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"Sorry" shouldn't be the hardest word [1]

by
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INTRODUCTION

HEALTH COMPLAINTS, litigation against health providers, indemnity issues and indemnity levies for health providers have received an inordinate amount of publicity recently. Daily, we are assailed by radio advertisements from various law firms of the "no win, no fee" ilk exhorting members of the public, who feel that they may have suffered some harm, either at the hands of a health provider or an employer, to visit 'Walk, Trot & Gallop" and receive a free consultation with regards to their specific problem with a view to litigation. This is a fairly facile way to put this because there is also significant evidence that many people are injured as a direct result of their contact with the health care system[1,2]. So, what happens next?

In a great many cases, the injured or aggrieved person will fume in private and then spread 'the word' about the health care provider(s) concerned. This is true of most complaints; however, more often these days, members of the public, including the armed forces, are becoming more likely to put their complaint in concrete form. Evidence has also informed us that the majority of people who have suffered an 'adverse event' have, as their prime motivation, not money but rather the need for a full explanation, an acknowledgment of what happened to them and an assurance that it won't happen to anyone else.[3] If the 'adverse event' has been catastrophic and has resulted in the loss of life (of a relative) or significant impairment of self or a relative, then there will also be anger and a desire for some kind of retribution.

CIVILIAN PROCESSES

Each State and Territory in Australia, with the exception of South Australia (SA), has legislation and a process in place to deal with Health Complaints. South Australia has legislation waiting in the wings, yet to be tabled, and health complaints are handled by the State Ombudsman. There is a fairly robust system of complaint resolution in many jurisdictions, and most, if not adopt the following process:

- **Complaint in Writing.** Although most areas are more than willing to talk over a complaint with a client over the telephone and can sometimes resolve it at that initial level, if there is any formalized resolution of the complaint required, legislation demands that the complaint is made in writing. Most will have forms available from a website for this activity.
- **Natural justice.** Most areas note that natural justice is owed to the respondent as much as it is to the complainant. Accordingly, unless there is some serious reason why it cannot occur, the respondent is made aware of the fact that a complaint has been raised, who raised it, and the nature of the complaint. In some areas, this involves sending the respondent the complaint. There is usually a timeframe on this, in most cases a minimum of 14 days from receipt of the complaint but maybe up to 60 days. Both the respondent and the complainant are entitled to impartial, independent, and unbiased adjudication and this is usually specified somewhere within the State or Territory legislation or charter on health complaints.
- **Direct Resolution.** Most areas note that 70-80% of complaints are resolved by this process. They offer assistance to the complainant to approach the facility/health provider and also assist with a conciliation process.
- **Referral to Registration Body.** New South Wales (NSW) has enshrined in its legislation that any complaint in writing to the Health Complaints Commission, about a health service provider who is

registered/licensed, must be referred to the appropriate Registration body. Other states have the power to review the complaint and to decide whether it is of such seriousness to merit that action.

- **Limit on Complaints.** There is little difference in the timeframes involved here. Normally, complaints will only be entertained if event concerned occurred within the previous twelve months. There are exceptions and there is ability to waiver this requirement on a case by case basis. Some areas do have an absolute cut-off. Western Australia (WA), for example, will not investigate any case which occurred prior to 1995.
- **Written Reports.** If a complaint has proceeded along formal lines and has been investigated accordingly, the results of that investigation and recommendations of the body concerned are provided in a written report, which is given both to the complainant and to the respondent.
- **Right of Appeal.** Both the respondent and the complainant have a right to appeal the findings of the body investigating the complaint. There is always the legal option if either or both feel that they have not been treated in a fair manner.

HEALTH COMPLAINTS WITHIN THE AUSTRALI AN DEFENCE FORCE (ADF)

Health complaints are often more than a little different within the ADF. Rarely is the complaint to do with the timeliness of health care, because the need to return servicemen and women to a full deployable health status is a key driver in military health care. However, there are many complaints about the Medical Employment Category (MEC), which is assigned to service personnel, particularly if the MEC concerned means that the member is non-deployable and will be discharged from service. Other complaints, now dealt with by the Defence Recruiting Organisation, encompass appeals against the outcome of Recruit Medical Procedures which may preclude individuals from a career in the military. These complaints, although ostensibly against health providers and the health system, will not be considered here, but rather the complaints which mirror those in the civilian system.

There are already several established recourses for the aggrieved serviceman and servicewoman within the ADF. Any member may make redress of grievance (ROG), a process that goes up through the chain of command and is referred to the Complaints Resolution Agency. There is also a new directorate within Defence for Alternative Dispute Resolution (ADR), which is often able to sort out problems before they begin to become cumbersome. Finally, there is also the Defence Ombudsman, who is often the last recourse for the complainant within the military system.

Health Directive 914[5] (currently in the throws of amendment) gives guidance for personnel in making a health complaint. This health complaint can be against an individual health care provider or a health facility. The process in this document follows the civilian process fairly closely, except that there is no attempt to take over the role of the Complaint Resolution Agency. For the purpose of this paper, the complaints covered will be limited to those within the National Support Area (NSA). It is stated categorically within this Directive that the filing of a health care complaint in no way abrogates the individual's right to the ROG process of indeed legal action. The common threads with the civilian process are as follows:

- **Resolve, if possible, at the lowest possible level.** Members are recommended, first of all, to take up their complaint with the health care provider or the health facility concerned. Obviously, if the member concerned is a Private soldier (equivalent) to request him/her to "take on" an Army Captain (equivalent) Medical Officer is a big ask. For that reason, the amended health directive will advise that a patient support officer should be identified in all health facilities. This is not to be confused with a patient advocate - the patient support officer is there to facilitate contact with the health care provider or health facility, not to take on the argument.
- **Written Complaint.** Should things have progressed beyond a telephone conversation or face to face contact, or if the member does not wish to confront the health care provider, guidance is given within the HD for the writing of a complaint. Once more, a patient support officer would be able to assist in this matter. Basically, the written complaint should encompass the grievance, identify time, date and

personalities, and give some idea of what outcome they would like to see. The written complaint also contains permission for release of his/her medical documents to the Area Health Service (AHS) or joint Health Support Agency (JHSA). There is also an acknowledgment that the complaint will be sent to the health care provider /health facility named in the complaint. The written complaint is referred in the first instance to the health facility (if the complaint is about a health provider) and/or to the Area Health Service for attention of the Senior Health Officer (SHO). It should be noted that complaints against health providers working within the operational context are referred through that chain of command to the SMO of the Formation (Navy and Air Force equivalents) and if necessary to the Operational Health Adviser of whichever Service is involved.

- **Natural justice.** Natural justice is no less a requirement in the ADF as it is in the civilian community. As soon as possible after receipt of the complaint, the respondent is contacted and given a copy of the complaint and the complainant receives formal notification of the receipt of the complaint.
- **Referral.** If the complaint cannot be resolved at AHS level, it is forwarded onto JHSA. After a response is received from the respondent, the JHSA Health Complaint Review Committee will conduct a limited investigation, accessing information/advice from Defence Consultative Groups as required.
- **Report of Findings.** The Director JHSA will advise the complainant and respondent in writing of the Committee's finding. It is stressed that JHSA is not a complaint resolution agency but rather a resource. The Director may refer the complainant to another authority or strongly suggest that the person concerned take their complaint through the ROG process. However, sometimes just the fact that someone has listened to them, taken them seriously and came back to them with some explanation satisfies the complainant. This is particularly so when JHSA can state that some practice or policy has been altered as a result of the complaint. On another note, it is amazing how often the first a respondent knows of a complaint is when they are contacted by JHSA

US MILITARY - HEALTHCARE OMBUDSMAN - ONE STRATEGY WITH HEALTHCARE COMPLAINTS

Following a previous association with the US Navy, where she was the first counsel for the Navy's Alternative Dispute Resolution program, Carole Houk of Resolve Advisers was involved with the National Naval Medical Centre (NNMC) in Bethesda, Maryland. This particular hospital treated not only military personnel on active duty (30% of patient load) but also congressional members, dependents, former military and retirees. In July 2001, NNMC initiated an Organisational Ombudsman/Mediator Program to address its growing medical malpractice experience. Since that date, over 200 cases have been referred to the 'Ombuds', as the role is known, all have been resolved and none involved any financial payment or filing of a legal claim. The Healthcare Ombuds approach to complaint resolution is that they get involved at the first hint of a problem (may be contacted by the healthcare provider) and resolve patient health care complaints at the lowest possible level, involving a minimal level of personnel. They often are involved in what they term 'shuttle diplomacy' and also offer other forms of assistance such as coaching, conciliation etc.[6] All patient concerns are tracked to closure and feedback is provided to management.

The success of this program has sponsored similar programs within hospitals in the US, both civilian and military. One such healthcare provider is Kaiser Permanente, the largest non-profit health care provider in the US (8 million members). They analysed the results of NNMC, and currently have six pilot sites in San Diego, Ohio, Northern and Southern California, Sacramento and Hawaii.

AN OUNCE OF PREVENTION

It would be foolish to suggest that all healthcare complaints can be prevented. Mistakes, both real and perceived, are going to happen, and, although they can be ameliorated by good risk management strategies and prevention techniques, I would suggest they will never be eradicated. This is supported by Weed's contention, as cited by Wilson *et al*., that the 'unaided human mind is incapable of performing consistently at the necessary level to provide optimal healthcare'.' People's perceptions and expectations are also difficult to fulfil to the optimum level; however, it is interesting to note the types of complaints.

A study conducted by the Health Care Complaints Commission of NSW in 1999 found that, while 64% of complaints were to do with clinical care, which is understandable, there was also a whopping 22% that involved

poor or inadequate communication. I recall, some ten years ago, attending a Director of Medical Services (OMS) conference at what was then the School of Army Health at Portsea (back in the days when they were actually in existence). One of the speakers was a lawyer whose role it was to represent respondents in lawsuits bought against them by disgruntled patients. He said that there were some important tools that doctors (and all other health care providers for that matter) should take on board. He called them the four 'C's: Communication, Competence, Compassion, and Confidence. He went on to explain that the most important of these, in his opinion, was not competence but communication. He had defended some perfectly competent medical practitioners, who had made a single mistake, but because of arrogance, real or perceived, were sued by their patients. Conversely, he could cite cases that could well have succeeded in court; however, the practitioners in those cases had such good rapport with their patients, usually had apologised to them and made such reparation as was available to be made, that the patients did not consider legal action, even when urged to do so by friends and relatives. This same experience is cited by Levinson and co-workers, who found with primary care physicians that they were far less likely to be sued if they spent time with their patients, kept them fully informed and used candour and humour.

The need for openness and honesty within the health care system has generated such initiatives as the Open Disclosure project. It was also the subject of several paragraphs in the report into the Bristol Royal Infirmary. The report comments on the frustration and anger of parents at not being able to find out information on the care of their child. It goes on to say that for respect, honesty and openness to flourish there "must be a culture of openness and honesty within the healthcare system as a whole".[10]

The contention that patients feel very strongly about being kept in the dark or when something adverse happens, the perception that the health care industry 'battens down' and prepares to 'repel boarders', has been borne out in several studies. In one study, more than one-third of the British patients involved stated that they wouldn't have proceeded to litigation had they received an apology and a full explanation." Wu states that, in his experience of over 25 years of representing physicians and patients, he found that the largest percentage of patient dissatisfaction was associated with the attitude and denial of health staff rather than the negligence itself.

WHAT TO DO

There are a myriad of suggested solutions to the health care complainant. These range from an apology, through conciliation, alternative dispute resolution, mediation, to full-on litigation. It is the first of these that we will consider, as time and space preclude a lengthy exploration of the others. It's time to get a little biblical. Proverbs 15:1 states that " A soft answer turneth away wrath but grievous words stir up anger". Once more, evidence has pointed us to the finding that, more often than not, a sincere apology will go a long way to resolving a health care complaint. As has been previously stated, an apology is not regarded as an admission of liability; however, it does depend somewhat on the quality of the apology. A half-hearted apology, which more or less blames the patient for the fact that the health care provider has to apologise at all, will most likely result in a patient even more aggrieved than before. Healthcare providers are advised to use the patient's own wording in their apology; for example, "I am sorry you felt that I did not take you fully into my confidence"." Sara Bird, in her article on the art of dealing with complaints, states that the response should be as prompt as possible, either verbally or in writing. If the former is the method used, a record of conversation should be kept. [13]

Several health facilities have now made it a policy that there is a duty of candour even when patients are unaware of the error, such as an unplanned event that might or might not reflect on the patient's future health. This has been carried out in various places, such as the Veterans Affairs Medical Centre in Kentucky, where errors are disclosed to patients even if they or their families were unaware that an error had occurred. This is done even if it involves error on the part of the hospital or its staff.

There are obviously a small percentage of complainants for whom no amount of apologies or any other strategy will work. Professor Paul Mullen, of Monash University, identifies these complainants as 'querulants' or chronic complainants. In a recent address at Russell Offices in Canberra, he stated that these were complainants with a quest. No matter what was done to resolve their complaint, it wouldn't be enough and the goalposts would

continue to shift. Their complaint normally had some basis in truth but it quickly became their whole raison d'etre, often to the detriment of their personal lives.

CONCLUSION

Health care complaints, like taxes, are one of the certainties of life. What we can do as healthcare providers is to mitigate these complaints so that the reasons for complaints become less numerous. Risk management strategies, close call registers, and learning from previous mistakes are good mitigation strategies. This is very similar to the aviation industry, as is the need to take part in human factors training; however, unlike the aviation industry, there is a real concern with litigation given the very human desire for revenge or, at the very least, for someone to blame. Professor Bruce Barraclough puts it succinctly when he states that both the health and aviation industries involve large, complex systems reliant on highly trained personnel working in a myriad of professional relationships and utilising advanced technology. In such a situation, despite all the planning and good intentions, mistakes happen.

Complaints against health care providers can be taken extremely personally, and with good reason.

It is natural for the health care provider to feel aggrieved, hurt and embarrassed; particularly if, in their opinion, they have done the very best that they can. It requires a walk in the patient's shoes. What were their expectations? Were they realistic – were they explained? Sometimes a simple apology, which in no way becomes an admission of liability, helps to soothe the patient's fears. If indeed an error has occurred, the sooner it can be addressed the better. In this case, it is fair that a free and frank discussion with the patient takes place; research has told us that they want an explanation, they want an apology, and they don't want this to happen to anyone else. If that can be encompassed, then the winner is the health care system as a whole. Above all, all of us in the health care industry need to learn from mistakes, to address loopholes and to ensure that the care that we give to our patients is the very best available.

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