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Reducing, identifying and managing vexatious complaints

Summary report of a literature review prepared for the Australian Health Practitioner Regulation Agency

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Contents

Executive summary	4
Background.....	6
What is (and isn't) a vexatious complaint?	6
Experiential and motivational definitions.....	6
Appropriate definition for healthcare complaints.....	7
Types of sub-optimal complaints.....	7
How common are vexatious complaints?	8
Need to quantify the problem.....	8
Evidence of incidence	8
Evidence from within healthcare	8
Comparing entities handling complaints and tip-offs	8
Claims of vexatiousness by practitioners who are the subject of complaints.....	9
What factors may contribute to vexatious complaints?	10
Complainant type	10
Psychopathology	10
Inadequate complaints systems and unmet needs.....	11
Complainant needs	11
Complainant needs and existing complaint systems	11
Role of initial complaint response.....	12
Complainant gain	12
Personal gain.....	12
Professional gain	12
What impact do vexatious complaints have on health practitioners and complaints-handling agencies?.....	13
Impact of complaints on individual professionals.....	13
Evidence from health practitioners.....	13
Impact of unreasonable complainant conduct	14
How can vexatious complaints be identified?.....	14
Elements of the definition	14
Potential indicators	16
What are the risks of not identifying vexatious complaints correctly?	16



What are the key principles for preventing and managing vexatious complaints?.....	19
Define the problem.....	19
Quantify the problem.....	19
Establish and enact overarching principles.....	19
Establish and enforce minimum standards of complaint acceptance, and criteria for complaint rejection	19
Carefully target interventions for different types of sub-optimal complaints.....	20
Manage expectations	20
Ensure appropriate staff skills	20
Empower staff with appropriate flexibility, autonomy and decision-making powers	20
Train staff in vexatious complaint identification and management.....	21
Conclusions.....	21
References.....	22
Appendix 1	29
Appendix 2	30
Appendix 3	31
Appendix 4.....	35

List of tables

Table 1: Incidence of substantive outcomes from entities handling complaints and tip-offs.....	9
Table 2: Factors associated with vexatious complaints, querulous complainant behaviour or unreasonable complainant conduct.....	17
Table 3: Risks of false negatives and false positives in identifying vexatious complaints	18

List of figures

Figure 1: Negative impacts of unreasonable complainant conduct, as described by the New South Wales Ombudsman)	15
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Executive summary

This literature review examines academic and grey literature regarding reducing, identifying and managing vexatious complaints in the context of health care regulation. Its purpose is to inform the approach to vexatious complaints within the National Registration and Accreditation Scheme for health practitioners (the National Scheme).

What is (and isn't) a vexatious complaint?

There is limited understanding among stakeholders about the defining features of vexatious complaints, and the difference between vexatious complaints and other types of sub-optimal complaints. Many stakeholders apply a loose definition in which 'vexatious complaint' means any complaint that does not result in substantive regulatory action (that is, defined by its outcome), or causes unpleasant experiences for the subject (that is, defined by its effect on the subject).

In line with regulatory and legal principles and precedent, a truly vexatious complaint is defined not by outcome or subject experience, but by a specific combination of basis and intent. That is, a vexatious complaint is a groundless complaint made with an adverse primary intent to cause distress, detriment or harassment to the subject.

How common are vexatious complaints?

We identified a major disconnect between the volume and fervour of anecdotal and editorial claims regarding the alleged extent of vexatious complaints in the Australian health sector, and the available evidence. Claims that the problem is rampant are largely based on a non-representative, self-selected sample of practitioner anecdotes. In numerous cases where a practitioner initially alleged that a complaint against them was vexatious, subsequent tribunal and court processes found that unprofessional conduct had in fact occurred.

There is a paucity of robust research about the actual incidence or impact of vexatious complaints in the health sector, but the best available estimates suggest no more than 1% of complaints are vexatious. The limited literature on vexatious complaints focuses almost exclusively on complaints made by members of the public who display obsessive and unreasonable complaining behaviour. There is essentially no empirical evidence on the incidence of professionals lodging vexatious complaints about each other for personal or professional gain, or as a bullying tactic.

What factors may contribute to vexatious complaints?

Evidence supports the idea that lay complainants who become vexatious may be driven by needs the complaints system has not addressed or cannot address, or psychopathology. Their behaviour is more likely to take on an obsessive and 'out-of-control' quality, and thus is often relatively easily identified as it intensifies.

By contrast, some people believe that professional complainants who become vexatious are more often driven by personal conflict with a fellow practitioner and/or a desire for personal or professional gain. It is suggested that their behaviour is more likely to be targeted and calculated, and thus more subtle and difficult to detect. However, we could not find evidence to support or refute these claims, due to the lack of evidence regarding the behaviour of professional complainants.

What impact do vexatious complaints have on health practitioners and complaints-handling agencies?

Although they are rare, when they do occur, vexatious complaints associated with repeated, unreasonable complainant behaviour account for a disproportionate share of complaints-handling organisations' resources. This is less likely to be true of more calculated vexatious complaints by practitioners, which are not marked by the same resource-intensive repetition, volume and obsessiveness.

There is substantial evidence that complaints in general have significant negative impacts on the health and wellbeing of practitioners, although they may also have positive impacts on practice in some cases. This review did not identify any empirical evidence for how these impacts may differ in cases of vexatious complaints specifically, but it has been suggested that the negative impacts may be greater in such cases.



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How can vexatious complaints be identified?

Identifying vexatious complaints is inherently difficult, as classification rests on two features that can be difficult to prove – complaint veracity and complainant intent. Preventing, identifying and managing vexatious complaints requires a sophisticated understanding of the different types of complainant, and the related patterns in their conduct and motives. In particular, it is important to distinguish between: vexatious versus other sub-optimal complaints, calculated versus unreasonable complainant conduct, and complaints about practitioners versus complaints about the complaints-handling process. Any efforts to address vexatious complaints need to take these differences into account, and not consider vexatious complaints or complainants as homogenous groups.

There is evidence that certain characteristics of complainants (e.g. middle-aged and male), complaints (e.g. verbose, grandiose, dramatic communication style) and complainant behaviour (e.g. excessive communication, demanding vengeance, claims of far-reaching personal losses) are associated with vexatious complaints that occur as part of unreasonable complainant conduct. However, this review identified no research regarding such 'red flag' characteristics for vexatious complaints that are the result of calculated complainant conduct.

What are the risks of not identifying vexatious complaints correctly?

There are risks associated with incorrectly identifying good-faith complaints as vexatious ('false positives'), as well as failing to identify vexatious complaints as such ('false negatives'). Existing evidence suggests that under-reporting of concerns about health practitioners is a far greater public interest issue than vexatious complaints. The relative rarity of vexatious complaints, combined with known obstacles to lodging a complaint and significant under-reporting, suggests that measures intended to prevent vexatious complaints may pose a net risk to public safety, by inadvertently raising the barriers faced by legitimate complainants. This in turn appears inconsistent with the stated principles of Australia's National Scheme, which explicitly prioritise public safety. For this reason, any measures to address vexatious complaints should be carefully designed and evaluated to mitigate the risk of deterring good faith reports, or wrongly classifying all types of sub-optimal complaints as vexatious.

What are the key principles for preventing and managing vexatious complaints?

Intentional misuse and abuse of complaints processes is a risk that regulators must be equipped to address. In other jurisdictions, approaches to vexatious complaints range from informal understandings based on experience, to formal policies and procedures. Organisations in these jurisdictions place faith in the judgement of frontline staff, empowered by flexibility and autonomy-promoting policies, to identify and dismiss vexatious complaints.

Some key principles for preventing, identifying and managing vexatious complaints are:

- Clearly define the problem (what is and isn't a vexatious complaint).
- Quantify the incidence of vexatious complaints and their impacts.
- Align management of vexatious complaints with overarching principles of fair, just, efficient and effective complaints-handling.
- Adopt a proactive institutional approach which recognises that managing vexatious complaints is an inevitable part of complaints-handling work.
- Recognise how various types of sub-optimal complaints differ, and carefully target interventions and approaches to each type.
- Establish and enforce minimum standards for accepting complaints, and clear procedures for rejecting or aborting pursuit of complaints.
- Use careful, repetitive and clear communication strategies to manage the expectations of all parties to complaints.
- Employ complaints-handling staff with investigative skills, good judgement, and strong interpersonal communication.
- Give staff specific training, informed by evidence and best practice, regarding identifying and managing sub-optimal and potentially vexatious complaints, and unreasonable complainant conduct.
- Empower staff with appropriate flexibility, discretion and autonomy to exercise their judgement in identifying potentially vexatious complaints.
- Combine staff-driven triage systems, based on experience and judgement, with rapid resolution powers, and mechanisms to divert vexatious complaints away from formal processes.



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Background

In the past decade in Australia, certain health practitioners, and representatives of the registered health professions, have expressed a belief that Australia's health complaints system is marred by a widespread problem with vexatious complaints.^[1-17] These claims became prominent in a recent senate inquiry entitled 'Complaints mechanism administered under the Health Practitioner Regulation National Law'.^[16, 18, 19]

Allegations of widespread vexatious complaints have led to increasing pressure on policymakers and lawmakers to substantially alter the systems of health complaints-handling, and the regulation of health practitioners, to address the problem.^[1, 3, 4, 9, 20-22] Proponents of change have suggested actions such as imposing financial costs for submitting complaints,^[9] compelling complainants to sign legal statements regarding the veracity of their complaints,^[23] imposing legal or financial penalties on complainants found to be vexatious,^[9, 15] increasing oversight by the professions in determining the veracity of complaints^[18, 22] and compensating practitioners who have been the subject of vexatious complaints.^[16] Opponents have noted that such measures risk deterring vulnerable people with genuine, well-founded concerns from lodging a complaint, and exacerbating the mismatch between community standards and the standards accepted by the professions, putting the public at risk.^[18, 19, 24, 25]

At the heart of debates about vexatious complaints in Australian healthcare are several empirical questions. These include questions regarding the incidence, causes and impacts of vexatious complaints, as well as the effectiveness of efforts to identify, prevent and manage them. However, to this point, despite the multitude of assertions and allegations about widespread vexatious complaints, public discourse has been notably short on empirical data.^[16] Indeed, the parties involved in the present debate do not even apply a clear or consistent understanding of what a vexatious complaint is.^[12]

In pursuit of a more informed debate, the Australian Health Practitioner Regulation Agency (AHPRA) commissioned the authors of this report to conduct a literature review into the issue of vexatious complaints about health practitioners. The goal of the review is to inform efforts to identify, prevent and manage the problem of vexatious complaints, so that any related measures are proportional, fair, effective, and aligned with the goals and principles^[26] of the National Scheme. Appendices 1 and 2 describe how various terms are used in this review, and the classification and sub-division of different types of complaints adopted throughout this review respectively.

What is (and isn't) a vexatious complaint?

Experiential and motivational definitions

In recent public discourse about practitioner regulation and health complaints systems in Australia, the term 'vexatious' has been widely used.^[1, 2, 5, 7-11, 16, 18, 19, 27-30] Several parties have noted that this usage has been loose and liberal, varying widely in its apparent intended meaning.^[12, 18, 24, 27]

In its general English usage 'vexatious' means "causing or tending to cause annoyance, frustration, or worry".^[31] Thus, in general English usage, the test for vexatiousness turns on the *experience* of the person subjected to the event. That is, the person experiences an event (such as being the subject of a complaint) as being annoying, frustrating and/or worrisome (i.e. they are 'vexed' by it). This definition is the 'experiential' definition.

Vexatious is also a term with a specific legal meaning, which differs in a key way from its general English meaning. In legal contexts, 'vexatious' means "denoting an action or the bringer of an action that is brought without sufficient grounds for winning, purely to cause annoyance to the defendant".^[31] Thus, in legal contexts, the test for vexatiousness turns on the *motivation* of the person causing an event, rather than the experience of the person subjected to that event. This definition is the 'motivational' definition. The motivational definition requires that the complaint is based on insufficient grounds, is a deliberate abuse of process, and has the primary intention of harming the subject.



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Appropriate definition for healthcare complaints

The legal/motivational definition of vexatiousness has been neglected in public discourse, and inappropriately replaced with the experiential definition, or an outcomes-based definition.^[12] This review uncovered many examples where a practitioner or professional organisation labelled complaints 'vexatious' (or other negative terms such as 'frivolous', 'baseless' or 'unfounded') merely because the complaint resulted in no regulatory action.^[5-11] Classifying complaints as vexatious on these grounds alone is inappropriate.

There are many reasons why a regulator, including a National Scheme entity, may decide not to take substantive action, or may not be able to take substantive action it wishes to take.^[19, 32] One of these reasons is because a complaint is considered vexatious.^[33] However, a variety of other reasons unrelated to vexatiousness may also apply.^[16, 19] For example, a complaint may be more suited to complaints resolution than regulatory consideration, or the risk the practitioner posed to the public may have already been sufficiently mitigated.^[19, 32, 34, 35]

Being the subject of a formal complaint is a difficult, confronting and distressing experience for health practitioners, regardless of whether a complaint is well-founded.^[36-42] Thus, most complaints about health practitioners could be classified as 'vexatious' by the experiential definition.^[27, 36-41] This includes those which are of a serious nature, are well-founded, and result in regulatory action.

Regulatory bodies need to wield sufficient authority to achieve their remit,^[43, 44] which necessarily includes the ability to impose processes and outcomes that, while fair, just and reasonable, are often unpleasant for the practitioner involved.^[26] Thus, a practitioner feeling vexed by a complaints process is not, in its own right, a reason to consider that process (or the complaint that triggered it), to be illegitimate or problematic.^[27] Therefore, it is inappropriate to apply the experiential definition of vexatiousness to healthcare complaints.

Applying the motivational definition, on the other hand, is consistent with Australian statutes regarding vexatious litigants,^[45, 46] as well as the Health Practitioner Regulation National Law (the National Law) as enacted in each state and territory,^[33] and the goals, operational realities and regulatory principles of the National Scheme.^[26] Approaching the issue with this motivational lens, as opposed to an experiential lens, is especially consistent with Section 237 of the National Law, which provides protection against liability for people making notifications (and those contributing information or other assistance with respect to a notification), but only if they do so "in good faith".^[33] Under the National Law, protection from liability is thus not contingent on the outcome of the notification in question, or the experience of the subject, but rather the motivation and genuine beliefs of the person submitting it.

Types of sub-optimal complaints

A sub-optimal complaint has one or more features that render it less than ideal for use in administering fair, efficient and effective regulatory oversight of practitioners. There are many reasons why a complaint might be considered sub-optimal, some of which are described in Appendix 3. These include complaints that are made in good faith and are truthful, but do not meet the threshold for regulatory action ('sub-threshold'), those which are not lodged with the most appropriate entity ('misdirected'), or those where the complainant misunderstands what is an acceptable standard of performance or conduct ('misconceived'). The categories in Appendix 3 are not mutually exclusive, and any complaint may fit several categories, or none at all.

Of the types of sub-optimal complaints listed in Appendix 3, the only one which automatically qualifies a complaint to be considered 'vexatious' in its own right is the category so named. Of the remaining types, only some, based on the motivational definition established earlier, may count towards categorising a complaint as vexatious. However, such categorisation depends on the exact details and circumstances of the complaint. In particular, the fundamental defining features of vexatiousness – being made without grounds and with the primary intent of causing harm to the respondent – must be present for a determination of vexatiousness to be made.^[12, 45-47]



How common are vexatious complaints?

Need to quantify the problem

In its 2015-16 business plan, AHPRA committed to adopting a risk-based approach to regulation.^[48] Ideally, this approach requires that regulatory decision-making not only take into account the risk posed by individual registrants, but also the risks posed by regulatory processes and priorities themselves. This is noted in the National Scheme's regulatory principles, which state that a risk-based approach applies to "all of our regulatory decision-making, including in the development of standards, policies, codes and guidelines".^[26] Therefore, any effort to combat vexatious complaints in the National Scheme should be based on a robust risk/benefit analysis, which in turn requires the nature and magnitude of the risks to be established and documented.

Evidence of incidence

Evidence from within healthcare

Many practitioners and their representatives have claimed that vexatious complaints are a significant and widespread problem within the National Scheme.^[1, 5, 7, 13, 16, 49] However, as the inquiry report noted, these commentators do not cite empirical evidence in support of these assertions.^[16] Instead, they rely on personal and/or second-hand anecdotes, which can lead to self-selection bias and sampling bias.^[29, 50]

The National Scheme does not currently formally quantify vexatious complaints, nor have an agreed, official definition of what a vexatious complaint is.^[19] However, findings from Professor Ron Paterson's review of chaperone conditions,^[51] an analysis of mandatory notifications by the University of Melbourne,^[19] complaints data from the National Health Practitioner Ombudsman and Privacy Commissioner (NHPOPC),^[50] and a study of practitioners and medico-legal advisors in Australia^[52] have all found that the proportion of vexatious complaints in the National Scheme is low. The latter study suggested sub-threshold and occupational complaints likely comprise the majority of sub-optimal complaints in the mandatory reporting context.^[52]

Australian and international regulators and complaints-handling bodies who we contacted during this review (not identified here for reasons of confidentiality) all agreed that vexatious complaints are rare, to the point where some entities described their incidence as 'negligible'.

Comparing entities handling complaints and tip-offs

As part of this review, we examined reports by a selection of Australian entities that are charged with handling or investigating complaints or tip-offs from the public. Specifically, we examined the proportion of complaints or reports to these entities which resulted in substantive outcomes (indicating that the complaint has been accepted as legitimate and reaching the threshold for action). The results are shown in Table 1.

The proportion of substantive outcomes occurred along a spectrum, which mapped onto the purpose of the relevant entity. Substantive outcomes were most likely when the entity receiving a report or complaint was focused on conciliation and/or benefitting legitimate complainants directly (i.e. a classic complaints-handling entity), and became less likely when the entity was focused on rule enforcement for the wider public good (i.e. a classic regulator).

However, the National Scheme was an exception, with its proportion of substantive outcomes being 1.4 to 4.3 times higher than entities with similar regulatory, non-conciliatory approaches. This suggests that, compared with other complaints-handling entities, the National Scheme does not receive a disproportionate number of unsubstantiated complaints. The reasons for this difference are unclear, but may include the complementary role that health complaints entities (HCEs) play in managing sub-threshold complaints and referring (and thus de facto triaging) a substantial portion of the notifications the National Scheme handles,^[33, 34, 53] and the substantial number of complaints lodged by practitioners/employers/educators (which are approximately 3 to 7 times more likely to result in substantive outcomes than those by members of the public^[54]).



Table 1: Incidence of substantive outcomes from entities handling complaints and tip-offs

	Designed to benefit legitimate complainants directly	Conciliation-based	Entity name	Proportion of complaints / reports resulting in substantive outcome (%)	Method of calculating proportion of substantive outcomes
Classic complaints entity	Yes	Yes	Telecommunications Industry Ombudsman ^[55]	92	Material complaint handling or conciliation outcome in complainant's favour / complaints
			Water and Energy Ombudsman Victoria ^[56]	79	
			Health and Community Services Complaint Commissioner (SA) ^[57]	47	
Mix of complaints entity and regulator	Yes - some complaint types	No	Australian Press Council ^[58]	21	Breach findings or corrective actions / complaints
	No - some complaint types		Commonwealth Ombudsman ^[59]	13	
Enforcement agency support	No (Except rare cases involving rewards)	No	Crime Stoppers ^[60]	7	Criminal charges / instances of community contact
Classic regulator	No	No	General Medical Council ^[61]	13	Regulatory action / fitness to practice enquiries
			Advertising Standards Bureau ^[62]	11	Breach findings / complaints
			The National Scheme ^[34]	30	Regulatory action / notifications

Claims of vexatiousness by practitioners who are the subject of complaints

Attempts to quantify the incidence of vexatious complaints must take into account that claims about the occurrence of vexatious complaints, even when made by professional organisations, typically trace back to assertions made by practitioners who are the subject of the allegedly vexatious complaints.^[1, 2, 9, 30] There are two key reasons that such claims must be considered with caution.

First, as already described, many claims that complaints are 'vexatious' are rooted in incorrect interpretations of what the term means.^[5-7, 9-11, 30] Many such claims apply experiential or outcomes-based definitions, to encompass any complaint which the practitioner experiences as disruptive or inconvenient to themselves, with which they do not agree, or which does not result in substantive action.

Second, even if the practitioner's understanding of the concept of vexatiousness is sound, they may still misapply it – either deliberately or mistakenly – in their own defence. In this context 'defence' can mean a legal defence, or the internal psychological defences used to shield oneself from unpleasant experiences and feelings. Notably,



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research has found that issues such as deliberate dishonesty and lack of insight are common among certain groups of practitioners who are the subject of complaints under mandatory reporting provisions in particular.^[63-65]

This review has identified three common scenarios in which 'the vexatiousness defence' is misapplied (these scenarios sometimes overlap).

Denial as a defence: When a practitioner decides to falsely claim that a complaint is inaccurate, misleading and vexatious, to deflect blame and/or avoid negative consequences. Such claims often rely on a lack of sufficient objective evidence, and the tendency^[54] of regulators to give practitioners the benefit of the doubt in such situations. For example, a practitioner who assaulted a patient may claim that related allegations are untrue and made out of spite, relying on the absence of independent witnesses.

Lack of insight: When a practitioner lacks insight into their conduct, performance or health issues, and therefore claims that well-founded complaints about them are vexatious. These individuals commonly have a health impairment (e.g. mental illness, cognitive disability or substance abuse disorder), and/or their protestations have a conspiratorial or persecutory tone.^[66, 67] For example, a subject whose performance is impaired by a psychotic disorder may claim that complaints about their performance are part of a wider conspiracy by jealous colleagues to derail their career.

Opposing accepted standards: When a practitioner does not dispute the facts that form the substance of complaints, but disputes that the events or circumstances comprise wrongdoing, or are inappropriate or inadequate practices. They often cite alleged political and ideological motives for the complaints, professional oppression, excessive use of administrative power, and attempts to curtail their fundamental freedoms. For example, a subject who provides sex-selection (for non-medical reasons) to patients receiving reproductive services may admit to providing these services, but claim that their behaviour is ethically virtuous, and that complaints about them are oppressive and ideologically driven.

What factors may contribute to vexatious complaints?

Complainant type

Different categories of complainants (e.g. members of the public, practitioners, employers, educators) typically have different motivations, knowledge of complaints systems, potential to gain from complaints processes, and behaviour patterns. Within the category of vexatious complaints there are two distinct patterns of conduct – calculated complainant conduct and unreasonable complainant conduct – which map closely onto two complainant types. These associations are general, but not universal.

One category of vexatious complaining behaviour involves complainants submitting only one or a small number of complaints (although possibly in concert with others), in a strategic and calculated manner, with a specific self-serving goal in mind (i.e. personal gain via causing harm to the subject).^[49, 68] This is 'calculated complainant conduct', and is most commonly described in reference to professional complainants and inter-collegial complaints.^[4, 49, 68]

Another category of vexatious complaining behaviour involves complainants who engage in a 'campaign' of repeated, escalating and often fervent complaint-lodging, which appears to be obsessive, and lacking in strategy, proportionality, restraint or even apparent purpose.^[69-74] This is 'unreasonable complainant conduct',^[70] and is most commonly described in reference to lay complainants (e.g. patients).

Psychopathology

Much of the literature about vexatious complainants arising from unreasonable complainant conduct proposes various forms of psychopathology – particularly 'querulent paranoia' – as a common underlying cause.^[69, 71, 72, 74] In law, a 'querulent' is a person who obsessively feels wronged, and as a result, repeatedly pursues recourse via



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groundless legal action, often in relation to petty issues.^[74] It does not include those who doggedly pursue recourse for major injustices, or those pursuing minor grievances in a proportionate and reasonable manner.^[74] The term has a similar meaning in psychiatry, where querulousness has been recognised as a mental disorder that exists at the intersection of delusional psychosis and personality disorders.^[75-78] The condition is rare,^[73, 79-81] and more likely to occur in people who are male and middle-aged,^[80, 82-84] and have a personality structure described as “obsessional, pedantic, combative, egotistic...distrustful and vindictive”.^[47, 85]

Querulousness can have significant negative impacts on the affected individual, individuals around them, and society in general.^[69, 71, 72, 82] It is argued that the prominence of rights and complaints systems as core pillars of modern Western societies may give the pathology of querulousness more channels of expression, and more claims to (false) legitimacy, amplifying its impacts.^[69, 71, 82] In English-speaking countries, querulousness is not often recognised as clinically significant by health professionals,^[69, 72, 82, 84] and is considered a legal problem, rather than a medical one.^[72]

Vexatious complaints regarding health practitioners or services is one way that querulousness may be expressed. The authors of a study of complaints to the Victorian Health Services Commissioner suggested that querulousness is a potential contributing factor in the behaviour of unusually persistent complainants to that service.^[69] Other forms of mental illness or cognitive impairment could also plausibly contribute to vexatious complaints, however, this review did not identify any empirical evidence regarding this possibility.

Inadequate complaints systems and unmet needs

Complainant needs

Patterns in complainant motivations and needs vary according to complainant type.^[65, 86, 87] Practitioners or employers who lodge complaints report motives such as personal medico-legal protection, helping an impaired colleague, and protecting patients.^[52, 64, 88] In this context, complainants report a need for complaints systems which keep them safe from negative repercussions for reporting, and deliver consistent and predictable outcomes that are effective, targeted and proportional.^[64, 88]

Lay complainants' most common motivation is to prevent similar events from happening to somebody else. While some complainants request monetary compensation, or punitive/disciplinary action, these motivations are much less common.^[87, 89-91] Lay complainants say they need to feel heard, to be told about changes made to protect others in future, and to receive an acknowledgement, apology and/or explanation.^[87, 89-92]

Where the above needs are not met by complaint mechanisms (including initial health service or practitioner responses), this may contribute to a complainant becoming vexatious. This may be more likely for lay complainants, whose complaints are far less likely to result in substantive outcomes than professional complainants,^[54] and who may be disadvantaged by complaints systems due to power imbalances, poor communication, medico-legal defensiveness, 'toothless' complaints entities, limited access to information, as well as dismissiveness and poor regard for their experiences, feelings and needs.^[87, 89-92]

Complainant needs and existing complaint systems

There are multiple channels through which complaints about health practitioners can be made, which vary in scope, powers, approach, processes and possible outcomes. Public understanding of which entities best serve which purposes, and what their powers and processes are, is limited.^[16-18, 35, 93]

This 'patchwork' of complain channels can lead to complainants being 'passed around' between entities (sometimes without their agreement),^[35, 94] falling through the cracks,^[35, 93, 94] or having their needs misunderstood by, or poorly matched with, the entity who handles their complaint.^[35, 90, 93-95] Complainants can also be left with no constructive outcome if a practitioner refuses to engage in voluntary conciliation through HCEs.^[17, 35, 94, 96]

Some commentators argue that the Australian system's attempt to separate 'complaint resolution' from 'regulatory oversight' is artificial, ineffective and fragmented, and contributes to there being no 'good option' for many



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complainants.^[94, 95, 97] The system has been accused of forcing complaints to be used either for public protection (via regulatory oversight), or for individual complaint resolution (via HCEs), with restricted capacity to effectively and coherently deliver both for any one complaint.^[94, 95, 97] It has also been accused of forgetting that complainants have needs at all, and treating them instead as disinterested sources of 'tip-offs'.^[35, 94, 95, 97]

As a result of the above issues and others, complainants are often alienated by the Australian complaints system. They may perceive it as cursory, biased, slow, onerous, secretive, inconsistent or impersonal, with a threshold for action that is too high, and excessive tolerance for unprofessional behaviour or poor clinical performance.^[17, 35, 94] This can breed discontent, a sense of injustice, and even conspiratorial notions (e.g. 'doctors protecting their own'), which may contribute to the occurrence of unreasonable complainant conduct and/or vexatious complaints.

Role of initial complaint response

There is evidence that poor handling complaints at 'lower' levels of formality (e.g. at the workplace, practitioner or HCE level) may result in complaints being escalated to higher levels in an orderly and reasonable fashion (e.g. escalating from a direct-to-service complaint to a regulator).^[89, 91] Improved complaints-handling can help to avoid this kind of reasonable escalation for the vast majority of complainants, who act reasonably.^[98] However, those inclined towards unreasonable conduct and vexatiousness are not readily appeased by high-quality initial complaints-handling.^[69, 70] Indeed, an Australian study found no relationship between the adequacy of initial complaint handling and the likelihood a complainant would become 'unusually persistent'.^[69]

Complainant gain

Different types of complainants stand to gain different things from making vexatious complaints. Some potential gains from making vexatious complaints are intangible, such as a sense of satisfaction from causing distress to the subject, or exercising power, control or revenge over them. An example is the use of vexatious complaints as a tool of intimate partner violence. These gains may drive vexatious complaints, but we did not identify any direct empirical evidence about this.

Notably, Australia's health practitioner regulatory system (as distinct from HCEs) does not offer complaint resolution services, compensation or conciliation to complainants. Therefore, most complainants to regulators, especially lay complainants, do not stand to gain anything material from making a complaint. However, a small subset – notably people engaged in calculated complainant conduct (likely professional complainants) – may gain either personally or professional by self-serving abuse of the complaints system.

Personal gain

Material personal benefits that may be gained from making a complaint typically relate to gaining an advantage in legal proceedings or relationship breakdowns, including divorce and custody proceedings, compensation claims (e.g. WorkCover cases) and criminal cases.^[3, 10, 22, 28, 99] Professional organisations have claimed that such vexatious claims attempt to undermine either the other party in a case, or unfavourable expert witnesses, medico-legal reports or medical records.^[3, 10, 22, 28, 99] Such cases could involve either non-practitioners (e.g. a claimant in a WorkCover cases) or practitioners (e.g. the practitioner spouse of another practitioner) as the complainants.

Professional gain

Professional benefits gained from making a complaint typically relate to advancing one's professional market share, restricting competition, commercial patch protection, or damaging the reputation of somebody who might otherwise raise concerns about oneself.^[1, 100] A complaint could be used to negatively impact the resources, capacity, professional autonomy, reputation and career advancement of a practitioner that one deems to be a potential competitor or professional threat.^[1, 100] This could include using complaints against trainees, students or applicants to anti-competitively reduce the supply of specialists.^[68, 100-102] This review did not identify any empirical evidence



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regarding such abuse of complaints systems, with information instead coming from assertions by health practitioners and their representatives.^[1, 4, 6, 8, 30, 49, 103]

With some possible exceptions (e.g. a layperson who owns a medical clinic), only practitioners stand to reap professional gains by making a vexatious complaint. This has led consumer groups, as well as a doctors' advocate, to suggest that the majority of vexatious complaints are likely made by practitioners, for whom the benefits of such action are much greater.^[13, 24] However, this review did not identify empirical data on the extent to which this is true. While this review did not identify any cases in which courts have made an adverse finding against practitioners for anti-competitive abuse of complaints processes, courts have made adverse findings against health practitioners for other forms of anti-competitive behaviour that reflect similar motives.^[104]

There have also been anecdotal claims that calculated complainant conduct may be used as a form of inter-collegial bullying or harassment.^[1, 4, 8, 10, 49, 52, 103, 105, 106] The present review identified only one study specifically addressing this issue. That study from Pakistan found that 13.3% of 60 psychiatrists claimed they were subjected to bullying in the form of unjustified complaints.^[42] However, as noted earlier, practitioners' claims that complaints about them are vexatious must be considered with caution.

What impact do vexatious complaints have on health practitioners and complaints-handling agencies?

Impact of complaints on individual professionals

Evidence from health practitioners

This review did not identify any evidence of the specific impacts of vexatious complaints on health practitioners. However, there is evidence regarding the effect of complaints and medico-legal proceedings in general (whether vexatious or not) on practitioner subjects. These include:

- Depression ^[36-40]
- Anxiety ^[36, 37, 39]
- Burnout ^[38]
- Anger ^[37, 39, 40]
- Shame ^[40]
- Guilt ^[40]
- Reduced work satisfaction / feeling unappreciated ^[37, 40]
- Suicidal ideation and thoughts of self-harm ^[36, 38, 39]
- Practising defensively ^[36, 37, 39, 41]
- Feeling victimised or stigmatised ^[36, 37, 107]
- Feeling bullied ^[36, 37]
- Taking time off work ^[36]
- Self-doubt ^[37, 39, 40]
- Thoughts of restricting or leaving practice ^[37, 39, 40]

The intentional misuse of complaints processes to lodge manifestly groundless complaints with harmful intent is a form of abuse. As such, the general negative effects of complaints on subjects may be heightened, or different, in the case of vexatious complaints. However, this cannot be determined from the available empirical evidence.

It is important to note that being involved in a medical error is, in itself, associated with burnout, depression and suicidal ideation, and this effect is difficult to distinguish from the impact of complaints regarding such matters.^[108-110] There is also some evidence that experiencing health issues such as those listed above may contribute to the risk of error, and thus, to the risk of complaint, in the first instance.^[111] Finally, all of the studies examined for this section of the review used self-selected samples of practitioners, which the authors acknowledged may skew the sample (and thus the findings) towards practitioners with more negative experiences of complaints systems.



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Studies have also found that, as the result of being the subject of a complaint or medico-legal proceeding, many practitioners report improving their practice in the areas of:

- Communicating risk ^[41, 112]
- Providing information and explanation to patients ^[112, 113]
- Responsiveness to patient and family concerns ^[112]
- Level of care and attention ^[41, 112]
- Disclosure of uncertainty ^[41]
- Tracking test results ^[41]
- Tracking and following up on non-attendance ^[41]
- Auditing clinical practice ^[41, 113]
- Detailed note-taking ^[113]
- Relating empathically to patients ^[41]

Therefore, complaints can positively affect practice, potentially preventing future complaints and patient harm, and thus the harm practitioners experience when involved in medical errors and complaints.

Impact of unreasonable complainant conduct

When vexatious complaints are accompanied by unreasonable complainant conduct, this may have additional impacts. Figure 1, sourced from the NSW Ombudsman's practice manual on managing unreasonable complainant conduct,^[70] summarises the negative impacts of such conduct.

Some vexatious complaints consume a disproportionate share of agency resources.^[47, 69, 70] However, the extent to which this occurs may vary between unreasonable complainant conduct and calculated complainant conduct. A single complaint lodged in the course of calculated complainant conduct would likely consume a relatively small amount of an agency's resources, mirroring the use of resources in any other single complaint. Therefore, due to the rarity of vexatious complaints in general,^[29, 50-52, 57, 114] much less the specific sub-category of vexatious complaints arising from calculated complainant conduct, the potential resource impact of these complaints on agencies is likely low. Thus, efforts to address them may consume more resources than they save, especially given the difficulty in identifying these complaints.^[69]

On the contrary, the cumulative effect of dealing with the copious, lengthy, repeated complaints characteristic of unreasonable complainant conduct does consume a disproportionate share of agency resources.^[69, 70] Therefore, given the burden of time and costs associated with unreasonable complainant conduct, and its easier identification due to the cues of volume and persistence,^[69] successful efforts to tackle these cases may result in a net resource saving for agencies.

How can vexatious complaints be identified?

Elements of the definition

This review did not identify any formula or checklist for determining if a complaint is vexatious. Given the complex factors and circumstantial nuances involved, successful development of such a tool is unlikely. The first step in identifying vexatious complaints is to develop a clear definition of what constitutes a vexatious complaint, as distinct from other forms of sub-optimal complaint. However, such definitions necessarily focus on two features that can be difficult to verify – the motivation of the complainant, and the veracity of their claims.

Motivation can be difficult to establish because a complainant may not state their motivation, or their stated motivation may not reflect their primary intent.^[15] Even if vexatious motivation cannot be proven, there may be factors that are associated with it, which can be taken into account in determining the likelihood a



Figure 1: Negative impacts of unreasonable complainant conduct, as described by the New South Wales Ombudsman)[sic]

Negative impacts of unreasonable complainant conduct		
Organisations <ul style="list-style-type: none">• loss of focus among affected and de-motivated staff• unable to effectively and fairly allocate resources• unnecessary time and resources responding to complaints made externally• loss of reputation and a poor public image• increased staff turnover and absenteeism leading to added recruitment and training costs for replacement staff and salary costs for staff who are absent from work• increased stress leave applications and compensation claims• duty of care and WH&S issues• increased financial expenditure on counselling, ADR, support and legal advice• damage to property and equipment	Staff members <ul style="list-style-type: none">• stress, anxiety and frustration• fear of attending work or reporting incidents• withdrawal, loss of motivation and/or indifference towards the job• loss of confidence, feelings of powerlessness and vulnerability• psychological and/or physical trauma• reduced productivity and timeliness• personal blame and/or guilt• loss of personal and/or professional reputation• irritability and deteriorating relationships at work and/or at home• emotional exhaustion and/or burnout• depression	Complainants <ul style="list-style-type: none">• unable to achieve the outcomes they are looking for• obsession or loss of perspective leading to losses that are greater than the original harm they suffered• increased likelihood of distrust for other organisations and their staff• stress• damage to reputation and credibility• damage to career, relationships, friendships etc.• depression• suicide
External review bodies and agencies <ul style="list-style-type: none">• additional demands on their time and resources, including dedicating staff to deal with escalated complaints• inequity and resource allocation issues - time taken away from other review applications• potential for all (or many) of the same impacts listed under 'organisations' and 'staff members'	The subjects of complaint <ul style="list-style-type: none">• stress due to interacting with the UCC and/or responding to escalated complaints made against them• damage to reputation• fear or apprehension for self or family• feelings of being under attack, victimised and/or powerless• emotional exhaustion	Other complainants/ service users <ul style="list-style-type: none">• inequitable allocation of organisational resources including staff time• reduction in service level received including, waiting times over the phone, delays in receiving correspondence etc.• discomfort when observing incidents involving UCC• feeling threatened and/or inadvertently being drawn into incidents• negative feelings towards the organisation and its staff resulting in more complaints

Source: New South Wales Ombudsman. *Managing unreasonable complainant conduct: practice manual*. 2012. Available from: http://www.ombudsman.gov.au/__data/assets/pdf_file/0022/35617/GL_Unreasonable-Complainant-Conduct-Manual-2012_LR.pdf



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complaint is vexatious. For example, some commenters have suggested that vexatiousness may be more likely if a complaint is lodged during the course of legal proceedings or relationship breakdown,^[3, 10, 22, 28, 99] or by a practitioner who has a personal^[10] or professionally competitive^[49, 100, 103] relationship with the subject of the complaint. However, this review did not find any evidence regarding these hypotheses. In addition, peers or those personally close to a practitioner may sometimes be best placed to identify certain reportable issues.

In some cases, the veracity of a complaint can be clearly established, such as where an alleged incident has been digitally recorded (e.g. on camera), or witnessed by multiple independent parties. However, due to the often private, one-on-one nature of healthcare delivery, the veracity of complaints is commonly hard to prove. In situations involving care provision, substantial weight is often given to health records as the 'official' record of events. However, research has found medical records are often of poor quality, thoroughness and accuracy.^[115, 116]

Potential indicators

Some factors have been associated with querulous complainant behaviour, unreasonable complainant conduct and vexatious complaints in various sectors.^[69, 71, 74, 79, 80, 82-84, 117, 118] These factors, listed in Table 2, relate to the demographics and behaviour of the complainant, and the format and content of the complaint.

The most consistent findings relate to complainants' behaviour and communication styles,^[69, 71, 74, 79, 80, 82, 83, 117, 118] which one study found could predict over 30% of the variance in complainants' likelihood of becoming unusually persistent. Relevant features include the format, length, components and writing style of complaints, as well as the demands and validation-seeking behaviours of complainants (see Table 2). Once again, these indicators are more relevant to unreasonable complainant conduct, and less relevant to the harder-to-identify cases of calculated complainant conduct.

What are the risks of not identifying vexatious complaints correctly?

There are risks associated with incorrectly identifying good-faith complaints as vexatious ('false positives'), as well as failing to identify vexatious complaints as such ('false negatives'). The risks suggested in the grey literature are summarised in Table 3, however, this review did not identify any empirical research examining the validity, extent or consequences of these proposed risks. Notably, most of the commentary identified in this review that mentioned risks focused on risks to practitioners from false negatives, with little reference to the risks to the public from false positives.

Evidence indicates that when it comes to actionable concerns about health practitioners, under-reporting, as opposed to excessive or unnecessary reporting, is a larger problem in terms of both magnitude and impact.^[42, 52, 64, 65, 86, 106, 119-122] Also, the available evidence indicates the proportion of vexatious reports is low.^[19, 29, 50, 51, 69] Together, these findings suggest that the net negative impact of not identifying a small number of vexatious complaints as such would likely be less than the net negative impact of incorrectly identifying a significant volume of complaints as vexatious.^[19, 24]

As evident in Table 3, false positives typically place a greater burden of risk on the public, while false negatives typically place a greater burden of risk on individual practitioners. The regulatory principles of the National Scheme state:^[26]

*"While we balance all the objectives of the National Registration and Accreditation Scheme, **our primary consideration is to protect the public**"*

Therefore, the National Scheme's principles suggest that – in assessing the trade-off between false positives and false negatives – the scheme should prioritise protecting the public. On the limited evidence available at present, an approach that errs on the side of assuming complaints are made in good faith, unless there is good reason to believe otherwise, appears most consistent with this.



Table 2: Factors associated with vexatious complaints, querulous complainant behaviour or unreasonable complainant conduct

Complainant demographics	Complaint format	Complaint content	Complainant behaviour
Factors associated with vexatious complaints, querulous complainant behaviour or unreasonable complainant conduct			
<ul style="list-style-type: none"> - Male [69, 80, 82, 83, 123] - Middle-aged [80, 82-84, 123] 	<ul style="list-style-type: none"> - Multiple, excessive and unusual methods of emphasis (multiple text/highlighting colours, bolding, capitalisation, underlining, exclamation marks, inverted commas)[69, 71, 82, 123] - Marginal notes[69, 71, 82] - Rhetorical questions in written communication[69, 123] - Offensive language and expressions[69] - Hyperbolic, dramatic or language and expression[69, 123] - Unnecessary repetition[69, 82] - Three or more forms of emphasis used in one letter[123] - Communication is inappropriately lengthy / high number of pages[69, 123] - Includes excessive supporting materials or irrelevant information[69] [123] - Vague, incoherent or difficult to follow Unintelligible in parts[69, 123] - Includes written comments on supporting materials[69] - Attaches endorsements of own good character[69] - Attaches personal diary entries[69] - Attaches media report extracts[71] 	<ul style="list-style-type: none"> - Requests legal advice [123]*** - Complaint not clearly defined[123]*** - Seeks outcomes the complaints entity cannot deliver[69] / unrealistic expectations of what complaints agency can achieve[123]*** - Gives forceful instructions on how the complaint should be handled,[123] such as demanding:*** <ul style="list-style-type: none"> o Acknowledgement of mistreatment[69] o Specific apology[69] o Recognition of wider social implications of complaint[69] o Public recognition of struggles with 'the system'[69] o Punitive action[69] o Public shaming of alleged wrong-doers[69] o Justice 'on principle'[69] / on morals grounds or for public interest[123]*** o Their 'day in court'[69] - Claims general, overall damage to social and economic functioning[69] - Claims overall damage to health[69] - Claims loss of self-esteem[69] - Uses medical or legal terms inappropriately, or misunderstands the spirit and implications of the law[69, 71, 82, 84, 117, 123] - Alleges multi-agency conspiring against them[123]*** - Includes obvious misinformation[123]*** 	<ul style="list-style-type: none"> - More frequent communication[69] - Lengthier communication[69] - Uses multiple methods of communication[69] - Turns up at complaints office without an appointment[69] - Multiple requests for change of complaint handler[69]/ queries complaint-handler competence[123]*** - Varies nature and grounds of complaint over time[69, 71] - Intimidating, confrontational or rude[123]*** <ul style="list-style-type: none"> o Threats against others[69, 71, 123]*** o Threats of self-harm[69, 123]*** o Judged as especially difficult or intimidating by complaint handler[69] - Contacts/complains to multiple agencies[69, 71, 74, 79, 82, 83, 123]*** - Self-represents in legal scenarios[71, 74, 79, 80, 117, 118]
Factors specifically associated with risk of subsequent/repeated complaint submissions (in addition to above)[123]			
<ul style="list-style-type: none"> - Self-reported mental health problems 	<ul style="list-style-type: none"> - Reframing complaint in an attempt to have the case re-opened 	<ul style="list-style-type: none"> - Refusal to accept the decision of the complaints-handling agency - Asks for review of the decision - Seeks vindication, retribution or revenge - Provides previously withheld information at the end of the process in an attempt to have the case re-opened - Raises a range of minor or technical issues, arguing that these invalidate complaints agency's decision - Displays adverse consequences of pursuing complaints process 	<ul style="list-style-type: none"> - Makes Freedom of Information or Data Protection Act requests - Overtly angry or aggressive - Ingratiating or manipulative - Fails to fully disclose information requested by the complaints handler - Expects review of decision based on own dissatisfaction with initial outcome

***To avoid duplication, triple asterisk indicates features associated with vexatious complaints, querulous complainant behaviour or unreasonable complainant conduct that are also specifically associated with risk of subsequent/repeat submissions.



Table 3: Risks of false negatives and false positives in identifying vexatious complaints

	Risks of not identifying vexatious complaints as vexatious (false negatives)	Risks of incorrectly identifying complaints as vexatious (false positives)
Practitioners subject to complaint	<ul style="list-style-type: none"> - Reputational harm - Financial harm - Damage to psychological and physical health - Wasted time and resources - Loss of confidence in regulatory system - Unjust regulatory restrictions - Loss of job or career 	<ul style="list-style-type: none"> - Missed opportunity to intervene early and prevent professional repercussions (e.g. reputational, employment and financial) - Missed opportunity to intervene early and prevent personal repercussions (health/impairment, psychological and physical) - Reinforcing lack of insight, problematic behaviour or sub-standard practice
Reporting practitioners/ professionals	<ul style="list-style-type: none"> - Legal action and professional harm from making repeated vexatious complaints - Missed opportunity to identify own impairment or mental health problems (where relevant) 	<ul style="list-style-type: none"> - Loss of confidence in regulatory system/hesitance to report again - Reputational harm / ostracisation by peers - Psychological harm - Wasted time and resources - Loss of job or career - Retaliatory reports - Ongoing 'involvement by proxy' in sentinel events or problems - Future complaints not taken seriously
Reporting members of the public	<ul style="list-style-type: none"> - Legal action from making repeated vexatious complaints - Missed opportunity to identify and address own mental health problems (where relevant) - Damage to relationships - Financial losses and costs - Loss of employment - Social isolation 	<ul style="list-style-type: none"> - Loss of confidence in regulatory system/hesitance to report again - Loss of confidence in the healthcare system - Retaliation/ unfavourable reputation among practitioners - Loss of therapeutic relationships - Psychological harm - Wasted time and resources - Ongoing harm due to the reported issues - Future complaints not taken seriously - Denied due remediation for harm
Public / patients	<ul style="list-style-type: none"> - Delays in regulatory processes affecting patient safety - Delays affecting patient experience of regulatory processes - Unnecessary temporary or permanent loss of reported practitioners from workforce - Unnecessary temporary or permanent separation from usual treating practitioner - Unnecessary loss of confidence in practitioners - Investigatory intrusion of patient privacy - Inter-professional conflict and low morale 	<ul style="list-style-type: none"> - Loss of confidence in regulatory system/not believing in value of reporting - Loss of confidence in the healthcare system - Breakdown of regulatory system efficacy and public protection - Physical, psychological, social, financial harm resulting from reported issues (including death or permanent disability) - Unnecessary temporary or permanent loss of reporting practitioners from workforce - Unnecessary temporary or permanent separation from usual treating practitioner who was a reporter - Risks of inter-professional conflict / low practitioner morale
Regulatory / law enforcement agencies	<ul style="list-style-type: none"> - Loss of confidence in regulatory system - Wasted time and resources - Regulatory inefficiency and increased costs - Political pressure to reduce/revoke powers - Reputational damage and bad publicity - Abuse of staff by respondents and their allies - Increased involvement in legal action (time, resources and costs) - Damaged relationships with key professional stakeholder groups and entities - Political inquiries 	<ul style="list-style-type: none"> - Loss of confidence in regulatory system - Decreased reports of serious issues by public and professionals - Failure to adequately protect the public leading to harm - Failure to intervene early – long-term cost - Political pressure for roll-back or removal of powers - Reputational damage and bad publicity - Abuse of staff by complainants and their allies - Increased involvement in legal action - Damaged relationships with key professional and consumer stakeholder groups and entities - Political inquiries
Table references: [1-13, 15, 16, 18-22, 24, 25, 27, 28, 30, 36, 39, 40, 47, 49-52, 64, 65, 67, 69, 70, 72, 79, 85, 86, 88, 91, 93, 95, 97, 99, 105, 111, 117, 118, 124-136]		



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What are the key principles for preventing and managing vexatious complaints?

To inform this review we contacted 12 regulatory and complaint-handling organisations in the health sector, in Australia and around the world, requesting information about their experiences, policies and procedures regarding vexatious complaints. We received responses from nine organisations from the UK, New Zealand, Canada, Northern Ireland, the Republic of Ireland and Australia. These organisations and their responses have been deidentified to maintain confidentiality. Some organisations had no formal policies regarding vexatious complaints. Those that did had a mix of policies that covered vexatious 'subject complaints' (where the target is a practitioner), and vexatious 'process complaints' (where the target is the regulatory or complaint-handling entity or its staff). Combining this information with available literature highlights some key principles for identifying, preventing and managing vexatious complaints.

Define the problem

The first step in effectively managing vexatious complaints is to have a clear, consistent understanding of what a vexatious complaint is. Most policies we saw specifically noted that making multiple complaints, being persistent or passionate, and being emotionally charged are not synonymous with vexatiousness. It is also important to communicate clearly, internally and externally, about the various types of sub-optimal complaints, and the potential meanings of 'no further action' decisions. Defining unreasonable complainant conduct, and noting that it is not present in all vexatious complaints, is also important.

Together, these measures help to ensure that efforts to prevent and manage vexatious complaints are appropriately targeted. It is also important to recognise variation in the type of vexatious complainant behaviour (i.e. calculated conduct versus unreasonable conduct), complainant type (e.g. lay versus professional complainants), complaint target (i.e. subject versus process), and complainant motivation (e.g. personal needs versus professional gain).

Quantify the problem

An informed decision about whether to put specific measures in place to prevent and manage vexatious complaints, and what such measures should be, requires understanding the extent of the problem. This ensures that any response is reasonable, necessary and proportional, and appropriately balances the risks to the public, practitioners and others, as required by regulatory principles.^[26] The empirical evidence, and the experience of complaints handlers cited in this review, consistently suggest that the extent of the problem is very small (typically described as less than 1% of all complaints).^[19, 29, 50, 51, 57, 114]

Establish and enact overarching principles

It is important to examine and remain faithful to the operating principles, legal powers and remit of a regulator, as well as broader established legal and ethical principles such as natural justice and procedural fairness.^[26, 124] Many regulators, including those that operate under the National Scheme, have formal principles under which they are required – either by law or community expectations – to operate.^[26, 137] It is important that regulators ensure new strategies or initiatives are consistent with existing principles, and their powers and responsibilities under law.

Establish and enforce minimum standards of complaint acceptance, and criteria for complaint rejection

Minimum standards that complaints must meet to be accepted for consideration and possible investigation, as well as specific criteria describing when a complaint can be rejected, should be codified and implemented. Some examples of issues that minimum standards of acceptance might address include regulatory scope, complaint format, identification of the subject, time limits and relevance to public safety. Criteria for rejection should focus on the apparent primary purpose of the complaint, the grounds of the complaint, and the manner in which the complaint is pursued (the latter by defining a threshold for unreasonable complainant conduct). It is advisable that such



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standards and criteria clearly state they are not intended to be absolute rules, professional judgment is allowed and encouraged, and that not all decisions need to be sent to the board/council/committee/ombudsman for formal review.

Carefully target interventions for different types of sub-optimal complaints

Implementing strategies to prevent and manage various other types of sub-optimal complaints (e.g. sub-threshold or misdirected complaints) – such as minimum standards for accepting complaints – may prevent or filter out certain vexatious complaints. However, efforts to address different types of sub-optimal complaints should be specifically targeted to the differing audiences, causes, motives, risks and impacts associated with each. The information in Appendix 4 demonstrates how the relevance of particular interventions may vary across type of sub-optimal complaint.

Manage expectations

The nature of an entity's processes, the possible and most likely outcomes of complaints, and next steps at each stage, should be communicated clearly and prominently via all channels accessed by actual or potential complainants.^[35, 70] This applies before and during lodgement of a complaint, and throughout the complaints process.

Wherever possible, the expectations and needs of all complainants should be explored, clarified and noted at the outset of a query or complaint. If these needs are better achieved by another entity, the complaint should be proactively referred, with the complainant's permission, to the most appropriate entity.^[35] This requires clear, agreed criteria and processes for referring complaints between entities.^[17, 35] With appropriate legislation and agreements in place, this approach need not prevent a regulator pursuing a complaint that raises public safety concerns, while simultaneously taking steps to ensure the complainant's need are met by another entity.^[17]

Ensure appropriate staff skills

There is value in employing staff based on their relevant investigative, dispute-resolution, analytical and interpersonal skills, rather than their current or former profession. Other regulators have improved their effectiveness and efficiency by moving away from preferentially employing members of the regulated profession(s), to regulation-specific skills-based employment practices – including employing many people from outside the regulated group.^[138] Academic literature,^[139, 140] a series of high profile cases,^[141-144] a report commissioned by the Medical Board of Australia,^[145] and investigations into medical culture,^[146, 147] have shown that what practitioners accept as normal and tolerable in their conduct and practices is often substantially at odds with public norms, expectations and values. As such, employing non-practitioners in healthcare regulation may help align regulatory processes and judgment with societal norms. There is also evidence that practitioners significantly underestimate how common healthcare errors are.^[41, 112] This may further contribute to practitioners in regulatory settings not believing, or 'under-responding' to, complaints.

Empower staff with appropriate flexibility, autonomy and decision-making powers

Regulators who contributed to this review argued that careful consideration and judgement from experienced staff – paired with appropriate levels of staff discretion and autonomy – is an effective and appropriate means of identifying and 'filtering out' vexatious complaints. In particular, staff should be empowered to dismiss complaints without always having to seek formal approval from a board, council or committee. Only one international organisation we examined maintained a committee that must assess all complaints (due to legislated requirements), and thus did not provide the discretion afforded to staff in other organisations.

Some organisations maintain a rapid resolution team and/or complaints triage team, with a specific focus on the needs of complainants and subjects, and differentiating between 'customer services' issues and regulatory issues. The General Medical Council adopted such an approach in 2015, following a pilot in which the Council made greater use of the option for staff to carry out lower-key internal investigations ('provisional enquiries') first, before proceeding to a formal investigation. This led to a decrease in the proportion of complaints proceeding to full investigation.^[61]



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Train staff in vexatious complaint identification and management

Staff should be trained to recognise the known signs and risks factors of potential unreasonable complainant conduct,^[70] as described in Table 2, and this training should be mirrored in relevant policies. Examples of topics that might be covered include: deciding to cease consideration of a matter; officially classifying a complaint or person as vexatious; communicating with the relevant person; deciding to restrict or limit communication/contact with a person; reporting threats or abuse to police; and review or appeal options available to the relevant person.

Conclusions

While the issue of vexatious complaints has attracted a lot of attention through anecdotes and assertions by practitioners and their representatives, little if any empirical evidence is offered to support these claims. The empirical evidence that is available suggests that vexatious complaints – defined as groundless complaints made with adverse intent – are very rare. The disconnect between the wealth of rhetorical claims, and the dearth of empirical evidence regarding vexatious complaints, suggests that caution should be exercised before making substantive changes that may inadvertently restrict the ability of complainants to raise genuine concerns about risks to public safety.

From a policy perspective, the available evidence suggests that under-reporting of concerns about health practitioners is a larger and more impactful issue than vexatious complaints. This suggests that any measures to tackle vexatious complaints would need to be carefully designed, calibrated and implemented so that they are proportional to the extent of the problem, and the nature and balance of the related risks to the public, practitioners and others. Further highly-specific research is required to quantify the extent of the problem and its impacts in the Australian health complaints system.

Professionals making targeted vexatious complaints against each other is an under-researched phenomenon, dwarfed by research into the stereotyped 'out-of-control', obsessive and querulous lay complainant. Research is needed to examine the phenomenon of calculated complainant conduct among professional complainants, to create a more balanced picture of the nature and source of vexatious complaints, and the role of practitioners and professional cultures in generating them.

The likelihood of certain factors contributing to any particular vexatious complaint is closely associated with the type of complainant, their pattern of conduct, their motives, and whether their complaint is a subject complaints or process complaint. For example, lay complainants engaged in unreasonable complainant conduct may be more likely to be driven by unmet needs in a flawed complaints system. On the other hand, professional complainants engaged in calculated complainant conduct may be more likely to be driven by the desire for professional gain in a competitive workforce environment. Therefore, attempts to understand and address the factors contributing to vexatious complaints must not consider vexatious complaints, or those who make them, as a homogenous group. Further research into the various sub-categories of vexatious complaints and complainants identified in this review would support this aim.

While vexatious complaints are rare, at an individual level they can still take a significant toll on practitioners and complaints staff. Intentional misuse of complaints processes to lodge manifestly groundless complaints with harmful intent is a form of abuse which regulators must be equipped to address. Preventing, identifying and managing vexatious complaints requires that flexibility, agility and common sense take a central place in complaints-handling. This includes developing and enforcing detailed standards for accepting or rejecting complaints, and empowering highly-skilled staff with the autonomy to apply these standards according to their professional judgement. It is also important to clearly communicate the roles and limitations of various complaints channels, and proactively ensure that the needs of complainants are met as much as is reasonably possible, within the bounds of fairness. Finally, any potential initiatives and measures should be consistent with established overarching regulatory principles and goals, including a consistent focus on protecting the public from harm.



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Appendix 1

The following defines how selected terms are used in this review. The meaning of some terms is explored in more detail elsewhere in this document. A summary of the system for classifying complaints used in this review and some ways that vexatious complaints can be sub-divided, is included in Appendix 2.

Complaint

Used broadly to encompass formal expressions of concern (provided in writing, or provided verbally through formal channels) about the conduct, performance or health of a health practitioner as it relates to their professional practice, or the quality and safety of a health service. For the purposes of this review, it is taken as synonymous with the way 'report' and 'notification' are used in the Australian context ('notification' is the term used by the National Scheme).

Subject

The health practitioner about whom a complaint is made; that is, the 'subject' of the complaint.

Substantive action / substantive outcome

Administrative, regulatory or legal action by a complaints entity, regulator or entity within the judicial system (e.g. tribunal) which imposes a specific penalty or restriction on a health practitioner, as the result of one or more complaints being found to be true, and to meet the threshold for such action. Examples include (but are not limited to) a fine, official finding of wrong-doing, reprimand, caution, conditions imposed on registration, suspension of registration, or cancellation of registration.

Lay complainant

A person who lodges a complaint about a health practitioner in that person's capacity as a private, individual citizen, and not in their capacity as a health practitioner, employer of health practitioners, educator/trainer of health practitioners, or any other professional role.

Professional complainant

A person who lodges a complaint about a health practitioner in that person's capacity as health practitioner, employer of health practitioners, educator/trainer of health practitioners, or any other professional role.

Subject complaint

A complaint that is about the conduct, performance or health of a health practitioner.

Process complaint

A complaint that is about the way another complaint to a regulator or complaints entity has been handled, or about the person who handled it. The complaint is about complaints-handling by a third party, and not about the practitioner who was the subject of the original complaint.

Unreasonable complainant conduct

A persistent pattern of obsessive, obstinate, unreasonable and/or intractable behaviour, of an abusive or harassing nature, by a complainant towards one or more people or entities that handle complaints, and whose handling of such a complaint the complainant objects to. The behaviour is disproportionate to, or not sensibly connected with, the nature and extent of the issues in question.

Calculated complainant conduct

When a complainant makes a carefully targeted and formulated complaint (or small number of complaints) for the primary purpose of achieving a specific, pre-meditated and self-serving goal (for example a competitive advantage over the subject). The behaviour is often disguised as expressing a legitimate concern, with the pretence of being primarily motivated by a desire to protect others (e.g. patients).

Sub-optimal complaint

A complaint which, as a result of one or more features, is less than ideal for use in administering fair, just, efficient and effective regulatory oversight of practitioners. Only a portion of these complaints are vexatious.

Vexatious complaint

A complaint against a health practitioner that is manifestly without grounds, and which is an abuse of process due to being lodged and/or pursued primarily for the purpose of causing the subject annoyance, distress, detriment or harassment. A vexatious complainant is a person who lodges and/or pursues a vexatious complaint.



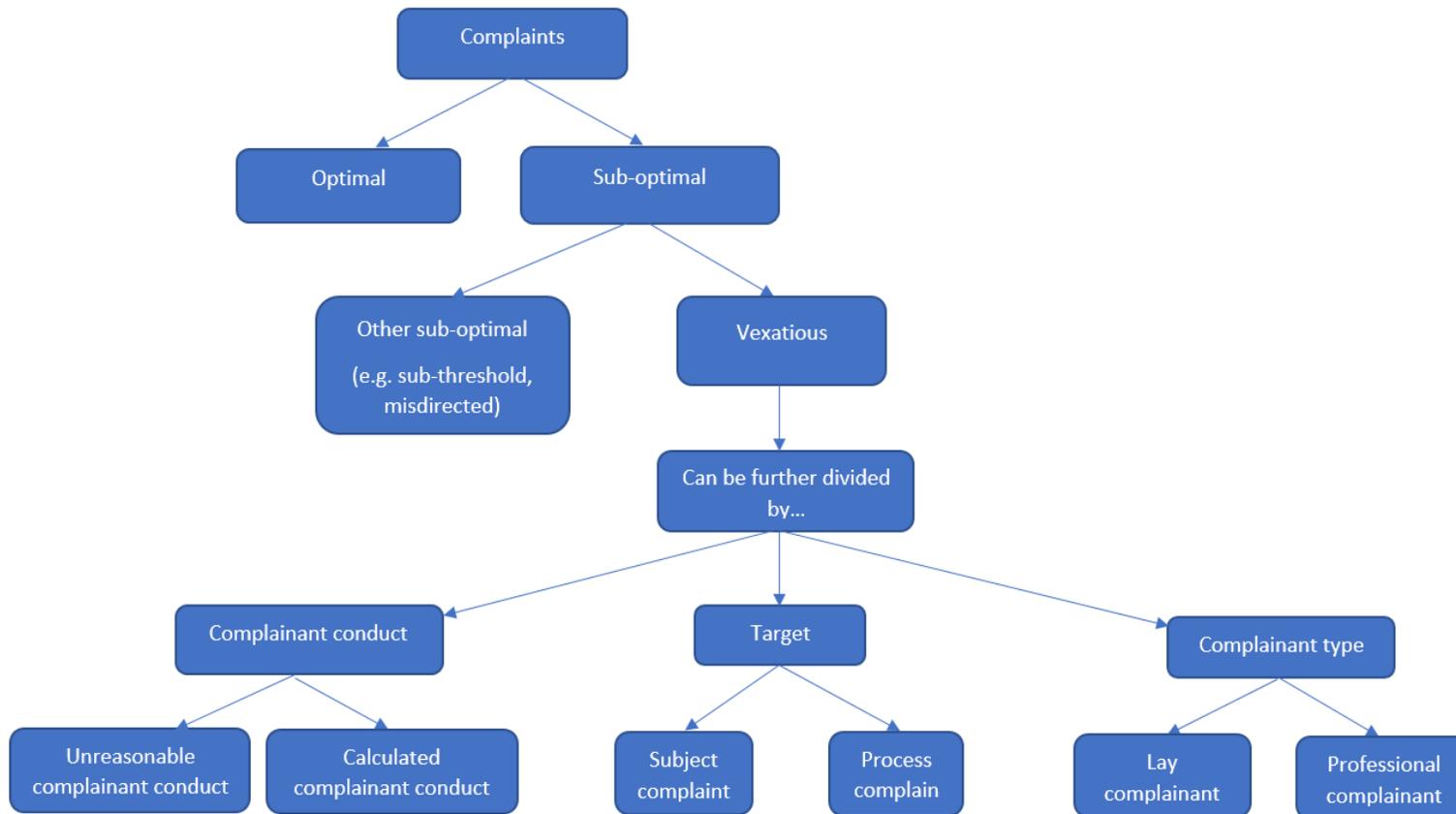
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Appendix 2

Figure A: Classifications and sub-divisions of complaints used in this review





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Appendix 3

Table A: Types of sub-optimal complaints

Type of sub-optimal complaint (example(s) of alleged instances in reference(s))	Description	Hypothetical example	Potential grounds for consideration as vexatious
Anti-competitive ^[49]	Has the express intent (not just the effect) of limiting the pool, viability or success of professional or business competition to the advantage of the complainant.	A new occupational therapist (OT) sets up a practice in a rural town which previously had only one long-standing OT. The original OT lodges a complaint against the new one, containing several exaggerated stories alleging that the new OT is incompetent, with the primary intent of using regulatory action to damage the reputation and professional autonomy of his competitor, and 'drive her out of town'.	✓
Disputed ^[148]	Contains claims or information about which the complainant and subject disagree, but regarding which there is no unequivocal independent evidence to determine the truth.	A patient who experienced an allergic reaction in hospital claims that she told an emergency department doctor about her allergy to the drug that was subsequently administered to her, but the doctor was not holding any papers at the time, so did not immediately write it down. The doctor claims the patient never mentioned her allergy. There are no other witnesses to the claimed exchange.	
Fraudulent ^[148]	A complaint is lodged in which the complainant falsely claims to be another person, falsely claims to be acting on another person's behalf, or deceptively puts their name to the complaint while acting in concert with the true initiator of the complaint.	A doctor wishes to make a complaint about another doctor, but does not want to be identified as the source of the complaint. Instead of submitting the complaint anonymously, she drafts the complaint, and convinces her friend (who has no other knowledge of or involvement in the situation) to sign the form identifying himself as the complainant.	✓
Historical ^[136, 149]	Relates to events or issues that occurred or were noticed by the complainant a long time ago.	Upon learning about the existence of a regulator based-complaint system for the first time, a patient submits a complaint about a chiropractor. The complaint concerns the chiropractor's out-of-scope treatment of her dying mother (who is now deceased) nine years earlier.	
Ideological ^[6, 150, 151]	Raises issues about the respondent's behaviour regarding controversial ethical issues which would not constitute a breach of law if proven.	A member of an anti-abortion group lodges a complaint about a GP who provides pregnancy counselling, including abortion referrals, to women who have been refused abortions by a nearby denominational hospital. The complaint alleges that the doctor is breaching ethical obligations by undermining the clinical advice of the hospital.	✓



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Type of sub-optimal complaint (example(s) of alleged instances in reference(s))	Description	Hypothetical example	Potential grounds for consideration as vexatious
Impaired ^[10]	Arising specifically as a result of (not merely in the presence of) psychological or cognitive illness, impairment or disability, such that the complaint would not be submitted or deemed reasonable by a person without such an impairment.	A person with a psychotic illness believes that women who wear purple are members of a sect of secret agents who wish him harm. He does not have insight into the delusional nature of his beliefs. He lodges a complaint about a nurse from a mental health clinic that he attended, who wore purple on the day of his attendance. He alleges that she was 'out to get him' for knowing the truth about the sect.	
Inaccurate ^[9]	Contains information or claims that can be demonstrated as unequivocally factually incorrect by a disinterested third party or reliable, independent evidence. The inaccuracy is the result of a genuine mistake (e.g. a misunderstanding), rather than malicious or deliberate deceit.	A patient experiencing severe post-operative pain is genuinely convinced it is the result of a surgical instrument being left inside him after surgery, and lodges a complaint to that effect. Independent follow-up scans confirm that no such foreign object is present in the patient's body.	
Incomplete ^[152]	Does not include all reasonably available and/or necessary information or evidence.	A nurse who works for a telephone advice line lodges a complaint regarding discriminatory language used against callers by another nurse who worked one shift at the service. She does not know the colleague's surname, so does not include it in the complaint.	
Misattributed ^[11, 148]	The complainant names a person who they genuinely believe is responsible for the events or issues of concern, but that individual is not responsible, or is not the most responsible, for those events or issues.	A GP gives a patient a request for an abdominal CT. The patient chooses an imaging provider from the list on the back of the request form. The radiologist reading the scans provides an incorrect report resulting in harm to the patient. The patient's complaint about the incident names and blames only their GP for the harm caused, because the GP suggested the scan in the first place.	
Misconceived ^[152]	Contains a factually accurate description of events, but the perception of wrongdoing or inadequacy is incorrect, due to misunderstanding accepted ethical, legal, medical or other standards and requirements.	The parent of a patient lodges complaints about a GP and pharmacist, after her 16 year old daughter was prescribed and sold the contraceptive pill. She does so because she mistakenly believes that people under 18 cannot legally receive medical treatment without parental consent.	
Misdirected ^[35]	The complaint does not fall within the remit of the regulator, or the complainant's desired outcomes are best served by another entity.	A patient lodges a complaint because a physiotherapist was running so late attending to appointments in his private clinic, that the patient was late to pick up his child from childcare, and incurred a late fee from the childcare centre. He wants the physiotherapist to reimburse him for the cost of the late fee.	



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Type of sub-optimal complaint (example(s) of alleged instances in reference(s))	Description	Hypothetical example	Potential grounds for consideration as vexatious
Misleading ^[10]	Contains information or claims that can be demonstrated as unequivocally factually incorrect by a disinterested third party or reliable, independent evidence. The inaccuracy is the result of malicious or deliberate deceit, rather than a genuine mistake.	A doctor claims that their colleague was under the influence of alcohol at work on three separate days in the same week, and claims to have attended two of the parties where the doctor drank before the days in question. A check of passport records later reveals that the accused doctor was out of the country on the dates in question.	✓
Occupational ^[10, 52, 153]	Lodged by an employer or colleague in order to manage (or be seen to have managed) genuine issues which could and should have instead been addressed, at least initially, through workplace mechanisms.	The head of nursing and midwifery services at a community health service becomes aware that one of the service's midwives has a substance abuse disorder that has the potential to interfere with her work. The head of nursing and midwifery services does not try to mitigate the problem through supervision, management, workplace support, provision of employee support services or referral to health services. Instead, he allows the problem to escalate until a client is harmed as a result of the midwife's impairment. He then reports the midwife and stands her down from her position.	
Out-of-scope ^[153, 154]	Raises issues about events or behaviour that are considered to be private matters beyond the reasonable scope of a professional regulator.	A member of the public lodges a complaint about a psychologist, alleging unethical behaviour, purely on the grounds that the psychologist is a listed member of a collective that campaigns peacefully for legalising same-sex marriage.	✓
Prejudiced ^[128, 155]	Motivated by discriminatory attitudes, prejudice or bias regarding characteristics of the subject that are legally protected, or not materially relevant to the issues raised. These motivations are not necessarily explicitly stated.	A consultant physician is prejudiced towards people of the Islamic faith, believing that they should 'fit in or get out'. She lodges a complaint about a trainee doctor she supervises who wears a headscarf and speaks with a Malaysian accent. The trainee is excelling in training by all appropriate measures, and is an effective team member. However, the complaint claims, without due evidence or basis, that the doctor is 'not a team player' and is 'not socially suitable' to work effectively in a team environment.	✓
Remedied ^[156]	The complaint raises issues or risks that can be shown to have subsided, or which have been resolved or sufficiently mitigated, by the time the complaint is considered.	After an incident resulting in patient harm, a doctor is reported because a colleague believes her knowledge and skills in prescribing psychiatric medications are outdated and inadequate. The doctor responds that she recognised the problem when the complaint was made, and produces evidence that she has successfully completed an appropriate training course to update her knowledge and skills.	



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Type of sub-optimal complaint (example(s) of alleged instances in reference(s))	Description	Hypothetical example	Potential grounds for consideration as vexatious
Sub-threshold ^[35, 94]	The complaint is deemed credible (in part or in full), but the issues raised do not, on their own, meet the threshold for regulatory action.	A colleague reports that a dentist often gets very drunk at weekend parties. This allegation is supported by many witnesses. However, there is no allegation, nor any evidence, that the dentist has ever practised while intoxicated, or experiences impaired professional performance due to alcohol.	
Vengeful ^[2, 10, 128, 148]	Has the intent of exacting revenge upon the subject due to a perceived personal slight against the complainant.	Two optometrists are involved in protracted divorce and custody proceedings after one engaged in adultery. The spouse who did not commit adultery lodges a complaint about the one who did, alleging that the other has engaged in years of habitual disruptive unprofessional behaviour. The complaint is not based on fact, and is submitted with the sole purpose of creating 'dirt' that can be used to hurt and disadvantage her former spouse in legal proceedings.	✓
Vexatious ^[49]	The complaint is knowingly made without sufficient or truthful grounds, and with the specific intent (not just effect) of causing annoyance, frustration, worry, or material, professional or personal harm to the subject.	A group of osteopaths who don't like a colleague make a pact to each submit a baseless but difficult-to-refute complaint, in order to shroud their colleague in suspicion, and cause her significant financial hardship, and emotional and procedural stress.	✓



Appendix 4

Table B: Relevance of selected practical measures for addressing different types of sub-optimal complaints

		Misleading	Fraudulent	Anti-competitive	Vengeful	Vexatious	Prejudiced	Ideological	Out-of-scope
Possible methods for prevention (National Scheme)	Public education/ information						✓	✓	✓
	Practitioner education/ information						✓	✓	✓
	Position statements						✓	✓	✓
	Monitoring, surveying and audits to improve educational information						✓	✓	✓
	Online/ telephone advice line							✓	✓
	Enforceable prohibition	✓	✓	✓					
	Register of complainant history, including problematic complainants	✓	✓	✓	✓	✓	✓	✓	✓
	Register of complainant/ respondent combination history	✓	✓	✓	✓	✓	✓	✓	✓
	Close ties to other enforcement and regulatory agencies	✓	✓	✓			✓		
Possible methods for prevention (other entities)	Record-keeping standards		✓						
	Communication with consumers		✓		✓	✓	✓	✓	
	Consumer support		✓		✓	✓	✓	✓	
	Personal and institutional complaints-handling	✓	✓		✓	✓	✓	✓	✓
	Human resources policies and procedures	✓	✓		✓	✓	✓	✓	
	Practitioner support	✓	✓		✓	✓	✓	✓	
	Institutional and professional culture	✓	✓	✓	✓	✓	✓	✓	✓