Chapter 1

Introduction

Bullying and harassment in the Australian medical profession

1.1 There has been considerable focus in the Australian community in recent years on the issue of workplace bullying and harassment in the medical profession. A series of reviews and reports have indicated that bullying and harassment is a significant problem across a wide range of practice types and regions.[1]

1.2 On 2 February 2016, the Senate referred the medical complaints process in Australia to the Community Affairs References Committee for inquiry and report, with the following terms of reference:

(a) the prevalence of bullying and harassment in Australia's medical profession;

(b) any barriers, whether real or perceived, to medical practitioners reporting bullying and harassment;

(c) the roles of the Medical Board of Australia, the Australian Health Practitioners Regulation Agency and other relevant organisations in managing investigations into the professional conduct (including allegations of bullying and harassment), performance or health of a registered medical practitioner or student;

(d) the operation of the *Health Practitioners Regulation National Law Act 2009* (the National Law), particularly as it relates to the complaints handling process;

(e) whether the National Registration and Accreditation Scheme, established under the National Law, results in better health outcomes for patients, and supports a world-class standard of medical care in Australia;

(f) the benefits of 'benchmarking' complaints about complication rates of particular medical practitioners against complication rates for the same procedure against other similarly qualified and experienced medical practitioners when assessing complaints;

(g) the desirability of requiring complainants to sign a declaration that their complaint is being made in good faith; and

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1 See, for example: Victorian Auditor-General, *Bullying and Harassment in the Health Sector*, March 2016, p. x, http://www.audit.vic.gov.au/reports_and_publications/latest_reports/2015-16/20160323-bullying.aspx (accessed 9 November 2016); Askew, D.A. *et. al*., 'Bullying in the Australian medical workforce: cross sectional data from an Australian e-Cohort study', *Australian Health Review*, vol. 36, no. 2, May 2012, pp 197–204, http://search.proquest.com/docview/1022629267?pq-origsite=summon&http://search.proquest.com

(h) any related matters.

Guidance on terms of reference

1.3 The committee subsequently published additional guidance on the inquiry's terms of reference, highlighting that the inquiry's focus was on the intersection between bullying and harassment in Australia's medical profession and the medical complaints process:

> To guide the inquiry process, the committee would like to provide clarity on how it is interpreting the terms of reference (ToR). The overarching issue under inquiry is the prevalence of bullying and harassment within Australia's medical profession (ToR a).
>
> The other ToR should be read according to how they relate to bullying and harassment within Australia's medical profession, and how such bullying and harassment may ultimately impact on individual medical practitioners and patient outcomes.[2]

1.4 That guidance further added the following additional notes on individual terms of reference:

> ToR a This is the overarching issue under inquiry. The committee defines 'Australia's medical profession' as including both nurses/midwives and medical practitioners (doctors), as well as students for those professions.
>
> ToR b Is there anything preventing medical practitioners from reporting bullying and harassment?
>
> ToR c Are the complaints and investigation processes of the relevant medical boards, nursing and midwifery boards and AHPRA able to be used vexatiously for bullying or harassment, particularly by other medical professionals?
>
> ToR d Does the legal framework under which the relevant medical boards and AHPRA operate have appropriate safeguards against being used vexatiously for bullying or harassment?
>
> ToR e Has nationalising the registration and monitoring of medical practitioners improved medical care in Australia?
>
> ToR f Should there be stronger requirements for patient outcome specific data to be used both in lodging and investigating complaints?
>
> ToR g Is there evidence to suggest vexatious complaints are being made, and if so, what systems could be put in place to reduce the prevalence?[3]

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2 Available on the inquiry's Terms of Reference webpage, http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Medical_Complaints/Terms_of_Reference.

3 Available on the inquiry's Terms of Reference webpage, http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Medical_Complaints/Terms_of_Reference.

1.5 The issue of bullying and harassment in Australia's medical profession received concentrated public and media attention following a series of prominent doctors making public comments about the profession's culture. Most notably, vascular surgeon Dr Gabrielle McMullin described the sexual harassment of female doctors as rife within the profession[4], and neurosurgeon Dr Charlie Teo noted that bullying is 'more extreme than you've been led to believe'.[5]

1.6 The committee notes there have been a number of recent inquiries into workplace bullying and harassment in Australia. Notably, the House of Representatives Standing Committee on Education and Employment inquiry into workplace bullying in 2012 highlighted that bullying was a significant issue across a range of industries and professions.[6]

1.7 A 2015 report by the Expert Advisory Group established by the Royal Australasian College of Surgeons (RACS) found that 'discrimination, bullying and sexual harassment are pervasive and serious problems in the practice of surgery in Australia and New Zealand'.[7]

1.8 The Australian Medical Association (AMA) suggests that the findings of the RACS survey are likely to be representative across the whole medical profession, suggesting 'anecdotal evidence and feedback from members would indicate that this experience is replicated in other medical specialties'.[8]

1.9 As the submission from mental health advocacy group Beyondblue notes, the effects of workplace bullying and harassment can be serious and wide-ranging, particularly in the medical profession:

> Research shows a clear link between bullying and harassment and the experience of depression and anxiety conditions. These conditions are potentially disabling, and associated with a wide range of adverse outcomes for affected individuals, including the risk of premature death by suicide. These conditions also impact on family, friends, workplace colleagues, and on society more broadly.

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4 'Sexual harassment rife in medical profession, warns surgeon', *ABC Radio AM*, 7 March 2015, http://www.abc.net.au/am/content/2015/s4193059.htm (accessed 16 November 2016).

5 'Top Doc calls for royal commission into medical bullying, *Ten News*, 16 February 2016, https://tenplay.com.au/news/national/february/top-doc-calls-for-royal-commission-into-medical-bullying (accessed 16 November 2016).

6 House of Representatives Standing Committee on Education and Employment, *Workplace Bullying: We just want it to stop*, October 2012, pp 8–10, http://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=ee/bullying/report.htm (accessed 15 November 2016).

7 Expert Advisory Group on discrimination, bullying and sexual harassment, *Report to the Royal Australasian College of Surgeons*, 28 September 2015, p. 4, http://www.surgeons.org/about-respect/what-we-have-done/building-respect,-improving-patient-safety/expert-advisory-group/ (accessed 9 November 2016).

8 Australian Medical Association, *Submission 9*, p. 2.

> Bullying can lead to poor health and low morale, engagement and productivity among workers who witness bullying. In the medical profession the negative impacts of bullying and harassment have the potential to impact on patient care.[9]

Focus of the inquiry

1.10 This inquiry was established to investigate the role of the existing medical complaints process to deal with certain types of bullying and harassment. A focus for this inquiry was how the medical complaints process in Australia, overseen by AHPRA and the National Boards, has itself been misused by some medical practitioners as a form of bullying and harassment. The committee has also investigated broader questions of bullying and harassment within the profession, including its prevalence and barriers to the reporting of it.

1.11 Throughout this inquiry, the committee received examples of medical practitioners whose careers and lives have been affected by what they believe are vexatiously made complaints lodged against them by colleagues or competitors.

1.12 While concerned about the prevalence of a wide range of forms of bullying and harassment within Australia's medical profession – and the consequent effects that has on patient outcomes and public safety – the committee's focus in this inquiry has largely been on the misuse of the complaints process. The medical profession needs a robust, transparent and respected complaints process in order to ensure public safety.

National regulation and accreditation of medical practitioners

1.13 Australia's medical complaints process is a consequence of the creation of a national scheme for the regulation and accreditation of medical practitioners. In 2006, the Productivity Commission recommended the establishment of a single national registration and accreditation scheme (NRAS) to enable the Australian health workforce to deal with shortages and associated pressures; to increase its flexibility, responsiveness, sustainability and mobility; and to reduce red tape.[10]

1.14 The Council of Australian Governments (COAG) agreed in 2006 to establish the NRAS, to ensure that all health professionals were 'registered against the same, high-quality national professional standards' and to allow 'doctors, nurses and other health professionals to practise across state and territory borders without having to re-register'.[11]

1.15 COAG signed the Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions in 2008. The scheme consisted of 'a Ministerial Council, an independent Australian Health Workforce Council, a national agency with an agency management committee, national profession-specific

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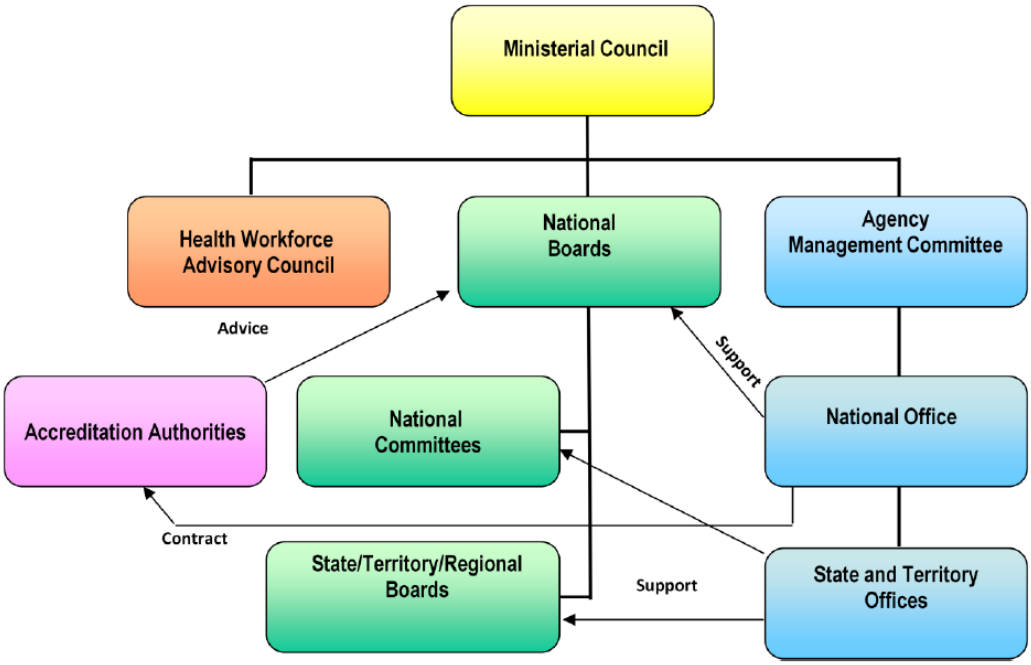
9 Beyondblue, *Submission 11*, p. 2.

10 Productivity Commission, *Australia's Health Workforce*, Research Report, January 2006.

11 COAG *Communique*, 13 April 2007, http://webarchive.nla.gov.au/gov/20070830052604/ http://www.coag.gov.au/meetings/130407/index.htm (accessed 10 March 2016).

boards, committees of the boards, a national office to support the operations of the scheme, and at least one local presence in each state and territory' (see **Figure 1.1**).

Figure 1.1 – National Registration and Accreditation Scheme



Source: Australian Health Practitioner Regulation Agency.[12]

1.16 The Department of Health outlined the objectives of the National Scheme, as set out in the establishing legislation:

- to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered;
- to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction;
- to facilitate the provision of high quality education and training of health practitioners;
- to facilitate the rigorous and responsive assessment of overseas-trained health practitioners;
- to facilitate access to services provided by health practitioners in accordance with the public interest; and

12 Australian Health Practitioner Regulation Agency, *Submission 70*, p. 7, in Senate Finance and Public Administration References Committee, *Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA)*, http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Finance_and_Public_Administration/Completed_inquiries/2010-13/healthpractitionerregistration/index (accessed 3 March 2016).

- to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.[13]

1.17 As the Commonwealth does not have the power to regulate health professionals, the legislative framework for implementation of the NRAS was enacted by the state and territory legislatures.

1.18 The *Health Practitioner Regulation National Law Act 2009* (Qld) (National Law) received Royal Assent on 3 November 2009. It details the substantive provisions for registration and accreditation. Other states and territories passed similar legislation to the National Law and jurisdiction-specific consequential and transitional provisions.[14] The NRAS legislation replaced 65 Acts across the jurisdictions and the bodies established replaced 80 state and territory boards. Several jurisdictions made amendments to the National Law, including New South Wales which opted for retaining its own complaints system. As the NRAS is based on state and territory legislation, the Commonwealth has limited capacity to modify complaints procedures.

1.19 The NRAS commenced on 1 July 2010 for all States and Territories except Western Australia, which joined the NRAS on 18 October 2010.

Improving health outcomes and patient safety

1.20 The NRAS was originally recommended as a productivity measure by the Productivity Commission.[15] However, in implementing the scheme, COAG emphasised the scheme's purpose in protecting health consumers and stated:

> The new scheme will deliver many benefits to the Australian community including health consumers. National standards in each profession will mean stronger safety guarantees for the community. Patients will know that wherever the health professional is from, they are registered against the same, high-quality national professional standards.[16]

1.21 As the Department of Health noted, the NRAS is one element of Australia's health system, but it does have particular responsibility for the protection of the public:

> This Scheme for the first time initiated nationally consistent standards for the registered professions, provided mobility for professionals to work across jurisdictions and allowed the development of a national public register of registered health professionals.[17]

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13 Department of Health, *Submission 13*, p. 9.

14 Australian Health Workforce Ministerial Council, *Submission 70*, p. 7, in Senate Finance and Public Administration References Committee, *Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA).*

15 Productivity Commission, *Australia's Health Workforce*, Research Report, January 2006.

16 COAG *Communique*, 13 April 2007, http://webarchive.nla.gov.au/gov/20070830052604/ http://www.coag.gov.au/meetings/130407/index.htm (accessed 10 March 2016).

17 Department of Health, *Submission 13*, p. 6.

1.22 From the perspective of the Medical Board of Australia, the Nursing and Midwifery Board of Australia and the Australian Health Practitioner Regulation Authority one of the National Scheme's notable achievements is improved outcomes for patients via greater public protection:

> … a national on-line register of practising practitioners and cancelled health practitioners which can be accessed by the public at any time, and prevents health practitioners who have committed misconduct and faced regulatory action to practise undetected in other states or territories.[18]

Creation of the Australian Health Practitioner Regulation Agency

1.23 The Australian Health Practitioner Regulation Agency (AHPRA) was established as the national agency responsible for implementation and ongoing management of the NRAS, and currently oversees 14 professions, including medical practitioners and nurses/midwives. The 14 National Boards currently part of the NRAS are:

- Aboriginal and Torres Strait Islander Health Practice Board of Australia;
- Chinese Medicine Board of Australia;
- Chiropractic Board of Australia;
- Dental Board of Australia;
- Medical Board of Australia;
- Medical Radiation Practice Board of Australia;
- Nursing and Midwifery Board of Australia;
- Occupational Therapy Board of Australia;
- Optometry Board of Australia;
- Osteopathy Board of Australia;
- Pharmacy Board of Australia;
- Physiotherapy Board of Australia;
- Podiatry Board of Australia; and
- Psychology Board of Australia.[19]

1.24 AHPRA has the following roles:

- maintaining up-to-date and publicly accessible national lists of accredited courses and registered practitioners with entries relating to individuals to include any conditions or restrictions on professional practice;

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18 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 8.

19 AHPRA website, http://www.ahpra.gov.au/National-Boards.aspx (accessed 19 October 2016).

- administering the resources of the scheme and ensure the scheme is as efficient as possible;
- acting in accordance with any policy directions from the Ministerial Council;
- reporting annually to the Ministerial Council;
- following agreement with the boards, setting fees, and where there is no agreement, referring this to the Ministerial Council;
- at its discretion, contracting or delegating functions, excluding registration and accreditation functions, with any delegations reported to the Ministerial Council;
- in consultation with the boards, developing and administering procedures and business rules for the efficient and quality operation of the registration and accreditation functions and the operation of the boards and their committees, consistent with ministerial policy direction and the objects of the legislation;
- in accordance with the objects of the legislation and any policy directions of health ministers, set frameworks and requirements for the development of registration, accreditation and practice standards by the national boards to ensure that good regulatory practice is followed;
- advising the Ministerial Council on issues relevant to the scheme; and
- establishing a national office.[20]

National Boards and the regulation of individual practitioners

1.25 There is a National Board for each of the 14 regulated health professions. National Board members are appointed by the Ministerial Council. At least half, but not more than two thirds of National Board members must be practitioner members and the remaining members are appointed as community members to ensure a degree of oversight from people outside the profession. Members of State and Territory Boards (Professional Boards) are appointed by the Minister for Health in each jurisdiction, with the same requirement for ratios of community members.

1.26 The functions of the Boards focus on protecting the public and guiding the professions. This includes responsibilities for registering health practitioners who meet the requirements of approved registration standards, investigating and managing concerns (known as notifications) about the performance, health or conduct of practitioners and developing standards, codes and guidelines. National Boards have delegated many functions to AHPRA and Board committees (national or State and Territory or regionally-based) to support the efficient functioning of the National Scheme. Registrations and complaints procedures are delegated from the National Board to the relevant state or territory Boards.

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20 Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions, pp 12–13, https://www.ahpra.gov.au/About-AHPRA/Ministerial-Directives-and-Communiques.aspx (accessed 19 October 2016).

Reviews of the NRAS

2011 Senate Finance and Public Administration References Committee inquiry

1.27 In June 2011, just under a year after the NRAS took effect, the Senate Finance and Public Administration References Committee reported on its inquiry into the administration of health practitioner regulation by AHPRA. That report acknowledged the scale of the undertaking, but highlighted that implementation of the NRAS had been problematic.[21]

1.28 The committee wrote:

> The committee points to the impact on patients and health service provision as yet another example of the serious implications of AHPRA's administrative failures. The committee notes that it has exacerbated patient waiting times, and compromised health service provision, particularly in rural and remote communities which are already particularly vulnerable.[22]

1.29 The committee made ten recommendations, including one relevant to this inquiry's focus:

> **Recommendation 5**
>
> The committee recommends that complaints processing within AHPRA be reviewed to ensure more accurate reporting of notifications and to reduce the impact of vexatious complaints on health practitioners.[23]

2014 Independent review

1.30 In 2014, the National Scheme was reviewed by an Independent Reviewer, Mr Kim Snowball. The final report of this review was published in 2015 and made 33 recommendations. The Australian Health Workforce Ministerial Council accepted the two recommendations specifically related to AHPRA's notification and investigation process.[24]

1.31 The first of these, Recommendation 9, concerned increased and improved communication from AHPRA to both the notifier and the medical practitioner,

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21 Senate Finance and Public Administration References Committee, *Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency*, June 2011, p. 111.

22 Senate Finance and Public Administration References Committee, *Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency*, June 2011, p. 81.

23 Senate Finance and Public Administration References Committee, *Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency*, June 2011, p. xi.

24 Department of Health, *Submission 13*, p. 3; see also COAG Health Council, meeting as the Australian Health Workforce Ministerial Council, *The Independent Review of the National Registration and Accreditation Scheme for Health Professionals*, Communique, 7 August 2015, http://www.coaghealthcouncil.gov.au/Announcements/ArtMID/527/ArticleID/71/Reissued-Communique-Final-Report-of-the-Independent-Review-on-the-National-Accreditation-Scheme-for-health-professionals (accessed 2 November 2016).

including establishing the notifier's expectation for matters referred to a National Board. The Ministers asked AHPRA to 'action this recommendation as a matter of priority and provide a progress report by December 2015'.[25]

1.32 Recommendation 28 was that AHPRA should, in consultation with the National Boards, Tribunals and Panel members, conduct specific education and training programs for its investigators, with the aim of developing 'more consistent and appropriate investigative standards and approaches… including the primacy of public safety over other considerations within the matters'.[26] The ministerial council accepted this recommendation and requested a progress report from AHPRA by December 2015.[27]

1.33 In their submission, the Medical Board, Nursing and Midwifery Board and AHPRA recognised that:

> … the management of notifications and complaints has not always met community expectations, including concerns about delays in the management of some notifications and confusion in roles with partners such as the health complaints entities.[28]

1.34 Consequentially, they have been working to improve the process, particularly in terms of timeliness and communication. They identified three main areas in which improvements were being made:

- implementing processes that deliver early triage of notifications and greater clinical input to ensure we continue to improve the timeliness of assessment of notifications;
- working with health complaints entities to ensure roles and processes are as clear as possible for notifiers and practitioners. A common assessment matrix has been developed and agreed to determine which entity is best placed to manage each matter and public information has also been produced; and
- correspondence with notifiers and practitioners has been reviewed and improved and more meaningful progress reports are now being provided to notifiers and practitioners during the course of investigations.[29]

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25 COAG Health Council, meeting as the Australian Health Workforce Ministerial Council, *The Independent Review of the National Registration and Accreditation Scheme for Health Professionals*, Communique, 7 August 2015, p. 4.

26 COAG Health Council, meeting as the Australian Health Workforce Ministerial Council, *The Independent Review of the National Registration and Accreditation Scheme for Health Professionals*, Communique, 7 August 2015, p. 6.

27 COAG Health Council, meeting as the Australian Health Workforce Ministerial Council, *The Independent Review of the National Registration and Accreditation Scheme for Health Professionals*, Communique, 7 August 2015, p. 6.

28 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 7.

29 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 7.

Conduct of the inquiry

1.35 The inquiry was referred to the committee on 2 February 2016, with a reporting date of 30 June 2016 set.[30] It lapsed with the dissolution of the 44th Parliament on Monday 9 May 2016 and was re-referred by the Senate on 15 September 2016.[31] A new reporting date of 16 November 2016 was set, but was subsequently extended until 30 November 2016.[32]

Handling of submissions

1.36 The committee invited submissions to be lodged by Friday 13 May 2016. Following the inquiry's lapse and re-referral, the committee decided not to formally call for further submissions but continued to accept submissions.

1.37 In total, the committee received 129 submissions from individuals and organisations. A list of submissions to the inquiry is available at Appendix 1.

1.38 The committee received a number of submissions from individual medical practitioners, as well as from family members or others on their behalf, discussing their personal experience of bullying and harassment, including via the complaints process. The majority of these submissions provided detailed accounts of individual cases.

1.39 To respect the privacy of those submitters, as well as of other medical practitioners, patients and employees of the health system, the committee decided to accept all such submissions in confidence. While individual cases and examples will not be referred to in this report, the committee acknowledges the concerns expressed by those who made submissions to this inquiry. These submissions assisted the committee to gain a firsthand understanding of the issues involved – the ways in which the complaints process has been implemented, concerns about AHPRA's management of the assessment and investigation process and the effects on practitioners' careers and lives as a result.

1.40 The committee also held two public hearings: one in Sydney on 1 November 2016 and a second in Canberra on 22 November 2016. Transcripts of those hearings are available on the committee's website and a list of witnesses who gave evidence is provided in Appendix 2. The committee acknowledges and thanks all those who contributed to this inquiry by providing written submissions or appearing at the public hearings.

Structure of this report

1.41 Following this introductory chapter, this report consists of three further chapters.

1.42 Chapter 2 outlines the medical complaints process in Australia, discussing the process of assessing and investigating complaints – known as notifications – lodged

30 Journals of the Senate, *No. 135–2 February 2016*, pp 3661–3662.

31 Journals of the Senate, *No. 7–15 September 2016*, pp 224–225.

32 Journals of the Senate, *No. 15–10 November 2016*, p. 451.

against medical practitioners and how vexatious complaints are dealt with. It then discusses concerns with this process, specifically in relation to its relationship to bullying and harassment. In particular, this chapter draws on evidence the committee received which suggests that the complaints process – the making of a notification and the investigation by AHPRA and other bodies – can be itself used as a tool of bullying and harassment within the profession. The chapter then discusses the ramification of this, including its negative impacts on practitioners' careers and lives and consequences for patient safety.

1.43 Chapter 3 addresses broader questions of bullying and harassment in Australia's medical profession, including the responses to these made within the profession itself.

1.44 Chapter 4 discusses the broader context of this inquiry, noting that this inquiry into the intersection of the medical complaints process and the prevalence of bullying and harassment within the profession has drawn the committee's attention to systemic questions and concerns about the medical complaints process in Australia as a whole. The chapter outlines areas the committee considers to require further investigation that is beyond the scope of this inquiry's terms of reference.