NZRDA and NZMII Joint Submission to the Review of the Act and the Code

1st August 2024

Thank you for the opportunity to provide feedback on the *Review of the Health and Disability Commissioner (HDC) Act 1994 and the Code of Health and Disability Services Consumers' Rights*. This is a joint submission from the New Zealand Resident Doctors' Association (NZRDA) and New Zealand Medical Indemnity Insurance (NZMII). Both NZRDA and NZMII would welcome the opportunity to make an oral submission should the opportunity present and/or work with the HDC on how to implement any of the enclosed recommendations.

The **NZRDA** represents 3,000 Resident Doctors (referred to as Resident Medical Officers 'RMOs') in Aotearoa New Zealand. We are the largest and most experienced RMO union: run by RMOs for RMOs since we were founded in 1985. Our membership is spread across all specialties at house officer and registrar level. Our purpose is to protect and promote the interests of our members, including taking care of doctors' rights and interests at work, within the health sector and in the wider community. For nearly 40 years we have worked hard to achieve these goals including safe rosters, better education and training, and fair pay for RMOs.

NZMII is an Aotearoa New Zealand-based team of Kiwis who provide world leading medical indemnity insurance to our country's Healthcare Professionals. NZMII represents over 4,500 Healthcare Professionals including over 3,500 medical doctors ranging from those at house officer and registrar level to vocationally registered senior medical officers and general practitioners. Our network of experienced medico legal professionals have a long association and expertise within the HDC complaint process. With over 25 years' experience right here in Aotearoa New Zealand our vision is to be the most trusted provider of indemnity protection for Healthcare Professionals, giving them the confidence and protection to practice at their best.

Background to this submission

For a long while now our medical workforce has been in crisis, grappling with the challenges of:

- Having to work longer and sometimes unsafe hours due to longstanding staff shortages and issues with recruitment, turnover, and hiring freezes.
- Having to work at unsafe staffing levels and incorporate workarounds to plug the gaps in a failing healthcare system.
- Increasingly having to undertake administrative tasks that detract from providing direct patient care.

These systemic failings place an unfair burden of exposure to and accountability for clinical risk on individual practitioners. This issue, and the resultant risk of HDC complaints, has already been recognised by Parliament's Health Committee in the Annual Review of Health New Zealand – Te Whatu Ora.[1]

That is not to say that all complaints are frivolous or that the few bad actors should not be held accountable through the HDC process. Rather, we must acknowledge our medical professionals are being asked to do more with less, in an increasingly resource-constrained environment, and this puts them at greater – and importantly, unfair – risk of HDC complaints in the first instance. It is within this background that we make the following submission.

Submission

Our submission responds directly to issues raised in Topics 1 and 4 of the consultation document. We begin with the matter of the appeals process under Topic 4 as the primary focus of this submission, before moving to the issue of non-retaliation under Topic 1.

Topic 4: Considering options for a right to appeal HDC decisions

While the purpose of the HDC under section 6 of the HDC Act is "fair, simple, speedy, and efficient resolution of complaints", procedural aspects continue to contravene these aims, compromising principles of natural justice for all parties involved.[2] This includes:

- The HDC operating in an environment of rising complaints, reporting a 43% increase in complaint volumes over the past four years, which then increases the time taken to triage, investigate, and resolve complaints.[3]
- Lengthy investigation times consequently create a significant backlog of unresolved complaints, with around 35% of complaints remaining open for more than six months and 11% of complaints being open for more than two years.[4,5]
- Longstanding under resourcing of the service, exacerbated by a recent $2.9 million budget cut (16.5% reduction in operating budget) for FY2024/25, which will only further prolong complaint investigation times and resolution rates. In fact, the HDC anticipates this will represent a decrease in the complaint resolution rate, from 86% to 70%.[6]

With these existing operational challenges in mind, we are deeply concerned that the HDC consultation document is proposing doing more, with less, by proposing the introduction of a right to appeal HDC decisions. This will create serious issues around time delay, finality, and cost – inadvertently compromising the HDC's foundational principles.

First, and most obviously, introducing an appeals process will increase the time for investigation and resolution of complaints, counter to the principles of "simple" and "speedy" resolution. A lengthy complaint process can be re-traumatising for complainants (or affected patients), and in the longer-term can result in a loss of trust and confidence in the HDC as a public watchdog.

Second, and relatedly, these delays will only create prolonged uncertainty for complainants who are seeking closure, and a state of protracted limbo for individual practitioners who are the subject of complaints. Save for a few extremely rare cases, medical practitioners intend the very best care for their patients, and where patients experience any form of harm this can weigh heavily on practitioners themselves.

Being subject to the complaints process can have devastating impacts; even if it is ultimately decided that no investigation is warranted. Going through the process itself can feel adversarial, not to mention the ongoing time and resources involved in responding to the complaint. One study found that involvement in the HDC complaints process entailed an average time of 63 hours for practitioners.[7]

An extended complaints process only worsens the impacts for those subject to the complaint. These impacts can include anxiety, depression, sleep disturbances, loss of self-confidence and self-worth, practising with excessive caution, intent to leave the profession, and in extreme cases suicidal ideation and self-harm.[89] This compromises the wellbeing of doctors, as well as their ability to practice safely and confidently, with impacts lingering for many years after a case is closed.[10]

Third, an appeals avenue would impose further financial costs for all involved. For the HDC service itself this will entail additional time and resources to re-investigate decisions and respond to an increase in appeals volumes. Relitigating complaints also comes with further legal costs for complainants and individual providers. The appeals process would also, over time, introduce an added level of risk for the medical profession, resulting in rising professional indemnity insurance premiums. This is an increased cost that will ultimately be borne by the wider profession both in financial terms as well as emotional and physical terms increasing the risk of burnout by our already overstretched healthcare providers.

To reiterate, we are not opposing patients' rights to complain or advocating that providers should not be held accountable for their clinical decisions. We also acknowledge the importance of redressing the power imbalance between patients and medical providers, beyond checks and balances already in place, such as the HDC Act, the Health Practitioners Competence Assurance Act 2003, as well as the Medical Council of New Zealand standards. We are, however, concerned about introducing an appeals process to an already stretched-thin service. The HDC is already failing to meet its current performance targets for time taken to resolve complaints.[11] Proposing to add a substantial appeals provision will only create further harm through delays and inefficiencies.

The consultation document sets out three options for a right to appeal HDC decisions. We speak to the limitations of each below and propose an alternative way forward.

Option a. Introduce a statutory requirement for review of HDC decisions

This option seeks to formalise the less publicised, existing internal HDC review process. Currently this discretionary process is restricted to reviewing procedural aspects of the HDC decision, with limited options to challenge the outcome.

The consultation document already identifies the additional time and resources required for this option. We also see other issues arising around consistency, transparency, and independence.

For instance, it is unclear under whose discretion the review process is contingent upon, who is involved in the process, and the grounds for decision-making. The expertise and authority of the final arbiter also remains unclear, as does the number of times a complainant (or a subject of complaint) could pursue this option. Even excluding the original decision-maker from the review and/or requiring peer-review involvement would not provide the necessary level of independence, since this remains an internal review.

Option b. (i) Lowering the threshold for access to the HRRT to the level of the Privacy Act

This is a slightly higher threshold for accessing the Human Rights Review Tribunal (HRRT) and would likely only apply to complaints that have been through the HRC investigation process. HRC estimates this could generate an additional 40 cases per year; although we believe this is a

very conservative estimate of additional case numbers. Regardless, there will be an increase in caseload that would further delay the process and complaints resolution time.

The HRRT process itself is not without its criticisms and has a considerable backlog of cases with an average case resolution time of 576 days.[12] The Tribunal also does not have a mandated delivery time for its decisions. Introducing even 40 extra cases annually could easily add substantial delays to an already backlogged system.

Lowering the threshold for accessing the HRRT to the level of the Privacy Act would also mean that where the HDC has determined a case does not warrant an investigation, this decision itself could become contestable by judicial review application to the High Court under the basis that non-investigation has denied a complainant from pursuing the next step (i.e., accessing the HRRT). This would have the effect of opening more than 3,000 cases (i.e., more than 90% of complaints not formally investigated each year) to review.

Option b. (ii) Lowering the threshold for access to the HRRT to the level of the Human Rights Act

This option has the lowest threshold for accessing the HRRT. The consultation document identifies issues around inundating the HRRT with inappropriate complaints, as well as the fact that this would significantly exceed the existing resourcing capabilities of both agencies. We could not agree more. This option is fraught with issues and realistically there is no way the existing HRC and HRRT systems could uphold the anticipated volume of complaints.

This option would also result in a longer, more expensive, and more litigious process for all parties. This is particularly so for complainants who would be forced to choose between fronting up huge legal fees for representation or deciding to self-represent, which could set them up for failure. Not only is this counter to the HDC aims but it would also inevitably reduce the accessibility of the process for complainants. For these reasons, this is the least viable of all options presented.

Our proposed solution: Implementing an HDC Ombudsman

We understand the need for the HDC to balance speedy resolution with accountability, but we also need pathways for finality. The process must realistically end at some point to provide closure for complainants, while also ensuring an individual provider's ability to continue providing a high level of clinical care is not compromised by an unnecessarily onerous process.

As a happy medium, **we recommend establishing an independent HDC Ombudsman as a pathway for appeals**. While there are numerous ways this could work in practice, we propose the HDC Ombudsman would function independent to the HDC, with complainants and providers having a right to apply to have the HDC's final decision reviewed by the Ombudsman.

The Ombudsman could have limited jurisdiction, but could pursue any number of options including:

- Deciding no investigative action is warranted,
- Directing the HDC to open all or part of an investigation, including the power to make recommendations to the HDC to make further inquiry or consideration,
- Making a breach finding, and
- Referring the appellant to issue proceedings in the HRRT, even in the absence of a breach finding – such as in cases where the HDC has exhausted its processes, or in

other circumstances where it may be appropriate for them to bring a case to the Tribunal.

The appeals criteria would need to be useable but non-exhaustive to ensure this pathway was fit-for purpose. While there would be costs associated with establishing this function, it would be easier to account for as a budget line item than the less predictable (and potentially infinite) costs that would otherwise arise from an endless cycle of appeals.

In this way, our solution melds the strengths of the proposed options in the consultation document by formalising the existing internal review process (as outlined in option a), whilst introducing structure, clarity, and independence (as provided for by the HRRT in option b). It would reduce confusion around the pathways available to complainants and individual providers post-HDC decision. We can also be confident in its viability, since it is a tried and tested solution (i.e., the Privacy Ombudsman).

In addition to implementing an HDC Ombudsman at the appeals end of the process, it is our view that **entry into the HDC system could also be streamlined through having more stringent inclusion criteria for complaints and a more well-defined triaging system that applies said criteria**. A strategic approach to funnelling in complaints into the HDC system will ensure the process is expedited in its resolution of patient complaints and improve trust and confidence that the HDC is serving its intended purpose.

Topic 1: On introducing a non-retaliation clause in Right 10

A second concern we have is around the introduction of a non-retaliation clause under Right 10 of the Code. As the consultation document notes, other rights in the Code already provide this protection – such as Rights 1, 2, and 4. There are also existing professional standards issued by the Medical Council of New Zealand that cover this via guidance on good medical practice and managing the doctor-patient relationship.[13,14]

We do not object in principle to patients (and complainants) having protections against non-retaliation; however, a heavy-handed approach could introduce issues if the patient-provider relationship had deteriorated to such an extent that the provider is no longer able to safely and appropriately provide the level of care required. In these instances, a non-retaliation clause should not constrain the termination of this therapeutic relationship or the transfer of care to another provider, if it would otherwise be to the detriment of the patient and/or the provider.

We therefore recommend that the introduction of any non-retaliation clause should be qualified; reserving the ability for medical professionals to reasonably, appropriately, and in good faith respond to complaints where needed, and recognising that part of this response may involve terminating the patient-provider relationship in guidance of existing standards and protocols.

We note that introducing a non-retaliation clause could also add further complexity and subjectivity in HDC determinations. It can be difficult to objectively assess whether something is ‘retaliation’ or not – and appropriate consideration would need to be given to how this would inform HDC decision-making, especially since cases are decided on paper and often unable to capture the full context. Again, existing standards for ending the patient-provider relationships should inform the development of any additional protective clauses introduced into the Code.

Conclusion

To summarise, we do not believe the proposed changes of introducing appeals process will be productive in meeting the principles of "fair, simple, speedy, and efficient resolution of complaints", and could in fact contravene the very purpose and objectives of the HDC.

Good work needs sufficient resourcing, and while we understand the best intentions behind the proposed changes, setting out to introduce measures that require significantly more resources than is currently available to the HDC is simply setting up the HDC for failure, and setting up the parties involved for inevitable disappointment and emotional turmoil.

Our summary recommendations are therefore:

1. To implement an independent HDC Ombudsman that complainants and providers could apply to, as an independent appeals pathway for reviewing HDC decisions. This would require non-exhaustive appeals criteria, a transparent decision-making process, and sufficient authority for the Ombudsman to be able to recommend access to the HRRT even in the absence of a breach finding. In parallel, we recommend complaints could be more effectively streamlined through a more selective inclusion criteria and triaging process.
2. If a non-retaliation clause is introduced, to include a caveat that reserves medical professionals' rights to appropriately and in good faith, be able to respond to and terminate the patient-provider relationship, in cases where this has deteriorated sufficiently and to the detriment of either party.

References

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