To
The Legislative Council,
Hong Kong SAR.

Submission on Medical Complaints Mechanism
The Practicing Estate Doctors' Association

Advances in global communication, and in particular the Internet, mean that patients are better informed (and misinformed) about health issues. They are more ready to challenge decisions made by the profession and there is evidence that the blame culture is spreading to all parts of the globe. This trend is fuelled by the media, who always seem ready to make headlines out of anything related to doctors and other healthcare professionals; unfortunately, there are no signs of their fascination with 'healthcare' stores diminishing. (Tim Hegan, International Operations Manager, MPS) To add fuel on fire, the Hospital Authority has in the past been dishing out high hopes for the public and expecting frontline doctors to work to the brim to fulfill the unrealistic promises made.

We agree with the concept of Section 80 of the SHW's Consultation Paper: *An effective complaint mechanism is a powerful tool for driving improvement. The complaint may have arisen from an unintended mistake or a mere misunderstanding, but there is always something to learn. A complaint mechanism that is unbiased, transparent and credible helps improve the trust of the community in the health professionals and providers, which is conducive to effective operations and improved quality.*

We concur with Sections 95,96 and 100 that there are numerous channels for patients to lodge complaints against the profession. The Medical Council of Hong Kong, the Department of Health in accordance with the Civil Service Regulation, the Hospital Authority's Head Office and the Hospital Authority's Public Complaints Committee, the Office of the Ombudsmen, the regulatory Councils, the Complaints Division of the Legislative Council, the complaints mechanism of individual providers and the Civil Court.

Hong Kong is getting close to what Dr. John Hickey described in New Zealand in his article "Double jeopardy?" (October 2000). He wrote: *"There are 12 ways in which New Zealand doctors can be held accountable-subjected to multiple jeopardy-out of one incident, as compared with the UK, which is much more streamlined."* With the list of complaints channels listed above, the analogy is clear and the Complaint Office is obviously unwanted. Dr. Hickey went on to define Medical Mishaps as *'complications of treatment with a rare and severe outcome' and there's less than one per chance of it occurring. There's no error on the doctor's part, but by just normally treating people over a lifetime you are going to get medical mishaps occurring.* This is something not emphasized enough by the Hospital Authority and the Medical Council and something totally ignored by the press. Dr. Hickey concluded that *"There is no doubt that good investigative journalism has its place, but too often the facts go by the board in an effort to get the story and they are not prepared to give a balanced point of view".*

We totally disagree with Section 97 of the Consultation Paper which stated that "*it is difficult to find a doctor to testify against another doctor, the findings tend to be biased in favor of the practitioners, as illustrated by the very small number of successful complaint cases in the past*". The latest Medical Council Inquiry in early March 2001 paraded 3 doctors in private practice to testify against one private practitioner who was subsequently found guilty of professional misconduct serves as the most convincing example to the contrary. If there is no case and no fault can be apportioned, of course it would be difficult to find a doctor to testify against another doctor. The small number of successful complaint cases in the past is in line with complaints to Medical Council in other countries including the United Kingdom and Canada. It demonstrated the frivolous nature of most complaints and its non-association with professional misconduct. Since the Secretary of Health and Welfare has served in the Medical Council for a long time, he should be aware of these facts and relate them to the public instead of making these an issue. If *there are indications in the community that the confidence in the existing patient complaint mechanisms is declining*, then the Government, Medical Council as well as the Hospital Authority is to be blamed for not properly explaining to the public what is misconduct, what is negligence and what is mishaps. The Hospital Authority should also be blamed for creating another complaint office outside the Medical Council to confuse issues and make a doctor stand trial twice.

Despite the improvement measures by the Medical Council and depicted in Section 101, *including the setting up of a committee to address standards, increasing the number of lay members to enhance transparency and publication of guidelines to assist complainants in lodging complaints,* the Consultation Document in Section 102 *believe that the above measures proposed by the Medical Council of Hong Kong would not be ale to satisfy the concerns of patients.*

We are surprised that the Secretary for Health and Welfare Bureau would attempt to satisfy the grievance of all. The public doctors were not satisfied with the 2-tier system and the Hospital Authority turned a deaf ear to their demonstration. The citizens of Hong Kong has asked for a time-table for a democratic election and Government has ignored the plea. Why should this Bureau suddenly take interest in the patients' wish when they are also wishing for the best free medical system in the world?

On a Radio program by Metro Finance FM104 on 11 February 2001, Ms. SH Lau of a patients' right group agreed with the Chairman of the Practicing Estate Doctors' Association that **for complaints launched to the Medical Council, she would accept the decision to dismiss a PIC case had it involved a lay person, she would accept the prosecution process if it were more transparent all the way, and she would accept a verdict, for or against the patient, if the reasoning behind it was spelt out clearly by the Inquiry each time. This we propose, should be the way forward.**

We do not regard the Complaint office in Section 102 as the right way forward. How can the Department of Health, *taking on the role of an advocate for health and a regulator to ensure quality, assist the patients in lodging complaints* without bias. Spending millions of dollars, the Department *will conduct investigations into the*

complaints, assist complainants to obtain expert advice, and brief complainants as much as passible of the facts of the case as known. Drawing reference from Tim Hegan and John Hickey, the Complaint office will only provide unfair opportunity to the patients to use public resource to gather information to sue their doctors. If the complaint is malicious, and if there is no penalty for a wrongful complaint, this office will only create more lawsuits and disharmony and not vice versa. if the fault lies with the policy maker and not the front-line staff, the Complaint Office may not dare to target the root of the problem if it is the Health and Welfare Bureau or Hospital Authority.

The proposed Complaint office will not be able to help front-line staff. It has been reported (Medics in the firing line SCMP 11 February 2001) that *front-line staff are exposed to physical abuse* (acid, physical assault and punch in the eye) as well as verbal assaults. *But although dissatisfied patients can lodge complaints with the Hospital Authority, medical staff are discouraged from doing so. Unreasonable complaints could sometimes put mental stress on staff.* Unless the Complaint Office can act on the complaints by the front-line staff as well, it has to be bias.

We agreed with the Hong Kong Medical Council that if a Complaint Office is to be set up, it should take on a directive purpose, referring and liaising with respective Boards and Councils. We accept the Secretary for Health and Welfare bureau's current view point, reflected to our Chairman on 23 March 2001, confirming that the Complaint Office will serve, as directed, as the Executive Arm of the Medical Council.

On Medical Errors and their prevention

Medical errors are common, but since we are now deeply immersed in a blame culture, and everyone is looking for a scapegoat once an error occurs, it is difficult to persuade the doctors to report an error even though they may have caused no harm. Any error indicates a breakdown in the system or a wrong decision. To learn from mistakes, we need to know how these mistakes happen and we need to handle the individual making the report sensitively. This will require a dramatic change in finger pointing culture currently in place.

Errors may be due to systems failure, fatigue, putting junior staff on the job, and clear definition of clinical responsibilities is needed. Dr. K.S. Lo of the Hospital Authority said: *Currently*, there is *a blame culture where people blame one another when things go wrong because of the lack of a clear definition of hierarchy and responsibilities*

A recent BMJ Editorial suggested that '*better training programs, fewer operations and procedures during the night, a computer linked pharmacology system, such as that described from Birmingham, seems an ideal preventive and learning tool. This system sends warnings when incompatible or otherwise dangerous drugs are prescribed, and the introduction of such a system nationwide could prevent hundreds, indeed thousands of errors*'. We suggest that with the billions of dollars poured into the high technology computer system of the Hospital Authority, this should be

explored to prevent mistakes.

However, doctors are human and born fallible and will remain so. Perfect safety and zero occurrence of errors are just impossible. (BMJ 3 February 2001) *Being careful helps, but it brings us nowhere near perfection. Attend more to the details and check each other out. That reduces the error rate. But just trying harder makes no one superhuman. Exhortation does not help much, nor will suspending the doctors, nor will outrage in the headlines, nor even will guilt. Suspend every doctor today who makes an error today, and the error rate tomorrow will be exactly the same as today's. There is no remedy to be found in selecting heroes, nor in seeking Superman. Tomorrow, like today, we will be human.*

Donald Berwick, president and chief executive officer of the Institute for Healthcare Improvement answered: '*The remedy is in changing system of work. The remedy is in design. Other than equipment productive redesign, we can using modern principles from human factors engineering, reliability sciences, research on group dynamics, communication theory, and semiotics devise better job and task designs, better alarms and signaling systems, better communication patterns, better team training, and better simulation environments for skill building.*

The goal should be extreme safety, but we cannot reach it through exhortation, censure, outrage and shame. We can reach it only by commitment to change, so that normal, human errors can be made irrelevant to outcome, continually found, and skillfully mitigated. So long as it involves human, and thank God it does-health care will never be free of errors. But it can be free of injury.'

On Improvement

Improvement can only come about through frank discussion. As stated earlier, finger pointing will only make the profession sweep dirty scandals under the carpet and prevent it from coming to light.

The Medical Council as a whole should be empowered with the right to discuss and look back at inquired cases when its members are concerned with its verdict. Only through discussion can we improve. Currently, *the Council may on its own initiative review any decision or order within 14 days after the conclusion of a hearing.* However, *the Council* is interpreted as the members who attended the inquiry only and not other members of the Council. This restricts other Council members who were not in the inquiry, or who were present in the inquiry but did not participated in the judgment, from initiating any review of any decision even though it may be viewed as erroneous. Obviously, members who attended the inquiry would have made up their mind and further discussion would be unlikely. Recently, the Council has gone as far as forbidding Council members to discuss in public or even write in Association Newsletter about any case tried by the Medical Council under the threat of removal from seat of Medical Councilor. This, to us, is obviously a step backward and in violation of the Councilor's freedom of speech.

Council members may lack the legal expertise to ask questions. Many a time, both

the senior counsel for the Secretary and the counsel for the defending doctor as well as the Medical Council's legal advisor left questions unanswered from both witnesses and the defending doctor and forced council members to take the initiative to find out more. The techniques of questioning may be aggressive to onlookers, but without legal advice, council members are unaware of their demeanors. The answer may be to **hire some legal expertise such as a retired judge to chair the inquiry and guide and advice on the questions.** The profession is **unconcern about the number of non-professionals sitting in the inquiry as long as they are intelligent, unbiased and without fear or favor.**

On the composition of membership of an Inquiry, we are ashamed that there was a suggestion that Council members need to draw lot to attend. We consider that Council members have the duty and obligation to attend the Inquiries and that there should be no need to force them to draw lots. Consider this scenario if forced onto Legislative Councilors to attend meetings. A front-page article on 2 May 2001 claimed that private practitioners are biasing the Inquiries. It showed that appointed members attended 45 times. Elected private practitioners, including the chairman who do not usually need to cast a vote unless there is a tie, attended 77 times. Elected professors, 4 in total, attended 7 times. Appointed lay members attended 18 times. Appointed assessors, including two professors, a hospital authority consultant and two lay persons (who came when a quorum cannot be filled) attended a total of 9 times. Thus, appointed persons and university professors attended a total of 79 times while elected private doctors attended 77 times between 23 September 1999 and 11 April 2000. How could private doctors have biased inquiries by this attendance ratio? Furthermore, the newspaper failed to report that amongst the 13 disciplinary inquiries conducted by the Medical Council in 2000, 11 were found guilty of professional misconduct and only 2 were not. Now, **how can one find evidence of bias when almost 85% of doctors tried were found guilty of misconduct?** An inquiry is a time-consuming procedure. We praise our colleagues who sacrifice their time and forfeit their clinic hours to attend inquiries and safeguard the public. We are sure that the medical profession, like all other professions, is an honorable one and doctors would not elect colleagues into the Medical Council to free the rapist, drug-pushers or those who would endanger the life of the public. We have faith in the integrity of our colleagues and we trust that the doctors we choose to represent us in the Medical Council are men of integrity, looking at the evidence of the inquiry only, without fear or favor. Except for increasing the number of lay person in the inquiry just to satisfy public demand, we see no reason for change short of the legal input that is needed as mentioned.

We hope that the result of the deliberation in the chambers be clearly reflected to the profession and the public so that the profession can learn from the mistakes of others and the public can understand the rationale behind the sentence. Since the full text is not reprinted in the press, we suggest that the **Medical Council pay for a column in the newspaper the next day to release its verdict.** This can be simultaneously done in the website as well. There should be no reason to worry that the verdict, if properly written, would be used by the Defense Counsel for appeal.

This is our submission to the Legislative Council.