COLLEGE OF INTENSIVE CARE MEDICINE
OF AUSTRALIA AND NEW ZEALAND

12 August 2024

Ms Morag McDowell
Health and Disability Commissioner | Te Toihau Hauora Motuhake
Via email: review@hdc.org.nz

Tēnā koe Ms McDowell,

Re: Review of the Code of Health and Disability Service Consumers' Rights and the Health and Disability Commissioner Act

The College of Intensive Care Medicine, Australia and New Zealand (CICM or the College) thanks Te Toihau Hauora, Hauātanga (Health and Disability Commissioner) for the opportunity to review and provide feedback on the review of the Code of Health and Disability Service Consumers' Rights (the Code) and the Health and Disability Commissioner Act (the Act).

About the CICM

The CICM is the world's first Intensive Care Medicine (ICM) College and is the body responsible for ICM specialist training and education in Australia and Aotearoa New Zealand. We have over 1300 Fellows and over a thousand trainees throughout the world, and we graduate between 50 and 60 new Fellows (including local trainees and specialist international medical graduates - SIMG) each year.

We set and maintain standards for intensive care units and provide continuing medical education, professional development, and advocate to governments and the community. We provide a high-quality training program, with supervision of clinical training, administration of assessments, and a range of workshops and courses.

General comments

It is important to note that intensive care as a specialty is at the centre of many clinical scenarios where a complaint results due to complications or suboptimal outcomes. Patients and whanau often express dissatisfaction with the healthcare received prior to admission to intensive care, the care they received during their stay in intensive care and with the care received in transition services after being discharged from intensive care. We would welcome the opportunity to discuss issues in acute care, after hours hospital care, and patient deterioration further with the Commissioner.

Broadly, the College is in support of the proposed changes to the Act and Code. However, we encourage the Commissioner to develop strategies to mitigate extended wait times to resolve complaints, which exacerbate distress for all involved. Many clinicians report that the HDC complaints process feels punitive, prolonged, and incredibly distressing.

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Clinicians also report that HDC processes lack transparency, and many clinicians report receiving little insight into how decisions were made. It would be valuable for the HDC to consider how it could improve transparency and clarity of its processes amongst both providers and consumers. Additionally, the CICM recommends that complaints regarding intensive care medicine specialists should incorporate the review of an Australian and New Zealand vocationally registered intensive care specialist. This does not routinely happen at present, which can be problematic as there may be a lack of understanding of the speciality and scope of practice.

There also seems to be a lack of understanding in the complaints process of systemic issues that cause complaints. Many intensive care specialists in Aotearoa New Zealand are working in underfunded and understaffed hospitals, which create the conditions for suboptimal medical decision-making. We also note that intensive care specialists are often treating extremely ill patients in emergency scenarios, where they must make snap decisions. Understanding the situational and contextual factors for time-pressured decisions in the framework of contemporary resilient healthcare safety models would be something we highly encourage.

The HDC complaints process is very individualising which is problematic for intensive care specialists in a few major ways:

- intensive care is a team-based, multidisciplinary specialty, where many medical professionals are involved in a single patient's care, not just one specialist or doctor
- the complaints process should also consider doctors not present but could have reasonably expected to attend to the patient
- many of the causes of complaints are systemic in nature, rather than the fault of an individual clinician.

We understand that the HDC does do some work advocating for systemic changes. We would encourage greater visibility of this, as well as an accommodation in HDC processes for systemic factors that affect the behaviour and decision-making of clinicians. It would also be helpful to receive reporting from the HDC that identifies what systemic issues are causing complaints in the health system, so the health sector can work collaboratively to advocate for systemic changes that would reduce complaints.

The CICM is pleased to see greater inclusion of tikanga Māori in the proposed Act and Code. We also support the creation of a right for all consumers to have their *mana* upheld in the code but would appreciate clarity on what this would look like in practice, and clarification that these rights apply equally to providers as well as consumers.

Right to Appeal

The CICM is concerned that creating another appeals process to an already extended complaints process could further increase delays. The lack of timeliness in the current HDC process causes significant amounts of distress to patients, whanau, and doctors. Particularly as the number of HDC complaints are increasing, it would be more practical to seek methods of improving the timeliness of complaint resolution, rather than adding additional layers of bureaucracy.

As the consultation document outlines, measures such as lowering the threshold for Human Rights Review Tribunal could lead to an increase of minor, frivolous or vexatious complaints. We also note that the HDC has received a 36% increase in complaints in 2022/2023. With the limited resources available to the HDC, the CICM would strongly prefer that the HDC use these resources to improve the timeliness of their complaints process. The CICM also wishes to understand how the HDC would ensure all complaints have an end point, if a strengthened right to appeal was implemented.

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Issues with written consent in intensive care

In principle, the College supports measures that would strengthen patients' rights to informed/written consent. However, it can be challenging to always acquire written consent from patients in ICU, given the nature of the patient cohort. Additionally, due to the nature of the specialty, some interventions in ICUs have significant risk of serious adverse effects. We suggest that specific wording be included to allow for scenarios where clinicians cannot obtain written consent from the patient or whanau.

We hope that the information contained in our submission is helpful. Should you have any queries or comments regarding our feedback, please feel free to contact [redacted]

Yours sincerely,

Assoc Prof Peter Kruger
President

Dr Jonathan Albrett
Aotearoa New Zealand National Committee

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