

## Why don't country people whinge more?

**Ann Mara** and the Resolution Service of the NSW Health Care Complaints Commission

In early 2008 the public became aware that a specialist in obstetrics and gynaecology was practising contrary to the restrictions placed on him by the New South Wales Medical Board's Professional Standards Committee in 1997. This is a well-known case and the practitioner Dr Graeme Reeves, dubbed the "Butcher of Bega" by the media, has now been deregistered and there are criminal charges pending.

This case resulted in many changes including a review of Area Health Services credentialing procedures, and changes to legislation which, among other things, allows for practitioners to be suspended immediately if they work contrary to restrictions placed on them.

This case highlighted a number of issues particular to rural areas. The Area Health Service were so grateful to have secured his services they overlooked thorough employment checks. Health practitioners and patients alike tolerated his unorthodox behaviour or poor outcomes for some time, either hesitating before making formal complaints, or failing to report their concerns altogether. Reportedly they feared that the practitioner would leave and these communities would be back to having no local gynaecological or obstetric services. According to media reports (The Australian 1.2.09 The 'Butcher of Bega' is in hiding") there were 500 complaints from women that Dr Reeves has sexually assaulted or mutilated their genitals. Between 1990 and 2007 the Health Care Complaints Commission received 24 complaints about 25 patients.

This case highlights why complaints bodies and so-called 'whingers' are important and the role they have to play in guarding public health and safety. The New South Wales Health Care Complaints Commission is an independent body dealing with complaints about health services provided in New South Wales. The Commission is impartial and acts to protect the public health and safety. Anyone can make a complaint including patients, parents or guardians, relatives or friends or health service providers or another concerned person.

The Commission deals with complaints about any health service provider in New South Wales including registered practitioners such as doctors and nurses and dentists. It also deals with complaints against unregistered providers such as acupuncturists, naturopaths and psychotherapists. The Commission also deals with complaints against health service organisations such as public and private hospitals, medical centres and Justice Health.

Complaints must be in writing and the Commission can provide assistance with this. After a complaint has been received the Commission will usually provide a copy of the complaint to the health service provider so they have the opportunity to respond to the complaint. The Commission has 60 days to assess the complaints and in doing so it considers the information provided and obtains further relevant information for example medical records. When the Commission has assessed all the relevant information it decides how best to manage the complaint. All parties involved are notified of the assessment decision within 14 days of the decision being made.

### The role of complaints

In the last 20 years or so there has been an increasing emphasis on the role of complaints in maintaining and improving the quality of health services. They do this in a number of ways. Complaints

act as an early warning system providing opportunities for health service providers to fix problems before they lead to serious outcomes. For example, one complaint revealed that neither of the two staff in a small rural hospital could read an ECG, prompting training for all staff in all small facilities in that area. Complaints can prompt reviews or investigations into systems and processes and uncover unforeseen flaws or consequences.

The health system is enormous and complex and presents innumerable challenges in organising the people—the rich tapestry of health service providers with their variety of skills and patients with complex care needs and different expectations, and hundreds of thousands of episodes of care. The geographical challenges present other complicating factors such as transport to and from health services, discharge and admission processes and communication with families and between health service providers. There are plenty of opportunities for things to go wrong. And in fact, things do and will go wrong quite often, but maybe not as often as you'd expect with so many variables.

How we respond when things go wrong is the subject of this paper. There are plenty of courses where you can learn more about the nitty gritty of complaints management. This paper will help rural health workers to put the complaints and whingers into perspective and highlight the broad principles that you can use to guide your approach and response to complaints. This paper aims to cover the particular issues that arise for people living in rural areas who are either consumers of health services, providers of health services or both.

Most people in Australia live in metropolitan or outer metropolitan areas, where if you have an unsatisfactory experience with a local doctor, you can change doctors. This is unlikely to be very inconvenient, as, more likely than not there will be several other practitioners in the same suburb or the next suburb. If you go to one hospital and you are not treated well, you can go to another hospital. I've just spoken about doctors and hospitals but of course this applies to all health service providers. In the city there is competition for services, there are a greater range of services catering to different types or levels of need. There are more support services, more specialist services which are more readily available and, most of the time, accessing them is easier and cheaper for city folk.

For the last five years I have mainly dealt with complaints from people living in the Greater Southern and Greater Western Area Health Services covering 75% of New South Wales, less than 1 million people live in these areas. As this audience knows, there are many issues around delivery of quality health services to so few people over such a large area. I am not going to go into these here.

This paper will look at whether complaints have the same role to play in maintaining or improving quality health care services in rural areas, as they do in city areas. If the answer to that is yes, then what, if anything, do we do about the barriers that prevent people living in rural areas from making complaints? If we don't do anything to address the barriers does this mean that country people will not only be condemned to having poorer access to health services than their city cousins, but also poor access to quality health services? Does it follow that fewer complaints means fewer opportunities to reflect, to review and make changes aimed at improving services?

Is it possible that the barriers, which deter people from making all but, the most serious complaints—where there have been tragic outcomes—are depriving rural practitioners and facilities of the early warning opportunities presented by so-called minor complaints?

## What are the barriers?

In the last five years I have come across many different sorts of complaints from people in rural areas. Here are some examples that illustrate the real-life dilemmas for people making complaints in rural areas and for practitioners trying to resolve them. The names have been changed.

### The fear of consequences of making a complaint

Susan X complained to the Commission when her GP refused to treat her or her family. Susan had complained to the GP that his receptionist, a friend of hers breached patient confidentiality about his patients. The GP responded by firing the receptionist and refusing to treat Susan or her family, even writing to the Area Health Service advising that he would not even treat them at the Hospital. He was the only doctor in town. Susan doesn't drive and the next town is 40 km away. The Commission referred the complaint to the New South Wales Medical Board to discuss with the GP his obligations as a medical practitioner as outlined in the *Medical Practice Act 1992*. Under Sec 36 (1) (l) of the *Act*, it is an offence for a medical practitioner to refuse or fail, without a reasonable cause, to attend a person in need of urgent attention. As well a medical practitioner who is contracted to provide services in a public health facility is generally bound by the contract to attend to people in that facility even if the practitioner has refused to attend them in a private capacity. The outcome of this matter is still pending.

Area health services and small communities work very hard to secure medical practitioners. Some communities offering cash incentives, housing and other benefits designed to attract and secure their services for the town, often in competition with other local communities.

There have been numerous examples of people making initial enquiries about what they believed to be substandard care provided by practitioners and these matters are never pursued because of fears that there will be repercussions. For example, if they have small children they wanted to be able to use the Hospital Emergency Department. Where people have limited access to services they fear doing anything that will further diminish that access.

### Tension between individual and community interests

Mrs James made a complaint about the treatment provided in the Emergency Department to her adult son after an accident. She was on the Health Council (a consumer representative body in the town) and had played a key role in securing the practitioner for the town. Mrs James was so torn about pursuing the complaint because her son suffered a seizure caused by the treatment provided and he was seeking future employment in a job that required him to report seizures.

### Interconnectedness of private businesses and public services

Lakeisha is a young aboriginal woman, who could not get medical treatment for her baby who had been suffering gastroenteritis for 48 hours. There were two doctors in this town. The one that bulk billed was booked out for three weeks and did not have any emergency appointments. The other practice had appointments but refused to see her because she had an outstanding account. The triage nurse called the doctor on call, which was the same one to whom she owed money. He said he would come after he had finished consulting in his surgery. As you would know, in the country it is not uncommon for practitioners to do this, and only come to the Hospital in an emergency. This would not necessarily represent a deviation from an acceptable standard of care. However, for Lakeisha, it was hard for her to feel confident that her baby's care was not being compromised by limited options.

### Rapidly changing providers

Mr Willie is an elderly man in a small country town. The GPs in the practice he attends change every six months. He became extremely ill while waiting for surgery. Further inquiries revealed that he wasn't even on the waiting list for surgery and never had been. In this type of situation where five or six practitioners have provided care it can be difficult to track who, if anyone, was responsible for the omission.

Similarly, Mr Barry lodged a complaint because of a failure of a GP practice to diagnose his lymphoma until it was quite advanced. He had raised his concerns with several practitioners over a 12-month period; none had linked his family history of lymphoma to his symptoms. It can be difficult to identify which practitioner is responsible and if the mistake is not drawn to their attention they have missed the opportunity to learn from it, and the patient misses the opportunity to resolve the complaint.

### Personal differences

Cory was a young homosexual man in a small country town and his doctor, the only doctor, was a firm Catholic and openly hostile to him about his lifestyle. Although aware of a melanoma diagnosis some years earlier, the doctor failed to follow up the symptoms of a recurrence until it was too late. Whether or not Cory's homosexuality and the doctor's Catholicism had any bearing on the missed diagnosis, because of the doctor's earlier hostility, the family believed this was the case and they pursued the complaint after his death. That practitioner continues to practise in the same town. I'm not sure where the family receive medical services. In the city Cory could have got a second opinion or gone to a different doctor.

### Colleagues and fellow residents

The Commission also receives complaints from health care providers raising concerns about other health care providers. In this example, local GP obstetricians were involved in a complaint against a specialist obstetrician. The complaint was about the adequacy of the care provided and delineation of responsibilities. All the practitioners lived in the same town, their children went to the same schools and they all continued to practise at the same hospital. This "hothouse" environment creates particular stresses for everyone involved. Often the only resolution comes when one of the parties moves away.

There are similar consequences for nursing staff, such as the Nursing Unit Manager who worried that a particular specialist's handling of used dressings had the potential to spread MRSA infections. She raised her concerns with him to no effect. She called the Commission to ask about making a formal complaint but did not proceed for 2 reasons. Firstly, she was worried about her job. There were few other senior nursing positions available within a 200 km radius. And secondly, the hospital had struggled to find a visiting consultant in this area of specialty and if they did anything to put this one offside she was worried they would have no one to fulfil that role. She was also worried that she would be targeted for having caused trouble.

### Fear of bureaucracy

Another observation I have made over the years is that while significant numbers of aboriginal patients and families seek advice about health related concerns; something very bad has to have happened before they will proceed with a formal complaint to the Commission. What holds a lot of Aboriginal people, and some others, back is a fear of bureaucracy. They want the matter resolved but not to "get anyone into trouble", and they want it dealt straight away, rather than getting

involved in what can be a lengthy process over some months. In many cases a less formal process would better serve their needs.

Rural people do have a right to access not just health services, but quality health services. To ensure that quality is maintained we need to do what we can to ensure people who complain are not 'punished' or discouraged, because they may have a point. We need to embrace so called "whingers" as people of courage who have overcome the odds to raise their concerns. There are some things that we can all do to try and ensure that opportunities to make improvements are not missed.

## **Maximise opportunities to improve services by embracing complaints**

It is often at great personal expense, or with a fear of repercussions that people make health service related complaints. When rural people do proceed with formal complaints in almost all cases they have thought long and hard about it. Even when they make the decision not to make a formal complaint, they suffer the anguish of worrying about whether they did the right thing and if their failure will result in a bad outcome for someone else, possibly someone close to them such as a family member.

They may be more stressed and worried about the complaint than complainants in cities and may require reassurance. Here are a few ideas that might assist.

### **Try not to be defensive, listen and try to understand**

Health service providers and administrators need to try very hard not to be defensive and to accept at a deep level that complaints are a part of everyday life. This includes both "legitimate complaints" and "unreasonable/unfair/trivial" complaints. Also remember that unreasonable people can make reasonable complaints that should be acknowledged. No matter how much it sticks in your craw.

### **Do what you can prior to providing the service to match up expectations with reality**

Discontent or unhappiness usually arises where people's expectations vary considerably from what actually happens. We could all make more of an effort to prepare patients and their families so they know what to expect from the health system, from that particular surgery or from a particular health-care provider. A good way to test prior knowledge or expectation is to ask "What do you understand about why you are having this surgery and can you tell me what you think the risks are?" or similar questions.

When a complication or a known risk does happen—tell the patient/family it has happened. Also, in keeping with Open Disclosure Policies in NSW facilities must tell the patient/family when an error has been made.

Even where there is a poor outcome for a patient, everyone is more likely to be accepting of that outcome—if they have been made aware of the risk in advance and had the opportunity to make an informed decision about treatment. This is especially important in rural areas where there is tremendous diversity in experience and education levels of staff and patients.

Patients should be provided with accurate information regarding all costs and fees prior to receiving the service. This is providing informed financial consent. No matter that the doctor doesn't like talking about money, or the anaesthetist doesn't like to talk to people on gurneys and so doesn't speak to them at all. At the earliest opportunity all patients should be informed of the costs associated with obtaining services—prior to receiving services.

Similarly, transport issues should be discussed with patients in advance of their transfer, if possible. This allows for forward planning. It comes as a terrible shock to many rural patients to realise that they were flown to the base hospital in their pyjamas with no money and no Medicare card and they are expected to get themselves home.

### **Develop a robust complaints handling process and tell everyone what it is**

Health service providers and consumers need to have confidence in complaint handling processes. They need to know what the process will be when a complaint is made and they need to feel confident that it will be dealt with fairly and thoroughly. When you take a complaint tell the complainant what you are going to do and do it. Even if at that stage you have to say that you will need to get advice or think about what happened. Whatever you say you will do, do it and do it in a timely manner and keep the patient/family informed.

### **Maintain strict confidentiality**

One key component of a good complaints management system- especially in the country—is respecting people’s privacy. This is a particular issue in rural areas and can impact on health services and patients in so many destructive ways if it is not respected. If patients hear their termination of pregnancy being discussed around town, they may never access the service again, no matter how desperately they may need it.

### **What about the behaviour of patients?**

One question often asked by health-care providers is—Can I make a complaint about a patient? No matter how attractive that might seem that is not an option for any of us. You will need to have your own support mechanisms to deal with this sort of thing. However, this does not mean that you have to endure unacceptable behaviour either. There are options available to you to help in managing difficult patient/family behaviour. These can include

- Developing a management plan, which is negotiated with the patient/family. The plan details what each party undertakes to do/not do in future. For example, each time a patient threatens staff saying they are going to get a shotgun they should know staff will call the Police. If patients do not make such threats, the staff will not call the Police.
- For very disgruntled complainants you could assist them to document every one of their complaints and address each one in writing. This strategy can reassure the complainant that they have been heard, that their concerns have been taken seriously. It can also contain the complaint in cases where the source of the complaint keeps changing.

Some of these ideas will sound time consuming and time is something that many of you just don’t have. Look at it this way, the time taken preventing problems arising, or managing them is well spent. It takes a lot longer to deal with the complaint once the patient or family have lost trust, become angry, gone to the media, written to the local member or the Minister or made a formal complaint to the Commission.

### **In conclusion**

This paper has attempted to present some of the difficulties faced by administrators, health service providers and consumers in using complaints processes to maintain and improve quality health services in rural areas where access to health services is highly prized. The concept of using

complaints to improve services is useless in rural areas, unless we are acutely aware of all the forces that discourage complaints and address them in the complaints handling process.

By developing and adhering to strong and thorough complaints handling processes it should be possible to contain the complaint and deal with it on its merits in a timely and fair manner. In this way, most community members will, over time, develop respect for and confidence in the process.

We also need to remember it could be you seeking good complaints handling for yourself or your family one day!

## Presenter

**Ann Mara** has worked for the NSW Health Care Complaints Commission as an outposted officer for 5 years covering the Greater Western Area Health Service, about 70% of the state. Prior to that she worked for 7 years as the Deputy Director and Health and Indigenous Policy Officer for the Australian Council of Social Service. Her background also includes over 20 years' working in various roles in the not-for-profit community welfare sector.