw it open to you to talk to us about your work in relation to the terms of reference, and then will have a discussion and ask you questions.

Ms WILSON — I apologise in advance to those of you who know about the work of my office, but I will just give a brief summary, if that is okay by you.

The CHAIR — It is good to have it on the record.

Ms WILSON — Yes, indeed. The Health Services Commissioner's office has been offering alternative dispute resolution since we were established by the *Health Services (Conciliation and Review) Act* 1987. We will celebrate our 20th anniversary in March this year, and I have just begun my third five-year term under Governor in Council appointment. For want of better words, I guess we are really a — small 'h', small 'o' — health ombudsman.

We deal with all issues relating to health within the state of Victoria. I can receive and resolve complaints about doctors, dentists, alternative therapists; anybody who purports to be offering a health service within the state of Victoria comes within my jurisdiction, although I would rather couch that a bit more optimistically by saying that if they have a complaint lodged against them, they have access to the independent expert health complaints resolution agency. We also have jurisdiction over organisations as well as individuals — hospitals, for example.

Since 2001 my office has also administered the Health Records Act, which is health privacy legislation in Victoria. The government took the view that health information is far more sensitive than other kinds of information; they therefore did not want to just put it in with the privacy legislation, they wanted a separate, health-sensitive piece of legislation to be administered by an office like mine which is expert in health disputes resolution.

Most of the people who come to my office want three things: they want to know what went wrong; why it went wrong; and they want to make sure that what happened to them does not happen to somebody else. In other words, if they take the trouble to lodge a complaint, they are usually looking for a quality outcome — for example, 'wrong-side procedures', a euphemism that we lawyers use for when they chop off the left leg instead of the right leg. It is rare, fortunately, but it does occasionally happen.

We had one instance where a baby required eye surgery, and they did not get the wrong eye, they got the wrong baby. As you could imagine that one took very, very sensitive handling indeed. Fortunately there was no identifiable damage or injury done to the infant, but obviously no-one would subject their infant to that kind of general anaesthesia and procedure for no good reason.

In cases like that we want to see that there are procedures put in place so that the mistakes are not repeated. That is what most of the people who come to us want. Although we can arrange compensation to be paid in conciliation, most people are not actually after money. Quite often they will say things like, 'I don't want money. That would be an insult to my mother's memory' — or whatever — 'I just don't want this to happen again'. Complaints to our office have to be in writing, which can be difficult for people, particularly those of non-English-speaking backgrounds. We are aware of that, and we do our best to help them through outreach programs.

I have also got a full-time Aboriginal liaison officer on my staff, because Koori Australians will not use mainstream agencies unless there is a Koori presence there. At the moment we are targeting the aged and vision-impaired people. We are going out and trying to see how we can reach them better at the moment.

To be successful, alternative dispute resolution needs to be confidential and impartial. It needs to be expert and efficient, and we need to be accessible. Accessibility has been a big challenge for my office. I do over a hundred speeches a year. I do not knock back any invitation from Probus clubs or Rotary — all of those people —

particularly because they tend to be older and therefore quite heavy users of our health services. But every time I do one of those, up will go the hands, with, 'Why didn't I know about you before? We could have used you'.

I have chosen not to engage in heavy, expensive advertising programs partly because I do not want to alienate people who give my office a lot of assistance — the medical profession, for example. Although when the office was being planned for, the AMA strongly opposed it, Paul Nisselle, who was the then president, is now on my advisory council and one of our staunchest supporters. Things change. If I had advertisements out there saying, 'Have you got a complaint about your doctor?', I would lose a lot of the goodwill that we get at the moment. Doctors will come and give us evidence and sit in on conciliation proceedings because they believe in what we are doing, and of course, if we are an alternative to litigation, we are going to be pretty popular, even if we did not do well. But I think we do our job well.

In my office there are two kinds of dispute resolution, broadly speaking. There is mediation, which occurs in the early stages, and nearly all of the complaints are settled in mediation, but we also have formal conciliation processes. The conciliation is set up under the legislation. My conciliators are hired exclusively to do that work, and they are very skilled. It is not only confidential, it is privileged. The cases that go into formal conciliation are the ones that are complex. There might be a lot of parties involved, there might be a serious injury, and there is likely to be compensation paid. I do not let the lawyers into conciliation meetings without a very good reason. The conciliator is not there to resolve the dispute; they are there to manage the process, help people to talk to each other, provide a neutral venue and help people to resolve the complaint themselves.

If compensation is paid through the cooperation of the medical or other insurers, then people go away, have a think about it and come back. If they agree, a legal release is signed, and that is the end of the matter; it does not go any further. Most people are always assisted by a genuine apology. The apology is incredibly powerful. You see people angry and upset; if they get a genuine apology, they relax and the dialogue can begin. Is that enough of a summary?

The CHAIR — Okay. Perhaps to start off I will take you back to talking about some of the things that you did not do to promote the organisation. You said you talk to Probus groups and you do a hundred talks a year. What are some of the other things that you do that promote the fact of the office that try to redress that business of people putting their hands up and saying they did not know you were there?

Ms WILSON — I am very accessible to the media. I have reporters saying to me, 'Apart from you and the Ombudsman, Beth — you are the only people I can ring up and you answer the phone, and I can get my job done'. This morning I was on David and Kim's morning show talking about some of the hazards associated with laser therapy and IPL, light therapy. A lot of people have been burnt and scarred from the use of those kinds of things. So we use the media all the time to get the message across; seminars, conferences, I write a lot, but I just have not gone down the formal advertising paths, although if you ring the Department of Human Services and you are hanging onto the phone for a while, you will hear, 'The Health Services Commissioner is the independent health ombudsman'. That is certainly very helpful as well.

The CHAIR — Can the government do anything to support you?

Ms WILSON — They do support us, just through — —

The CHAIR — Through that example?

Ms WILSON — Yes, that example; obviously people ringing in to the Department of Human Services are going to have an interest in the kind of work that we do. We have information on the Department of Human Services health channel. That is particularly helpful as well. We cooperate with other agencies too. One of the reasons I argued for and accepted a third term in office was that I am, kind of, the grandmother of the commissioners at the moment. I am the one who has been around the longest, and there are a lot of new ones coming on board, so I thought that it was time for a bit of continuity. I want to do much more interagency work, which I have started.

We had very good success with the Office of Fair Trading in bringing to task a big firm of optometrists who were supplying spectacles that were not fit for the purpose for which they were created, and people were being ripped off hugely. That interagency work is something I am concentrating on in my last term. But that did not answer your question, I am sorry.

The CHAIR — No, it's okay.

Mr CLARK — There are at least two aspects of work as ADR in the health sector that are unique to that sector, and one of them is urgency, in that if there is a dispute going on about the medical treatment that a person is or is not receiving at the time, it does not wait too long. What procedures do you have in place to act in cases of urgency, and how do you shortcut the normal sort of protocols and procedures to tackle that?

Ms WILSON — We have to be very careful that we do not go and stick our noses in when in fact it is a job of the Guardianship Board, but we would liaise very closely with them. We might have an end-of-life situation where the family thinks that the person is not at an end-of-life situation, but the hospital clinicians think they are, and that can get very heated indeed. We would work in conjunction with the Guardianship Board in those kinds of difficult situations. However, there may be — I am trying to think of cases where I have intervened quite quickly. A lady had a stillborn baby in one of our hospitals. On the day of the baby's funeral she received in the mail an invoice addressed to 'The Foetus Smith'.

That kind of insensitivity causes great grief for people. In a case like that I am not going to be sending out notices and all that nonsense. I will get on the phone to the hospital and say, 'I want to have a meeting very quickly. I want you to apologise, I want you to use the baby's name, and I want you to tell them what you have done so it will not happen again'. Usually at the end of the process, at the end of an informal kind of mediation like that the person will say, 'Okay, I can let this go now and get on with my grieving'. That would be the kind of intervention that we might do. Common sense dictates a lot of that.

Mr BROOKS — My question was about that recognition of your service. In particular do the hospitals and other health service providers — either voluntarily or are they mandated — inform complainants about the existence of your service?

Ms WILSON — They are not mandated to do it. The way that it works with the hospitals is that under the funding agreements with the Department of Human Services they have to set up their own complaints mechanisms. So there are at least 150 people employed in Victorian hospitals who are sometimes called 'complaints liaison officers'; sometimes they are called a 'patient representative'. They deal with complaints at the point of service.

My legislation says that I have a duty to provide support and training for anybody who is dealing with complaints. It does not even say 'health complaints'; it says 'complaints', and I take that seriously. We try to provide orientation training for every single complaints officer within three months of their appointment. We have an ongoing support relationship with them. So that is how it works at the hospital level. You can tell a good hospital when you walk in and you see Reception and then behind that — this is the Austin, for example — 'Patient Representative' in big letters, nice rooms, a sink, they are well supported, and they have a comfortable place to sit down. They take their complaints processes seriously.

A lot can be resolved at that very early stage before things go off the rails. They certainly advertise our services, because if they cannot resolve them, then they send them up to us, and we get the more complicated and the more difficult ones, quite obviously.

Mr BROOKS — They do refer them?

Ms WILSON — Yes, the hospitals in particular. Lawyers sometimes do not tell people about us. I have been working with the Law Institute to try to remedy that. I do have a discretion to accept out-of-time complaints. One of the things that I will take into account was whether they visited a legal representative and whether they told them or not. General practitioners will very often be advocates for their patients.

The patients will tell them something has happened, and they will say, 'Look, here is the brochure for the Health Services Commissioner. Why don't you take it over there?'. We are involved in a pamphlet organisation that makes sure that our pamphlets are in hundreds of general practitioners' offices, for example. But I am sure there are a lot of practitioners who would rather people did not know about us.

Mr FOLEY — Patient advocates at hospitals seem to be common these days. I came across one at the dental hospital recently. Do you work with those kinds of professionals?

Ms WILSON — I certainly do. The public dental hospital has some very difficult clients, as you can imagine. We have been helping them to get their complaints and their advocacy service together and also putting them onto people who can give them training in dealing with vexatious or difficult people — what I would like to call 'the unusually persistent complainant'; the words have been chosen carefully!

Nursing staff can often be advocates for patients, too. Whilst I cannot take a complaint from another provider unless the patient is unable to complain on their own behalf or the patient has authorised them to complain to me, they can refer people on, and they often do.

Mr O'DONOHUE — Does all of your funding come from the Victorian State Government?

Ms WILSON — Yes, via the Department of Human Services. There have been some initiatives or attempts to have us privately funded. The last Secretary of the Department of Human Services established the industry ombudsmen — the banking ombudsman and the telecommunications ombudsman — which is the model that she was justifiably very proud of. She, having to be mindful of her own budget, thought that parties like the AMA — that is, the Australian Medical Association — or the medical insurers might make a financial contribution to my office. I opposed that on the grounds that impartiality is what makes us so successful. She did a thorough consultation, and they spoke to all of the stakeholders, and the idea was dropped for that kind of reason.

Mr O'DONOHUE — Fair enough.

The CHAIR — I just wanted to ask you about online ADR, which you talk about in your submission. What do you see as the possibilities of that in the health area?

Ms WILSON — It depends on what we mean by online. Of course, that is a big term. When I was the president of the Mental Health Review Board we were travelling three members of the board to places like Warrnambool, Portland and Traralgon in little aeroplanes. It was very expensive, and we introduced — this is actually about technology rather than online, but I hope it is still what you are asking me about — television hearings so that if a person had already been seen by the Board once, then they had the option of using the teleconferencing facility to hold their hearing. If the Board had any doubts about whether they had all the evidence, they could then actually go to the location if they wanted.

I was a bit concerned in the early days because there was a kind of delay, and those kinds of things can be a problem for psychiatrists who are trying perhaps to assess rapid eye movement or something like that. I was also concerned about people who have schizophrenia and are experiencing voices. I was wondering whether they were in fact able to discern whether — people who have televisions talk into them as part of their illness — they would be able to discriminate between their voices and ours. But there was absolutely no trouble with that at all; they knew who we were, and they know they were different from the voices.

However, a patient's child did come into the room. He lifted the child up on his knee and said, 'Talk to the lady on the television'. So the little boy said, 'Hello, lady', and I said, 'Hello, little boy'. And I thought, 'I wonder what is going to happen when that child of a father with schizophrenia goes to school and says, "The lady on the television was talking to me". So there are some hazards online. We accept complaints by email, but we are still actually getting our processes in place for those to make sure that they are properly filed and that we have the proper authorisations, because we cannot proceed without a signature. We cannot go and look at people's medical records, for example, without their express authorisation. But there is a lot of potential online, just as there is with all of the new technologies to enhance this. The tyranny of distance can be defeated in that kind of way.

The CHAIR — I guess I had not thought when I was reading the part of your submission that refers to online ADR of that kind of interactive television; I was thinking more when I was reading it off email. One of the pitfalls of email is that it does encourage automated responses, which can be an incredible turnoff.

Ms WILSON — Yes, indeed.

The CHAIR — Are you doing that kind of thing by way of information?

Ms WILSON — No, we will receive a complaint via the email, and then an officer will get on the phone and talk to the person, and normal letters will go out because we want hand signatures — that kind of thing — or we visit, if necessary, depending on the complaint. It is interesting that people sometimes argue that online is not

accessible to all groups, particularly in marginalised groups. But actually our first Koori complaint came in via email. So we have to be a bit careful we do not stereotype it.

Mr FOLEY — Beth, in terms of your pretty strong position that you said about state-funded and conciliatory, we have heard in other sectors — so there are obviously differences between sectors — of other models of ADR, that people are equally passionate about them, the fact that they are industry based and it is a condition of licence and that sort of stuff to make them industry based and that they are mandatory. What is it about your service that makes it particularly important to your mind, that it is voluntary and state based, and what does that say about alternative dispute resolution processes more generally?

Ms WILSON — I think that the industry-based ombudsmen are doing a fantastic job. We meet for lunch every six months to discuss relevant issues. With health complaints people are often very distressed — someone has died, or they have got a seriously-ill child. There is a perception that professionals stick together and look after each other — like doctors, for example. If we were funded by the Australian Medical Association, or nursing federation or whatever, I think the faith that the public has in our independence and impartiality would be at risk. That is the major reason.

There would be some great advantages if we could get some extra funding, because I have 25 people working with me. We get about 9000 calls a year, and a total case load of about 2000, some of which can be incredibly complex and we are very busy. But I do not think we would be anywhere near as successful if we were privately funded.

There are also, for example, the law firms. There was an initiative of the Registration Board, there are 12 registration boards who register doctors, nurses; there are 12 categories of registered professionals, and the way that we work with the registration boards is that if I get a complaint about a registered practitioner, I must tell the relevant board, they tell me about theirs. We share them. We decide, 'This one needs conciliation, that one needs serious investigation, because it is about unprofessional conduct'.

At one stage there was an initiative that any doctor who had been involved in conciliation proceedings in my office and where compensation was paid as a result, should have to report back to the Medical Board that that had happened. That is contrary to the very strict confidentiality that surrounds conciliation, so I personally got on the phone and rang all of the stakeholders — the law firms who act for the hospitals, the law firms who act for plaintiffs, medical indemnity people. The lawyers in particular said, 'If that information is given out outside of conciliation, we will not cooperate with you in the way that we currently do; we will treat you like any other party, and it would be a dispute, not a resolution process', so I am extrapolating from that as well.

The CHAIR — Beth, could you tell us a bit about your conciliators — how they are trained, and whether there are minimum training requirements?

Ms WILSON — When I came to the office there were two conciliators, and they kind of invented the game for themselves. Industrially they were in a great position — there were only two of them. Conciliation is quarantined from the rest of the office, so even I, as commissioner, do not always know what is going on with conciliations. There is good reason for that quarantining, but it makes it difficult to manage. I broke up that little duopoly and brought in a lot more people.

They trained them, but then I started interviewing for other organisations, like the then Accident Compensation Commission. I interviewed other conciliators, and they had all done the LEADR course; they had all done external training. My people, who had been doing this for years were a little resentful when I said, 'You have got to go and do some training'. They said, 'We do the training for other people. We do not need it'. I said, 'Well, first of all, you do, because if you want to leave here and compete on the open market, you need to compete with all these other people'.

I guess I got to see the profession of conciliator from a different perspective from outside my own office through conducting interviews. There are some fantastic people out there, and some very good courses. My staff now all go off and have that training, and they value it. LEADR is one, and we also participate with the Law Institute and with the medical indemnity people to have a conference every year on alternative dispute resolution in the health field.

The CHAIR — Do you do the different ones because they have different strengths?

Ms WILSON — Yes. My conciliators who have actually undertaken the courses would be in a better position to answer your questions about their relative merits than I would, because I have not actually done the courses, but I know that they think some are really good, and some are not so good.

Mr CLARK — Another opportunity that you would seem to have as Health Services Commissioner out of your work is to pick up systemic problems within the health sector and lead to reform there?

Ms WILSON — Yes.

Mr CLARK — Can you tell us a bit about how you manage that process — what sort of reports you are able to pick up and some examples of the sort of issues you have picked up?

Ms WILSON — Probably not as well as we would like to. Out of our alternative dispute resolution often there will be a quality change. We have not been able, because of lack of resources, to monitor that as well as I would like to do, but I think I found the solution to that. We have been trying to do it all ourselves. I think what I am going to do is enlist the support of the CEOs of the hospitals and come up with some way, in tandem with them, of them reporting back to us every six months whether that quality change has been maintained or not, because there are some real advantages for them in doing that — in managing their own staff.

An example of this happened in 2001, where there were terrible headlines about the Royal Melbourne Hospital. It was alleged that members of the nursing staff on the night shift were taking drugs, were drunk, were threatening and frightening patients, and even boasted of having murdered patients. Can you imagine the media coverage of that?

The Minister for Health quickly handballed that — sorry, 'referred' that — matter to me for formal investigation, which I undertook. Usually I do not undertake formal investigations. I have strong ombudsman-like powers if I want to do it, but I usually choose not to, because I find conciliation and mediation is better.

But, even so, even in conducting that form investigation we could have used our powers to go and seize documents — we could have got writs and all that kind of thing — but I chose not to. Instead we cooperated with the management of the hospital and said, 'Look, this is a fantastic opportunity for you to get some really big changes happening at your hospital'.

It took us three months. We did 55 recommendations. It cost $55 000, which, if you compare that with a royal commission of inquiry or whatever, is bargain basement stuff. We made it very doable. Of our 75 recommendations, most have been implemented, and we go back to the hospital. A panel of experts, the managers who are responsible for implementing our recommendations, come and tell us what they have done and where they are at. That is one way of monitoring that process.

Also, many other hospitals and similar services — Australia wide and internationally — took our recommendations and audited their own procedures. They said, 'Okay; how would we look if this team of Beth Wilson's came in and did this kind of investigation on us?'. That was not about the allegations of murder or misconduct. That all went to the Coroner and to the Nurses Board. My job was to go in and look at systemic issues in the hospital. What happened when people reported misbehaviour; was it acted on, or did it just disappear somewhere? What was the standard of record-keeping like? What were the protocols around the dispensation and storage of medication? It was those sorts of things, and that hospital has improved enormously since we did that report.

The CHAIR — Thank you very much. That has been very useful, and thank you for your submission. As I said, we will get a copy of the transcript to you to make any changes to.

Ms WILSON — I am used to that process.

The CHAIR — I think we have just about covered all the issues we had written down, but if there are other matters Kate will be in touch.

Ms WILSON — Thank you.

Witness withdrew.