Chapter 3

Investigations and national board decisions

3.1 This chapter will consider the investigation and decision making parts of the complaints process and their administration.

3.2 The committee has found that these parts of the process have the most impact on practitioners and notifiers. This chapter contains two key themes that have been brought to the committee's attention:

- the lack of confidence in the complaints mechanism; and
- questions about the decisions of the national boards.

Confidence in the decision making process

3.3 The complaints process under the National Law is a mechanism by which poor performing health practitioners and errors in their practice can be identified. It is important for patient safety that practitioners, patients and their family have confidence in the ability of the complaints mechanism to address practice issues.

3.4 It is clear that the current system does not enjoy the full confidence of many of the notifiers and practitioners who have engaged with it.

Notifiers and the relatives of patients

3.5 Notifiers and the relatives of patients have expressed a lack of confidence in the Australian Health Practitioner Regulation Agency's (AHPRA) investigative processes, its competence, staff and management.[1]

3.6 One factor that appears to have undermined confidence in the system is a perception that investigations often do not uncover all of the information necessary to make an informed decision about the notification.

3.7 For example, Mr Maxwell Brown lodged a number of notifications in connection with medical treatment his wife received.[2] The Browns believe that, in their case, the board made decisions without the patient's complete medical records.[3] As Mr Brown said to the committee:

> I always felt that the medical records of my wife that AHPRA had received were incomplete, and I felt that they should have had the experience to identify that they were incomplete. They would not accept that. They did not want to discuss it—no further action. So I got our solicitor to write letters to people I knew that would have them. I approached those people myself, and eventually that information came to light. I then took that

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1 Ms Marg Fitzpatrick, *Submission 126*, [p. 5]; Mrs Rhonda McNees, *Committee Hansard*, 31 March 2017, p. 10; Mr Ian McNees, *Committee Hansard*, 31 March 2017, pp. 11–12.

2 Mr Maxwell Brown, *Committee Hansard*, 31 March 2017, p. 12.

3 Mr Maxwell Brown, *Committee Hansard*, 31 March 2017, p. 12.

> information to Melbourne, and they reopened their investigation again because it was new evidence. From a member of the public's point of view, AHPRA are the people we go to to identify proper records. I am a farmer and I could see that this information was missing. These were important documents relating to what happened on the night of the operation on my wife. Right or wrong, they should have been in the medical records. They were not.[4]

3.8 In the case of Mr Ian and Mrs Rhonda McNees, an independent report by the Victorian Government Solicitor's Office found, among other things, that:

- not all aspects of the notifications were properly considered by AHPRA;
- the board was not provided with the relevant information necessary for them to make an informed decision; and
- in some cases the practitioner's account of events was accepted despite there being conflicting evidence from the notifiers.[5]

3.9 Confidence is undermined if notifiers do not believe that the investigators and the national board will conduct a rigorous assessment of their notification. A factor that may compound their initial misgivings is that, after making the initial notification or notifications, there is little opportunity for notifiers to be involved in the process unless the matter is referred to a health complaints entity.

3.10 Health complaints entities have the capacity to facilitate meetings between notifiers and practitioners to discuss issues and attempt to resolve matters.[6] However, the practitioner is often reluctant to engage with the notifier until the matter has been resolved through the complaints process.[7]

3.11 Unlike the health complaints entities, Mr Steve Tully, Commissioner, Health and Community Services Complaints Commissioner (SA) explained to the committee that the National Law was not designed to facilitate notifier engagement.[8] Instead, the National Law assumes that once the notification has been made the agency and the board will 'go about their business'.[9]

3.12 Where notifications are made by consumers concerned about their health or the health of someone close to them, Mr Tully told the committee:

> What they say they want in a complaints process is the ability to sit [in] on hearings, to eyeball the practitioner, to ask questions of the practitioner and

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4 Mr Brown, *Committee Hansard*, 31 March 2017, p. 12.

5 Mrs Rhonda McNees, *Committee Hansard*, 31 March 2017, p. 11.

6 Ms Karen Toohey, Australian Capital Territory Health Services Commissioner, Australian Capital Territory Human Rights Commission, *Committee Hansard*, 31 March 2017, p. 2.

7 Mr Leon Atkinson-MacEwen, Health Ombudsman, Office of the Health Ombudsman, Queensland, *Committee Hansard*, 31 March 2017, p. 4.

8 *Committee Hansard*, 31 March 2017, p. 2.

9 Mr Tully, *Committee Hansard*, 31 March 2017, p. 2.

> to face off with the practitioner about their situation and the impact it has had on their life.[10]

3.13 The desire for more active engagement was also highlighted by the Snowball Review:

> …notifiers commonly see themselves as party to their case and expect to have an active and ongoing role in the resolution of it, whereas the system views them as a witness to an allegation of misconduct.[11]

3.14 This highlights a fundamental tension in the current complaints system: notifiers are often looking for a resolution, but the board's primary concern is whether the practitioner's conduct fell below the relevant standard.

3.15 Only if a matter progresses to a panel hearing may a notifier make a submission; and only then if they have the leave of the panel.[12] Otherwise, notifiers are only entitled to limited information and limited involvement.[13]

3.16 As Ms Karen Toohey, Australian Capital Territory Health Services Commissioner relayed to the committee:

> I think there is certainly a sense that the process is focused on the disciplinary process for the practitioner rather than focused on the individual's or the consumer's experience.[14]

3.17 While the proposed 2017 amendments to the National Law will allow for greater information to be provided to notifiers, there are no plans for additional notifier involvement in the process.[15]

3.18 Ms Jen Morris, a member of AHPRA's Community Reference Group suggested that:

> …different policies and different procedures should be applied depending upon whether one is dealing with a lay person's complaint or that of an employer or another practitioner...[16]

3.19 This approach was also supported by some practitioners.

3.20 Dr Simon Rosenbaum argued:

> I press my argument for a genuine inquisitorial process and am convinced that most concerns about a medical practitioner…would be laid to rest after a meeting in a non-confrontational environment... This could be conducted

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10 *Committee Hansard*, 31 March 2017, p. 2.

11 Kim Snowball, *Independent review of the national registration and accreditation scheme for health professions*, December 2014, p. 28.

12 National Law, s. 187.

13 See for example National Law, ss. 151(3), 161(3), 180, 192(2), (4).

14 Ms Toohey, *Committee Hansard*, 31 March 2017, p. 4.

15 AHMAC, *Submission 75—Attachment 1*, p. 25.

16 *Committee Hansard*, 31 March 2017, p. 8.

> by a medical practitioner with or without a legal person. I am aware that this is the typical process in countries like France.[17]

3.21 Similarly Ms Kate Greenaway, an allied health practitioner, supported the proposition that the complainant and the notifier should be treated equally through the complaints process.[18]

3.22 Such a model may also be more consistent with the Australian Commission on Safety and Quality in Health Care's *National Safety and Quality Health Service Standards* which already apply in most places consumers receive medical care.[19]

3.23 The system is intended to protect the public, but the evidence the committee received is that some members of the public do not feel like they are being protected.

Health practitioners

3.24 The health practitioners regulated by the scheme have a significant stake in how it operates. While the committee only received evidence from a small proportion of practitioners, those that made submissions made their views strongly.

3.25 Making a mistake, or being accused of making a mistake, as a health practitioner is stressful, but the stress associated with it appears to be compounded by the complaints mechanism.

3.26 Dr Joanna Flynn, Chair, Medical Board of Australia (MBA), explained the stress doctors come under when a notification is made against them, saying:

> …it is devastatingly stressful for any doctor to be the subject of a complaint to AHPRA and the board. That is for two reasons. Firstly, having to answer to the board about your conduct is just the worst thing you could ever imagine happening. Secondly, doctors have a catastrophic view of the outcome of those processes. They have a mental model that many more doctors end up having their registration cancelled or severe restrictions, so they immediately feel very distressed. And that distress remains until the matter is closed-and, often, beyond.[20]

3.27 The Chief Executive Officer of the Australian Commission on Safety and Quality in Health Care also noted that doctors are often deeply affected by the mistakes they make:

> There is an expression in health called the second victim, which is that, when there is particularly a very serious mistake, obviously there is the patient who has suffered from that mistake, but then also there is the person or the group of people involved. They carry that with them really for the rest of their career. There is not a clinician that I know that cannot tell you

17 *Committee Hansard*, 31 March 2017, p. 16.

18 *Committee Hansard*, 31 March 2017, p. 17.

19 Adjunct Professor Debora Picone AM, Chief Executive Officer, Australian Commission on Safety and Quality in Health Care, *Committee Hansard*, 17 March 2017, p. 1.

20 *Committee Hansard*, 31 March 2017, p. 26.

> nearly every mistake that they have made that they are aware of. So it is felt very deeply.[21]

3.28 Regardless of their profession, practitioners routinely reported a sense of intimidation—of receiving a notification, of being investigated, of the boards.[22]

3.29 Practitioners attributed that fear to the scrutiny, professional embarrassment and financial hardship that they would experience (or believe they would experience if they became the subject of a notification) to the AHPRA administered complaints process.[23]

3.30 Some practitioners attribute harm directly to the complaints mechanism itself. One practitioner submitted that:

> A close friend killed himself last year, as a direct result, not of the complaint itself, but of the complaints process. Financially ruined, publicly humiliated, and personally devastated, when he could not take the strain any more, he took his own life, stating his innocence until the end.[24]

3.31 Ms Kate Greenaway observed that 'in many parts… it has become a punitive process'.[25] Dr Rosenbaum said AHPRA's actions were 'overly legalistic, punitive and deny natural justice'.[26] Dr Rachel Mascord, a dental practitioner, commented that the process 'is creating an adversarial environment in which patients and doctors are positioned on either side of a divide'.[27]

3.32 The question is whether any process would feel punitive or whether the existing system is perceived as punitive because of the way the process is structured or administered.

3.33 The Royal Australian College of General Practitioners (RACGP) submitted that there were problems with the administration of the process:

> It is perceived that the current complaints mechanism is more concerned with the prosecution of practitioners than protecting patient safety through remediation of the issues that lead to the complaint.[28]

3.34 Dr Edwin Kruys, the Vice-President of RACGP elaborated:

> …it appears that there is room for a lot of cultural change within AHPRA. I guess the big issue is that it is perceived as extremely punitive. You could say that 'if all you have is a hammer then all you see is nails'. It would be

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21 Adjunct Professor Debora Picone AM, *Committee Hansard*, 17 March 2017, p. 4.

22 Ms Kate Greenaway, *Submission 33*, p. 5; Ms Elizabeth Dolan, *Submission 71*, p. 2.

23 Ms Elizabeth Dolan, *Submission 71*, p. 2; Dr Rachel Mascord, *Submission 73*, [p. 2].

24 Dr Anne Malatt, *Submission 65*, p. 1.

25 *Committee Hansard*, 31 March 2017, p. 17.

26 *Committee Hansard*, 31 March 2017, p. 16.

27 *Committee Hansard*, 31 March 2017, p. 18.

28 RACGP, *Submission 41*, [pp. 1–2].

> really good if AHPRA had other options, like counselling or remediation, to solve problems, instead of just going down the punitive road.[29]

3.35 When Mr Martin Fletcher, Chief Executive Officer of AHPRA, appeared before the committee, he appeared cognisant that:

> …although our jurisdiction is a protective jurisdiction, we recognise that…for the practitioner involved it can feel like a punitive process.[30].

3.36 Some people consider it to be punitive because, unless the matter results in no further action, the only outcomes are formal in nature. As Medical Insurance Group Australia (MIGA) representative Mr Timothy Bowen expressed:

> What we have seen in the national system is a more punitive, disciplinary approach to dealing with [errors], using cautions to say 'you need to improve next time'.[31]

3.37 But Mr Bowen went on to explain that New South Wales operates quite differently:

> The New South Wales approach is somewhat different: it is a matter of getting practitioners with a senior peer at an earlier stage, talking through those issues and educating them to make sure it does not happen again. We think that is a better approach…[32]

3.38 Other witnesses concurred with that opinion.[33]

3.39 In principle, providing the national boards with powers that may permit a different approach is an option currently being considered by the Australian Health Ministers' Advisory Council (AHMAC). Ms Durham advised the committee:

> [AHMAC] are looking at amendments that might strengthen the role for the notifier in the disciplinary process, and powers for national boards to settle matters, so enabling greatest use of alternative dispute resolution between practitioners, notifiers and the national board. [34]

Advocates

3.40 A small number of submitters proposed that advocates be provided by AHPRA—to one or both parties—or that advocates be permitted to make submissions

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29 *Committee Hansard*, 17 March 2017, p. 27.

30 *Committee Hansard*, 31 March 2017, p. 26.

31 *Committee Hansard*, 17 March 2017, p. 35.

32 *Committee Hansard*, 17 March 2017, p. 35.

33 Ms Georgie Haysom, Head of Advocacy, Avant Mutual Limited, *Committee Hansard*, 17 March 2017, p. 35.

34 Ms Amity Durham, Acting Deputy Secretary, Department of Health and Human Services, Victoria representing the Australian Health Ministers' Advisory Council, *Committee Hansard*, 17 March 2017, p. 17.

to the board in an attempt to support notifiers and practitioners through the process.[35] The proponents of this recommendation focused on the support and guidance a support person could offer through the process.[36]

3.41 Mr Gary Clarke, a notifier, stressed that supporting complainants in preparing notifications is important because:

> Obviously if you do not get your points…in order and you do not specifically identify what the issues are, then you cannot get an investigation that delivers the right outcome.[37]

3.42 The Health Consumers' Council also suggested that consumer groups could also assist with 'orchestrating reviews and appeals'.[38]

3.43 Whilst it was not explicitly stated, these suggestions appear to be motivated by a perception that the complaints process requires assistance to navigate.

Committee view

3.44 The committee was concerned by the evidence it received from both notifiers and practitioners.

3.45 The committee acknowledges and understands the angst, dismay and frustration of notifiers who perceive that they have not been taken seriously by AHPRA or consider that their notifications have been mismanaged.

3.46 As consumers of health care, patients and their families are invited and encouraged to take an active interest in their own care. The committee notes that consumers have a right to comment on or complain about treatment they have received. Notifications are one of the few ways the board has to identify clinical practice issues that may need to be addressed.

3.47 Consumers have a substantial interest in resolving complaints and it seems inappropriate that they are marginalised to the degree that they are.

3.48 Equally, as the party being regulated, the outcome of the board's decision often has a significant impact on the life of the practitioner.

3.49 The committee is concerned about the effect that the complaints process is having on practitioners. Whilst having a professional mistake identified is always likely to be stressful, the committee is concerned by evidence that suggests the complaints process appears to be administered in a punitive way.

3.50 The committee understands that AHPRA's mandate is to protect the public, but that mandate does not require sanction for each mistake. Witnesses identified the

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35 Ms Cynthia Hickman, *Submission* 29, [pp. 3–4]; Ms Elizabeth Dolan, *Submission 71*, p. 4; Dr Jane Barker, *Submission 112*, [p. 1].

36 Ms Cynthia Hickman, *Submission* 29, [pp. 3–4]; Ms Elizabeth Dolan, *Submission 71*, p. 4; Dr Jane Barker, *Submission 112*, [p. 1].

37 *Committee Hansard*, 31 March 2017, p. 13.

38 Health Consumers' Council, *Submission 96*, p. 4.

New South Wales model as placing a greater emphasis on mentoring, education and conciliation options.

3.51 The committee acknowledges that there are circumstances in which the national boards need to take strong regulatory action, but the committee considers that, with a broader range of tools, AHPRA may be able to change the way it administers the process to make it both more rigorous and fair.

3.52 However, the committee recognises that these goals are hard to achieve if the information is not reaching the national boards that make the decisions.

Decisions of the national boards

3.53 The national boards can only work with the information they have available to them. Therefore, the quality of the information that is provided to them has an impact on the decisions they make.

3.54 As noted above, some information can be missing in investigations. This part will consider the information the boards are provided with and the concerns of witnesses that have engaged with them.

3.55 In particular, the primary concerns raised with the committee have been:

- conflicts of interest;
- the adequacy of documentation provided to the boards; and
- whether board members have sufficient specialist knowledge.

Conflicts of interest

3.56 Currently both notifiers and practitioners fear that the process is being affected by conflicts of interest.

3.57 Effective complaints mechanisms provide participants with procedural fairness. It is crucial that participants within the complaints mechanism are free from conflicts of interest.

3.58 The committee has received evidence which suggests that apparent conflicts of interest have occurred, or are systemic, in the complaints process.

3.59 An individual submitter provided evidence that, in one instance, an expert witness contributing to a notification assessment had an apparent conflict of interest resulting from competing professional interests.[39] Similar concerns were also raised in confidential submissions.

3.60 The employment of 'independent external witnesses' has raised concerns that such witnesses may have:

> a financial conflict of interest to write a report that aligns with the views of the agency paying for the report, particularly when they are a contractor who derives income from multiple reports for that agency.[40]

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39 Associate Professor Colin Moore, *Submission 55*, p. 1.

40 Name withheld, *Submission 68*, [p. 4].

3.61 If that is the case, there is a risk that the information being provided to the board has a particular bias. It is unclear whether the boards have the expertise to recognise and correct such bias if the advice has been sought to provide clinical peer expertise that is not otherwise available to the board.

3.62 A solution to financial conflicts of interest may be that independent experts are sourced from, and remunerated by, a central independent entity.[41] To ensure that the entity is able to retain the most suitable clinical peer available, the entity would need to be able to provide competitive remuneration to clinical peers to make it economically viable for practitioners. This would allow clinical peers with current clinical practice to be retained.

3.63 A potentially more insidious problem would be if the decision makers themselves were compromised. Notifiers provided examples to the committee of instances where they considered that conflicts of interest arose between members of the board and an aspect of the notification.

3.64 Mr Maxwell Brown notified AHPRA of a potential conflict of interest when he identified that a member of the board had also provided advice to his solicitor.[42] In another instance, it was suggested that a conflict arose between a member of the board and their senior position within another organisation whose employees were being investigated by the board.[43]

3.65 AHPRA and the MBA have submitted that appropriate processes are in place to avoid conflicts of interest.[44] The suggestion that there were conflicts of interest was adamantly denied by Dr Flynn, who insisted:

> …we have very clear conflict of interest policies and processes, and if there is a situation where too many doctors in a particular jurisdiction who are on the board know the practitioner who is the subject of a notification then the matter is referred to another state to be dealt with.[45]

3.66 When pressed, Dr Flynn suggested that not prospectively declaring a material conflict of interest would go against the code of required behaviour for board members and potentially be grounds for resignation from the board. However, the consequence of an undeclared conflict of interest of an MBA board member remains untested.[46]

Documentation provided to the boards

3.67 As has been noted above, submitters have raised concerns about the adequacy of documentation received by the boards.

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41 Name withheld, *Submission 68*, [p. 4].

42 Mr Maxwell Brown, *Committee Hansard*, 31 March 2017, p. 12.

43 Mrs Rhonda McNees, *Committee Hansard*, 31 March 2017, p. 11.

44 AHPRA and the MBA, *Submission 119*, p. 19.

45 *Committee Hansard*, 31 March 2017, p. 28.

46 *Committee Hansard*, 31 March 2017, p. 28.

3.68 Dr Rachel Mascord observed that there could be considerable problems for practitioners in obtaining the documentation necessary to defend a notification after a practitioner has left that place of practice.[47] As will be noted in greater detail below, some investigations can take years to complete.

3.69 Another notifier, Mr Garry Clarke, concluded from his experience that:

> What [health practitioners] are doing is they are not keeping medical records. My wife is an example of that. Close to 40 visits over eight years, and there were lucky to be medical notes for eight to nine visits over that period of time.[48]

3.70 These claims relate to ongoing concerns about whether AHPRA collects all of the necessary information and speaks to all relevant witnesses before providing the report and the evidence to the board. It also highlights the need for rigorous investigations and greater transparency.

Transparency

3.71 Some of the above concerns could be remedied with greater transparency.

3.72 Submitters to this inquiry endorsed introducing greater transparency to the complaints process to 'facilitate impartiality and address the issue of unnecessarily adversarial complaints'.[49]

3.73 Extensive evidence was received from individual practitioners who outlined the need for improvement to the transparency of AHPRA's assessments, investigations and decision making processes.[50]

3.74 The RACGP have also expressed concern that some of their members had been provided with limited information about complaints made against them and the reasons for commencing investigations were not explained to practitioners concerned.[51]

3.75 The goals in this area are clear. As AHPRA's Community Reference Group summarised:

> …improvements in the timeliness and transparency of notification assessment, investigation and decision processes are desirable and necessary to improve the effectiveness of making a notification as a patient safety measure, while minimising the burden upon practitioners.[52]

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47 Dr Rachel Mascord, *Submission* 73, [p. 3].

48 Mr Gary Clarke, *Committee Hansard*, 31 March 2017, p. 13.

49 Tasmanian Government, *Submission 131*, p. 2.

50 Ms Donna McGrath, *Submission 6*, p. 6; Ms Jennifer Ellis, *Submission 42*, p. 4; Dr Anne Malatt, *Submission 65*, p. 4; Dr Rachel Mascord, *Submission 73*, [p. 3]; Dr Simon Rosenbaum, *Submission 104*, p. 3; Dr Maxine Szramka, *Submission 109*, p. 8.

51 RACGP, *Submission 41*, [p. 3].

52 AHPRA Community Reference Group, *Submission 127*, p. 4.

3.76 However, practitioners are adamant that transparency in this case should not be public transparency; at least not until all of the appeal processes have been exhausted.[53]

3.77 Notifiers, both publicly and in confidential submissions, requested greater transparency at every stage of the process.[54]

3.78 AHPRA and the MBA reported that they are working to improve the complaints process, and as part of the progress made over the past four years, the MBA has 'improved accountability and transparency, including through introducing quarterly reporting on our performance'.[55]

3.79 But as Dr Flynn observed 'we have a big job to do to help people understand how the process works and to build confidence in it'.[56]

Knowledge of board members

3.80 The National Law requires national boards to make decisions about the management of notifications.[57] Members of the national boards are appointed by state and territory health ministers.[58] The degree of specialty that exists in the health professions means that the members of the board, even though some are practitioners, may not be practitioners with the same professional speciality as the practitioner whose conduct is under consideration.

3.81 Many practitioner submitters—some of whom had been the subject of a notification—questioned whether board members had the requisite specialty knowledge to make a proper assessment about specialist practitioners.[59] As RACGP submitted:

> The Medical Board of Australia is arguably the most diverse of all 14 National Boards, covering a large range of medical specialties. The RACGP recognises that this wide scope makes it inherently difficult for the Medical Board to represent all facets of the medical profession. However, in order for medical practitioners to receive a fair investigation, all cases should be assessed by a medical practitioner with in-depth knowledge and relevant experience in the specialty concerned.[60]

3.82 The committee notes that there is already scope to address these concerns within the existing legislative framework. Dr Flynn explained to the committee that

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53 RACGP, *Submission 41*, [p. 3].

54 Mrs Rhonda McNees, *Committee Hansard*, 31 March 2017, p. 12.

55 AHPRA and the MBA, *Submission 119*, p. 4.

56 Dr Flynn, *Committee Hansard*, 31 March 2017, p. 26.

57 See for example National Law, ss. 151, 156, 160, 169.

58 National Law, ss. 33, 36.

59 RACGP, *Submission 41*, [p. 2]; National Institute of Integrative Medicine, *Submission 94*, p. 2; Name withheld, *Submission 84*, p. 7.

60 RACGP, *Submission 41*, [p. 2].

the boards can already appoint additional members if clinical peer expertise is required.[61]

3.83 However, it was clear that appointing clinical peers to the board was not routine practice.[62] In answer to questions on notice, AHPRA dismissed the suggestion that additional specialist input was required because:

- some matters referred to the boards do not relate to a specialist field of medicine (such as communication, documentation or billing matters);
- approximately 40 per cent of registered medical practitioners do not hold specialist registration and in those cases specialist input would not necessarily result in more informed decision making;
- there are 23 fields of specialist practice and over 60 sub-specialties in the medical profession and ensuring that each decision making board or committee contained an independent specialist from the same discipline 'poses challenges to the complaints process in both protracted timeframes… and increased costs in the complaints process'.[63]

3.84 AHPRA also reiterated that it believes that specialist input can already be obtained where it is necessary.[64]

Committee view

3.85 The committee is deeply concerned about actual or perceived conflicts of interest. The committee recognises that this is a system that has significant ramifications for the practitioners concerned and, to a lesser extent, the families of the patients involved. As such it is important that all parties can have confidence in the system.

3.86 The committee is also concerned about the completeness of the information being provided to the national boards. The national boards rely on the information that is provided to them to make a properly informed decision. If information is incomplete, the board runs the risk of error. They must work with the investigators and the secretariat to ensure that all the relevant information is obtained and provided to the board.

3.87 Where outside opinions are obtained, the board must be able to justify why that practitioner was approached and know with confidence that there is no conflict of interest between the clinical peer providing the advice and the practitioner whose conduct is in question. The board should be able to demonstrate, by some independent means that the advising clinical peer was the most appropriate person.

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61 *Committee Hansard*, 31 March 2017, p. 27.

62 Dr Flynn, *Committee Hansard*, 31 March 2017, p. 27.

63 Mr Fletcher and Dr Flynn, answers to questions on notice, 31 March 2017, p. 3 (received 24 April 2017).

64 Mr Fletcher and Dr Flynn, answers to questions on notice, 31 March 2017, p. 3 (received 24 April 2017).

3.88 The evidence to the committee suggests there is an ongoing need to correct the transparency of the system.

3.89 The committee understands practitioners' desire for greater clinical peer input into the complaints process. The committee was surprised that, despite the well-known calls from practitioners for greater clinical peer input into the complaints process, procedures to obtain clinical peer input are not yet routine.

3.90 The committee is disappointed that AHPRA did not recognise the benefits that may accrue from having clinical peer advice provided at the earliest stages in the process. At the very least, the committee considers that the idea is worthy of trial.