31 July 2024

Morag McDowell
Health and Disability Commissioner
review@hdc.org.nz

Tēnā koe Morag

HDC Act and Code Review

Thank you for the opportunity to comment on the review of the Health and Disability Commissioner Act 1994 (the Act) and the Code of Health and Disability Services Consumers' Rights (the Code).

About RANZCOG

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) is a not-for-profit organisation dedicated to the establishment of high standards of practice in obstetrics and gynaecology and 'excellence and equity in women's health'. The College trains and accredits doctors throughout Australia and New Zealand in the specialties of obstetrics and gynaecology. The College also supports research into women's health and advocates for women's healthcare.

In New Zealand RANZCOG's Te Kāhui Oranga ō Nuku and He Hono Wāhine support College activities, taking into account the context of the New Zealand health system and the needs of women in Aotearoa New Zealand. In particular focusing on hauora wāhine Māori, equity and RANZCOG's commitment to te Tiriti o Waitangi.

RANZCOG's feedback is informed by discussion with our various Aotearoa New Zealand committees and leaders. Fellows have had an opportunity to provide input, and also have been encouraged to consider individual responses to the consultation.

TOPIC 1: Supporting better and equitable complaint resolution

Culturally supportive approaches

We support the suggested improvements outlined in the consultation document. We agree there needs to be:

- More people-centered processes, including more effective communication, trauma-informed approaches, and culturally responsive resolution
- A focus on preserving and restoring relationships alongside considerations of public safety, accountability, and service improvement
- Culturally responsive practice that is clearer and more inclusive
- Recognition that certain groups face barriers to accessing complaint resolution processes because of their fear of damaging the relationship or impacting their ability to access care

- Cultural responsiveness to reflect the needs, values, and beliefs of Māori
- Consideration of the needs of disabled people
- Consideration for the LGBTIQA+ community and ensuring gender-inclusive language

Emphasising equity of access and consideration of diverse resolution processes is important, for example access is an issue for Pacific people who are less likely to lodge a formal complaint because of their culture of "not complaining". We encourage HDC to consider using language that increases the likelihood of groups less likely to progress their concerns doing so. For example, framing such as raising a 'concern' or 'issue' rather than "complaint" could enable better access for conflict-adverse individuals and cultures.

Restorative approaches

HDC suggests that approaches such as restorative practice and hohou te rongo in complaint resolution can, in appropriate cases, support engagement, reduce the risk of further harm, and increase opportunities for healing, learning, and improvement.

Restorative approaches are internationally becoming prevalent and RANZCOG agrees that these should be encouraged. Improvement of outcomes (for all) is likely to result from restorative practice. It is valuable that this aligns with approaches advanced by HQSC and the Ministry of Health.

RANZCOG conditionally supports the introduction of restorative practices at all levels of complaint resolution. However, such processes are resource consumptive, and our support is conditional on appropriate additional resourcing that will improve timeliness of complaint resolution rather than further compromise timeliness. This will include provision of appropriate expertise.

While restorative practices would increase the potential for relationship preservation, if the current process is rate-limited by resource, it will rapidly lose credibility. RANZCOG has concerns about the provision of the necessary additional resource (especially for appropriately trained facilitators) in the current financial and political environment. It is noted that at a Te Whatu Ora level many districts are struggling with introduction of restorative practice principles for resource reasons.

RANZCOG also recommends that the introduction of restorative practice should be accompanied by a database that tracks outcomes, with comparison with the erstwhile investigative approach.

Timeliness of process

RANZCOG agrees with the broader community feedback outlined in the consultation document that HDC complaint processes are not always working, and complaint resolution principles of 'fair, simple, speedy, and efficient' are not being met as well as they could be. In particular, lack of timeliness increases stress for all parties.

We note that 70% of complaints close within six months. However, we believe that this number is likely to be heavily weighted toward complaints that are deemed not to require investigation. Our fellows tell us that timelines exceeding three years are not uncommon (multi-anecdotal). Fellows also emphasise the significant stress and anxiety that long-running HDC complaints processes create, and we presume that this also applies to patients who wait long time periods for complaints to be resolved.

We also note that opportunities for wider learning can delayed or lost by reporting on cases being delayed until some years after the original events.

HDC loses credibility by having very strict timelines for providers, with no sense of a timeline with their processes. We are unclear what the limitations are, but we presume this is a resource issue, related to increasing volumes and resourcing such as investigators or expert advisers (or both). We support efforts to streamline the process while retaining the key functions of the process.

We support strengthening of the Advocacy Service if it were to add to an increase in 'low level' resolution and improved timeliness. This would also help address the power imbalance between parties, and also increase the success of resolving issues locally and enabling restorative practice.

We call on HDC to improve timeliness of complaint resolution and also communication with both consumers and providers about expected timeframes. Prolonged and undefined timelines exacerbate conflict and increase stress.

HDC should consider ways to empower and support consumers to raise concerns directly with providers for 'lower-level resolution', with appropriate reporting mechanisms to HDC.

Protect against retaliation

We note the HDC proposal to make changes in Right 10 aimed at preventing a person from treating or threatening to treat another person less favourably because of a protected disclosure.

Whilst accepting the need for this, it is RANZCOG's view that there are times when there is a mutual interest for provider and consumer for the relationship to end and for an alternative provider to be arranged. Whilst this already occurs on occasions, some expression of the threshold for, and management of, such an outcome could be considered.

Improving the language in the complaints pathway

We note the intention to improve the language of complaint pathways in the Act. We agree with the statement in the consultation document that the expression in the Act to take 'No further action' can be considered as a disempowering description and not reflective of the work undertaken. We agree that 'No investigative action' may be more effective communication with complainants.

Similarly, the process of 'mediation conference' does not allow for a flexible resolution response to the needs and circumstances of those involved in a complaint. RANZCOG accepts that terms such as 'facilitated resolution' is more appropriate to capture other forms of resolution such as conciliation and restorative practices, and to explicitly recognise and provide for resolution practices from a te ao Māori perspective.

TOPIC 2: Making the Act and the Code effective for, and responsive to, the needs of Māori

RANZCOG supports making the Act and the Code more effective for, and responsive to, the needs of Māori to improve the experiences and outcomes of Māori in the health and disability system. We accept that promotion of the Code is not reaching Māori communities, and when it does, many perceive that Code rights and complaint processes are not designed for them. The code needs to ensure that its processes do not perpetuate the experiences of racism and cultural bias, but rather build trust and confidence in complaint processes and the health system.

RANZCOG notes that there has been significant work already undertaken to understand what needs to change to ensure the Act and Code meet the needs of Maori such as:

- Introducing hui ā-whānau and hohou te rongo
- Creating a Director Māori role with the small HDC team

- Incorporating tikanga into the Code, including to clarify for providers an understanding of upholding Māori rights
- Ensuring legislative change and education is proposed in conjunction with iwi and Māori organisations

We are supportive of these intentions, however, we would want to ensure that changes, such as introduction of hui ā-whānau and hohou te rongo, which are likely to be resource intensive, are appropriately resourced and so as not to slow down the overall complaints process.

We encourage HDC to seek further feedback from expert Māori groups such as Te Ohu Rata O Aotearoa Māori Medical Practitioners Association and Otago University Māori/Indigenous Health Innovation.

TOPIC 3: Making the Act and the Code work better for tāngata whaikaha disabled people.

RANZCOG is supportive of the Act and Code moving to better support and protect the rights of disabled persons. We agree it is appropriate to consider the safeguards that should be in place in circumstances where adults are unable to give their consent.

RANZCOG notes HDC's suggested legislative changes which on the face of it would appear to address current concerns. However, this is not our area of special expertise and we would defer to the opinion and experience of those who work or have lived experience with these issues.

RANZCOG is particularly interested in how the proposed changes relate to consent for research. We agree that the skills and expertise needed to consider research proposals involving tāngata whaikaha disabled people warrant having a specialist ethics committee to oversee such research.

The consultation document suggests that suitable persons interested in the welfare of the person should be able to veto their participation in the research. On the face of it this seems reasonable but who constitutes a "suitable persons" needs to be clearly defined. While tāngata whaikaha disabled people have significant vulnerability in research, they like women in general (who are underrepresented in medical research) are more likely to be left out of research because of the challenges of navigating the health and consent challenges.

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

We note that the Health Select Committee asked HDC to seek feedback on options for a right of appeal to HDC decisions, following a petition in 2022.

At present there are limited options to challenge HDC decisions.

- A decision to review a closed file may occur at the discretion of the HDC.
- It possible to lodge a complaint with the Ombudsman or seek Judicial Review in the High Court.

These approaches focus on procedural fairness rather than the actual decision made.

We note the following possibilities for change outlined in the consultation document:

a) Introduce a statutory requirement for review of HDC decisions. This would formalise processes that already exist at the discretion of the Commissioner.

b) Lower the threshold for access to the Human Rights Review Tribunal (HRRT). The HRRT can hear claims relating to breaches of the Human Rights Act 1993, the Privacy Act 2020, and the HDC's Act. The Human Rights Commissioner or Privacy Commissioner (respectively) must have considered the complaint but not necessarily found in favour. Hearings are usually public. In limited circumstances damages can be awarded for losses suffered, injury to feelings, humiliation, and loss of dignity. The HRRT's decision may be appealed to the High Court.

RANZCOG recognises the need for an appeal mechanism, given that current access to the Ombudsman or the High Court involves a limited jurisdiction related to fairness of process and only rarely any consideration of the facts (although referral back for reconsideration of facts is possible).

We make the following points:

- There is synergy and equivalence if the appeals process closely resembles the process and thresholds of appeal to the HRRT of the Privacy Commissioner and Human Rights Commission.
- We have some concern that if the threshold is simply at the discretion of the appellant, this may on occasions further draw out overall processes and resolution without benefit, particularly where the appeal is trivial or vexatious.

An appeal process will likely more frequently be commenced by consumers unhappy with the HDC's decision, either by not investigating or following investigation. Complainants are perhaps more likely to appeal when unhappy with the decision whereas providers, are only likely to do so after taking legal advice.

We support the development of an appeals process. We are persuaded that lowering the threshold for access to the HRRT would allow greater challenge of HDC decisions for complainants and providers. We are however concerned about the impact this might have on the time it takes for complaints to be resolved. We are also concerned, given the likely predominance of requests from consumers versus provider, that providers may be disadvantaged in having their concerns heard.

TOPIC 5: Minor and technical improvements

HDC has asked for feedback on the frequency of reviews of the Act and the Code. HDC feels five yearly review of the Act is too frequent and time consuming and to date (six reviews) there have been very few changes.

RANZCOG agrees that five yearly review is too frequent, however the urgent need for the issues outlined in Topics 2 and 3 to be considered indicates this review is timely.

The suggested changes enumerated under points b. to e. we have no specific concerns about.

b. Increase the maximum fine for an offence under the Act from $3,000 to $10,000 to bring into line with HPCAA 2003

c. Give the Director of Proceedings the power to require information. Currently relies upon cooperation of the parties involved.

d. Introduce a definition for 'aggrieved person', given the Act already allows an 'aggrieved person' to bring proceedings against a health or disability service provider in the Human Rights Review Tribunal.

e. Allow for substituted service. At times HDC is unable to locate a consumer or provider. Wish to be allowed substituted service when reasonable attempts have been made.

RANZCOG has significant concerns, however, with suggestion f.

f. Provide HDC with grounds to withhold information where appropriate.

We note that HDC is subject to the requirements of the Privacy Act and the Official Information Act 1982 (OIA). Meaning that HDC is required to undertake an assessment of every request for information held by the Office to assess whether release of that information is required.

HDC believe releasing information during the early stages of an investigation tends to favour providers (and their lawyers), who have greater familiarity with HDC's processes during an investigation and may seek tactical advantages.

We note that the Privacy Commissioner has suggested that HDC should have a similar ability to the Privacy Commissioner's office to withhold information during the course of an investigation while the investigation is ongoing, as this is an important safeguard for the integrity of a complaint investigation process.

Section 206 of the Privacy Act 2020 requires current and former Commissioners and all staff past and present to maintain secrecy of all matters that come to their knowledge in the exercise of their functions under the Act. However, it gives the Commissioner the ability to disclose any matter that they consider necessary for the purpose of giving effect to the Act. HDC suggest that there should be a similar amendment being made to the HDC Act. This apparently has the support of the Privacy Commissioner.

RANZCOG has considerable concern in relation to the HDC having grounds to withhold information during an investigation, usually under the Privacy Act and Official Information Act, "where appropriate" if this includes withholding information that is substantive to a provider's response or defense.

RANZCOG suggests that it is a natural justice right, that in answering a complaint one should have access to all substantively related information that allows the individual complained about to mount a full defense. We believe this matter requires careful consideration and we reserve the right to provide a formal independent medical legal opinion on this matter. **We ask that further detail is provided and that this is included in an open workshop with all medical colleges as recommended for points g. to i.**

With respect to matters g. to i. we agree with the feedback HDC has already received from providers:

- It is difficult to know when the Code applies.
- Lack of clarity is often a barrier to activities that ultimately would benefit people and improve service quality. For example, retrospective research at a population level where it is impossible to get informed consent for fear of breaching the Code.
- Expand the requirement for written consent for sedation that is equivalent to anaesthetic.
- Clarify that written consent is required when there is a significant risk of serious adverse effects.
- Clarify the Code's definitions of teaching, and of research.
- Respond to advancing technology.

The matters in points f. to j. are of great importance. RANZCOG believes there should be an opportunity for an open forum between all medical colleges to discuss these matters in a workshop environment with HDC.

Further submissions by RANZCOG

Pool of experts

The College has concerns about the paucity of experts available for expert reports. We believe this is in part related to rates of remuneration, and in part to the challenges of providing an independent opinion in a small professional community.

Feedback has been that the processes related to providing an expert opinion can be very frustrating, inefficient and at times distressing. Our specialists report that consumer rejection of provisional findings has led to personal attack of the expert, and there is also concern about expert opinions being overruled in investigation findings.

It has also been noted that though use of a single expert is a normal part of the legal process, it raises concern that it is neither just, nor fair. The process exposes the clinician who is willing to act in this role to adverse comment and criticisms from peers, especially when the clinician under scrutiny, is part of a small specialty group. Also, the matters under consideration are often nuanced and opinion across a range of qualified experts is likely to differ. Further, the location and experience of the expert will have an influence on their opinion.

We recommend that HDC consider alternative approaches to appointment of expert witnesses for establishing best practice. Ideas include using a panel rather than a single expert to provide a consensus opinion, in much the same way as is done in a hospital situation when looking at an adverse event. Or using a pair of experts where the New Zealand pool of experts is small or the specialty group small. This approach could allow for a local expert with knowledge of the context to balance an overseas expert.

Perhaps such an approach might only make sense in the more complex cases or when it is not reasonably possible to find an expert who is entirely independent. We acknowledged that there would be resource implications.

Remuneration of experts

The HDC implicitly acknowledges that the remuneration does not fully compensate expert time in report preparation by stating that "[t]he willingness of health professionals to contribute to the work of the Commissioner is recognised as a valuable public service." Remuneration is further restricted by the HDC stating how many hours they are prepared to remunerate, which increases the "public service" component of the work.

An example has been provided of an expert adviser being asked to comment on a consumer's rejection of the provisional findings without further remuneration and with refusal to provide the provisional opinion on which the consumer rejection was based. **RANZCOG asks for a review of the expert witness rate.**

Impact of resource constrained environment

RANZCOG fellows have expressed concern that in a resource limited environment it can be impossible to meet the standards expressed in a guideline. The expert adviser is asked to provide advice and an opinion as to whether the standard of care constitutes a breach of the code. Neither the expert nor the HDC process considers explicitly the impact the environment and resource limitations have on the ability of the provider to provide best practice care.

This matter is not explicitly recognised by the legislation, other than in Clause 3 which reads:
(1) A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.
(2) The onus is on the provider to prove that it took reasonable actions.
(3) For the purposes of this clause, the circumstances means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.

While Clause 3(1) indicates when a standard is not met because of a lack of resources that is beyond the control of the individual provider, the case can be made that circumstances precluded the standard being reached. However, the onus of proof is on the provider. This is often very difficult to demonstrate, particularly after the passage of time.

RANZCOG believes that there should be an explicit process, or requirement, to assess and consider the environment and resources available where these might reasonably be expected to have impacted on care.

Informed consent

Informed consent is an important issue and one that is often a factor in HDC cases. Members report that there can be discrepancies between individual hospital policies and the Medical Council of New Zealand’s statement *Informed Consent: Helping patients make informed decisions about their care.*

“When a patient is anaesthetised: Sometimes, a patient under anaesthesia needs more investigation or treatment than they have consented to. You must use good clinical judgement and act in your patient’s best interests. Sometimes, the treatment may need to be deferred.

If the situation is urgent, you should proceed on that basis, and discuss with your patient at the earliest opportunity. You should consider discussing with a peer, a clinical head, or your Chief Medical Officer any unexpected findings you come across during the course of treatment. You should document these discussions.”

RANZCOG encourages recognition that unexpected clinical situations do occur and doctors should be able to use reasonable clinical judgement to ensure patients do not have to undergo additional procedures, or delay in diagnosis, due to that situation not being anticipated or specifically consented.

Genuine human error and fostering a learning culture

Our members have suggested that the HDC process should acknowledge genuine human error to foster a learning culture. That if a genuine mistake is made, recognised and corrected immediately this should not constitute a breach. Penalising individuals for genuine mistakes may lead to covering up of error, rather than open disclosure and a learning culture.

Protecting the identity of individuals

In a number of recently reported cases HDC has removed names from the report to protect privacy, but we have been concerned that doctors are still identifiable. When the location of the O&G unit is identified, or the doctor is identified as a subspecialist, or where the gender of the doctor is specified, in a relatively small specialist group it can be possible to identify individuals.

Gender is becoming increasingly identifying for the O&G specialty, especially where a doctor is referred to as a registrar. Around 85% of RANZCOG trainees are female so referring to a registrar in a report by he/him is fairly identifying, especially if the location is also able to be determined.

We would encourage HDC to use gender neutral terminology for doctors in all reports and, wherever possible, not identify the location of the hospital (either directly or by providing information that suggests a location).

Media reporting

Reporting of HDC cases in the media seems to be increasing and becoming more sensationalized and not always entirely accurate. RANZCOG's concern is that creating fear risks reducing willingness to seek, or agree to, treatment and that this risks harm.

Thank you again for the opportunity to provide feedback. We are happy for our submission to be published in its entirety. If you need further information on any of our comments, please contact me through RANZCOG's Executive Director Aotearoa New Zealand, Catherine Cooper, on [redacted].

Nāku noa, nā

Dr Susan Fleming
Chair, Te Kāhui Oranga ō Nuku
Vice President Aotearoa New Zealand