Chapter 2

The complaints process as a tool of harassment

Introduction

2.1 A key focus of this inquiry was the ways in which the medical complaints process in Australia, particularly that run by the Australian Health Practitioner Regulation Agency (AHPRA) and the medical boards, may have been used as a tool of harassment within the medical profession. The committee received a considerable amount of evidence suggesting that one form of bullying and harassment within the medical profession is for one practitioner to lodge a notification against another with AHPRA, possibly leading to an investigation and findings against the latter.

2.2 This chapter will outline AHPRA's complaints process, identified by submitters as being vulnerable to be used for the purpose of bullying and harassment, and the option for the review of AHPRA's decisions through the National Health Practitioner Ombudsman and Privacy Commissioner. The chapter will then discuss the concerns with this process as identified by submitters and witnesses to this inquiry, including the lodging of vexatious complaints; timeliness; transparency and communication; conflicts of interest; qualifications of the investigators and the use of benchmarking.

Complaints procedures

2.3 Anyone can make a complaint (also called a notification) about a registered health practitioner's health, performance or conduct. The management of these notifications is a joint responsibility of AHPRA and the relevant National Board.[1] AHPRA is responsible for investigating registered health practitioners and providing information for the National Board to consider in making its decision.[2]

2.4 Different National Boards have delegated some of their decision-making to their State/Territory committees and AHPRA officers. There are a number of possible stages in the notifications process and they do not need to be completed in a linear sequence, nor does every notification go through all the possible stages. Many notifications are closed after assessment.

2.5 In New South Wales, complaints against health care practitioners are handled by the Health Care Complaints Commission. These complaints are handled in a process similar to those received by AHPRA.[3]

2.6 In Queensland, the Office of the Health Ombudsman is responsible for managing serious complaints relating to health practitioners, and determines which

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1 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 4.

2 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 4

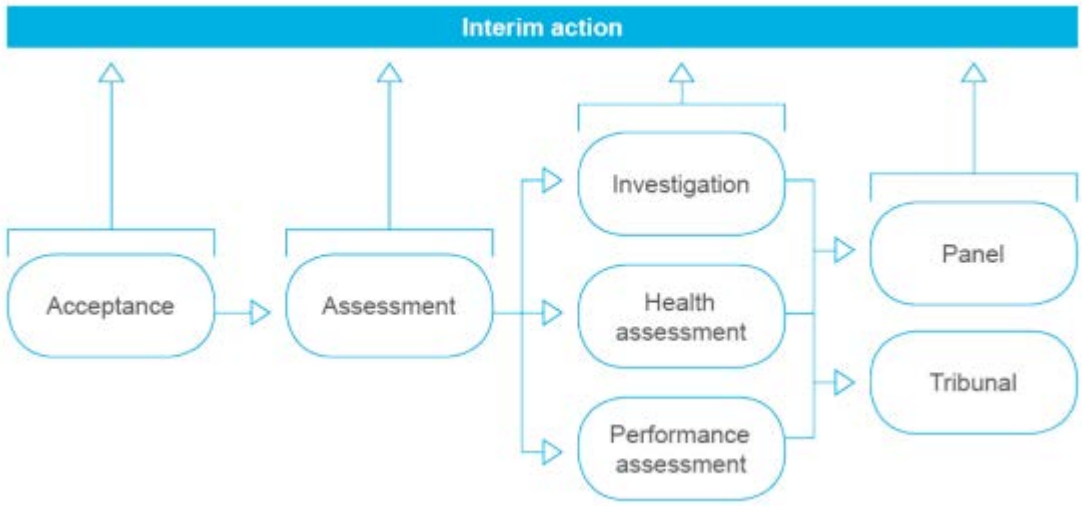
3 Department of Health, *Submission 13*, p. 3. See: http://www.hccc.nsw.gov.au/

complaints go to AHPRA and the National Boards after assessing their severity. AHPRA must then refer back to the Office of the Health Ombudsman any complaint where, during investigation, a suspicion of professional misconduct is developed.[4]

2.7 Decisions made at the state level in New South Wales and Queensland regarding a practitioner's conditions of practice or registration will be communicated to AHPRA for inclusion on the AHPRA public register of health practitioners.[5]

2.8 AHPRA's notification process can be seen illustrated in Figure 2.1, noting that interim or final action can be taken at any point in the process.

Figure 2.1 – AHPRA notification process



Source: Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 15.

2.9 In the Acceptance stage, the notification is received and a preliminary review is undertaken to confirm that the matter is grounds for notification, that it relates to a registered health practitioner (or student) and whether it could also be made to a health complaints entity.[6] Generally, at this point the practitioner about whom the notification has been made will be asked to respond, unless the issue relates to a matter that the Board cannot deal with or AHPRA is concerned that the notification

4 Department of Health, *Submission 13*, p. 3. See: http://www.oho.qld.gov.au/

5 Department of Health, *Submission 13*, p. 3.

6 Health complaints entities (HCE)s are state and territory-based bodies whose role is to investigate concerns about health service providers or systems. Regarding individual practitioners, HCEs can investigate specific concerns, primarily around fees and charges; they do not deal with issues relating to patient safety or practitioner registration. AHPRA and HCEs share information regarding complaints more relevant to the other, and sometimes will run a joint investigation. See: http://www.ahpra.gov.au/Notifications/Further-information/Health-complaints-organisations.aspx

raises issues that might pose a serious risk to the public, in which case the relevant National Board can take immediate action to protect the public.[7]

2.10 Once a notification has been accepted, it enters the Assessment stage. AHPRA may ask for more information, and will usually send the relevant practitioner a copy of the notification unless it would prejudice the investigation or place a person at risk. AHPRA presents the information to the Board for consideration, and the Board can either close the notification with no further action taken, propose to take relevant action (such as cautioning the practitioner, imposing conditions on their registration or accepting undertakings from them),[8] or refer the matter to the next stage of Investigation, Health Assessment or Performance Assessment. AHPRA aims to complete the Assessment stage for each notification within 60 days. Proposing to take a relevant action, however, can extend that timeframe, since the practitioner will be given the chance to show cause as to why that action should not be taken.[9]

2.11 If the Board is not satisfied with the amount of information it has been provided with at the Assessment stage, it can refer the notification back to AHPRA for Investigation, Performance Assessment or a Health Assessment. Investigations are carried out by AHPRA officers and seek additional information to aid the Board in its decision making. This information can take many forms, including additional information from the notifier and/or practitioner, information from other health practitioners involved, independent expert opinions or other information such as Medicare data or police records. Once the investigation is complete, the Board seeks to form a reasonable belief as to whether the practitioner has behaved in a way that constitutes unsatisfactory professional performance, unprofessional conduct or professional misconduct, or if they have a health impairment. If the Board cannot make such a judgement, it may decide to take no further action. AHPRA's aim is to complete each investigation in six months, but it notes that complex investigations make take longer. At six, nine and twelve months, each investigation is audited to ensure that it is proceeding appropriately.[10]

2.12 A Health Assessment is undertaken if the practitioner's health is suspected to be impaired and impacting their professional performance, particularly as it relates to patient safety. Practitioners have the right to make submissions to the Board as part of the Health Assessment stage and the results of the assessment are discussed with

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7 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 16.

8 Examples of conditions that may be imposed include the completion of additional training, undertaking a period of supervised practice, managing their practice in a specified way or reporting at regular times on their practice. Undertakings are voluntary and relate to limitations on the practitioner's practice. Both conditions and undertakings are noted on the national register. See: http://www.ahpra.gov.au/Support/Glossary.aspx

9 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 17.

10 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, pp 18–19.

them. Boards have a range of options for action after undertaking a health assessment, including taking no further action; cautioning, accepting an undertaking from, or imposing conditions on, the practitioner; referring the matter to another entity; investigating further; requiring a Performance Assessment; or referring the matter for hearing by either a panel or tribunal.[11]

2.13 A Performance Assessment is carried out by one or more independent practitioners to assess the knowledge, skill, judgement and care demonstrated by the practitioner. As with a health assessment, the results are discussed with the practitioner, and the Board has the same range of options open to it at the assessment's completion.[12]

2.14 Matters relating to a notification about a health practitioner can also be referred by the Board to a panel – either a health panel if the practitioner is believed to have an impairment affecting their performance or a performance and professional standards panel if a Board believes that the practitioner's practice or professional conduct may be unsatisfactory. The panel then has the same powers of the Board and additionally can issue a reprimand of the practitioner. Reprimands, like conditions and undertakings, appear on the national public register of practitioners.[13]

2.15 If a Board finds that a practitioner's conduct amounts to professional misconduct, the matter must be referred to a Tribunal hearing. Tribunals are headed by a judge or magistrate and include at least one professional representative and one community representative.[14] Like panels, tribunals have broad powers, but can also cancel the registration of a practitioner.[15]

Mandatory notifications

2.16 Under the National Law, health practitioners, employers and education providers have mandatory reporting responsibilities to advise AHPRA or a National Board if they have formed a reasonable belief that a health practitioner has behaved in a way that constitutes notifiable conduct in relation to the practice of their profession.

2.17 Notifiable conduct by registered health practitioners is defined as:

- practising while intoxicated by alcohol or drugs;
- sexual misconduct in the practice of the profession;

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11 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 19.

12 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 20.

13 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 20.

14 The Tribunal is the relevant administrative review tribunal in the state or territory. See: http://www.ahpra.gov.au/Notifications/Find-out-about-the-complaints-process/Tribunal-hearing.aspx

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

- placing the public at risk of substantial harm because of an impairment (health issue); or
- placing the public at risk because of a significant departure from accepted professional standards.[16]

2.18 Education providers have an obligation to make a mandatory notification about a student if the student has an impairment that may, either in the course of study or clinical training, place the public at substantial risk of harm.[17]

Statistics on notifications

2.19 AHPRA received 3 147 notifications about medical practitioners and 1435 about nurses and midwives in 2015-16. Of these:

- 369 (11.7%) of the notifications about medical practitioners were made by other medical practitioners and 620 (43.2%) of those about nurses and midwives were lodged by other nurses and midwives (these figures include self-disclosures);[18]
- 33 of the 3147 notifications about medical practitioners and 30 of the 1435 notifications about nurses and midwives identified bullying and harassment as a primary reason for the notification;[19]
- 32.5% of the notifications completed by AHPRA in 2015-16 received a full investigation or a specialised assessment. The remainder were closed following assessment;[20]
- 3.2% of complaints received by AHPRA in 2015–16 led to a panel hearing and 3.5% a tribunal hearing.[21]

2.20 These statistics demonstrate that the majority of notifications lodged—particularly against medical practitioners, less so regarding nurses and midwives—were from members of the public. Just under 12 per cent of the notifications lodged against medical professionals came from colleagues.

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16 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 14. Note: In Western Australia there is no legal requirement for treating practitioners to make mandatory notifications about patients (or clients) who are practitioners in one of the regulated health professions.

17 See: http://www.ahpra.gov.au/Notifications/Who-can-make-a-notification/Mandatory-notifications.aspx

18 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 6.

19 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 4.

20 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 5.

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

2.21 While the proportion of notifications lodged to AHPRA regarding bullying and harassment was low, this should not be taken to suggest that bullying and harassment levels are low, but rather illustrates that AHPRA's primary purpose relates to public safety. Bullying and harassment allegations would, in most cases, be more relevant to investigate through the individual workplace or the relevant professional college.

Review of decisions

2.22 The National Health Practitioner Ombudsman and Privacy Commissioner (the Ombudsman) is an independent statutory agency created to provide ombudsman, privacy and freedom of information oversight of the agencies of the National Scheme, including AHPRA and the National Boards.[22] As such, the Ombudsman handles complaints from people dissatisfied with an AHPRA decision. The Ombudsman's submission outlines the actions of AHPRA or a National Board that may be the subject of a complaint:

> • the actions taken by AHPRA to assess and investigate notifications or complaints made under the National Law;
>
> • the actions of a National Board when making a decision in relation to matters raised as a result of a notification or complaint; and
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> • the actions of a National Board when making a decision to refuse registration or place conditions on the registration of a health practitioner.[23]

2.23 Ms Samantha Gavel, current (and first) Ombudsman, further outlined her responsibilities and powers, emphasising that the Ombudsman's office is focused on AHPRA's procedures, rather than the details of the original complaint:

> It is important to note that the role of my office is not to review the conduct or performance of health practitioners; that is the role of the national boards. The role of my office is to consider the administrative actions of AHPRA and the board in relation to action that is subject of a complaint. We examine whether AHPRA and the board have acted consistently with applicable legislation, have complied with relevant policies and procedures and have taken relevant considerations into account. In particular, we look at whether AHPRA has gathered sufficient information during its investigation to inform the board's decision making and whether the board's decision is reasonable based on the information gathered by AHPRA.[24]

2.24 Actions open to the Ombudsman include recommending that AHPRA and the National Boards:

- reconsider a decision;
- review or change a policy or procedure;

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22 National Health Practitioner Ombudsman and Privacy Commissioner, *Submission 12*, p. 5.

23 National Health Practitioner Ombudsman and Privacy Commissioner, *Submission 12*, pp 6–7.

24 Ms Samantha Gavel, National Health Practitioner Ombudsman and Privacy Commissioner, *Committee Hansard*, 1 November 2016, p. 2.

- offer an apology to an affected person;
- expedite a delayed action; and
- provide a better explanation to a person affected by a decision of AHPRA or a National Board.[25]

2.25 However the Ombudsman can only make those recommendations; it cannot overturn an AHPRA or National Board decision or force a review.[26] Further, in New South Wales, the Ombudsman has no jurisdiction to respond to complaints (complaints there are handled by the New South Wales Health Care Complaints Commission) and in Queensland can only respond if the matter is transferred from the Queensland Office of the Health Ombudsman.[27]

2.26 In 2014–15, the Ombudsman received a total of 75 complaints. The largest category of these (35 cases, or just under 47%) was from notifiers unhappy with the result of their notification about a practitioner; while 17 (or just under 23%) were from practitioners regarding the handling of a notification against them. The majority of the remainder was related to registration issues from individual practitioners.[28]

2.27 The 2015–16 figures showed 40 per cent of complaints came from members of the public concerned about the results of their notification against a health practitioner. A further 14 per cent were from health practitioners who had been the subject of a notification, and 34 per cent related to registration issues.[29] From 2014–15 to 2015–16, therefore, there was a slight drop in the proportion of complaints received by the Ombudsman from practitioners regarding the way a notification against them had been managed.

2.28 The Ombudsman also has a role in providing feedback to AHPRA and the National Boards about systemic issues identified from complaints received and helping those bodies to improve their processes.[30]

Vexatious complaints handling

2.29 One of the key issues identified in evidence received by this inquiry is that of vexatious complaints. Multiple witnesses argued that complaints are too often made for vexatious reasons, using the complaints process as a tool of bullying and harassment. In this section, AHPRA's process for identifying and handling vexatious complaints will be outlined.

2.30 Section 151 of the National Law authorises National Boards to take no further action on any notification if it reasonably believes it to be vexatious or frivolous.

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25 National Health Practitioner Ombudsman and Privacy Commissioner, *Submission 12*, p. 7.

26 National Health Practitioner Ombudsman and Privacy Commissioner, *Submission 12*, p. 7.

27 National Health Practitioner Ombudsman and Privacy Commissioner, *Submission 12*, p. 8.

28 National Health Practitioner Ombudsman and Privacy Commissioner, *Submission 12*, p. 9.

29 Ms Samantha Gavel, National Health Practitioner Ombudsman and Privacy Commissioner, *Committee Hansard*, 1 November 2016, p. 2.

30 Department of Health, *Submission 13*, p. 3.

Section 237 protects those who make a notification in good faith. However, as the joint submission from the Medical Board, Nursing and Midwifery Board and AHPRA notes, classifying notifications as vexatious is not straightforward:

> However, determining that a notification is vexatious can be difficult, and hence data on vexatious complaints and notifications are difficult to quantify. For example, a complaint may relate to performance and risks to public safety but there may be elements of self interest from a notifier in relation to their professional or commercial interests.[31]

2.31 The Ombudsman noted that ready access to the complaints mechanism is important for public health and that, while complaints can be lodged vexatiously, there is limited evidence of this happening often:

> … the NHPOPC's [National Health Practitioner Ombudsman and Privacy Commissioner] experience in handling complaints about the administrative actions of AHPRA and the National Boards does not suggest that there is a high incidence of people intentionally using notification processes for vexatious purposes.[32]

2.32 Mr Martin Fletcher, Chief Executive Officer of AHPRA, made a similar point, drawing on existing research:

> What I am saying is that in all of the available data and research evidence that we have looked at there does not appear to be a big problem with vexatious complaints, and by 'vexatious' I mean a harmful intent on the part of the person making the complaint and no patient safety concern emerging when we look at the issue.
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> […]
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> If I can give you one example, we have a research partnership with the University of Melbourne. They looked at 850 mandatory notifications over a 12-month period. They found fewer than six that they believed potentially met the criteria for a vexatious notification. The point I am also making is that, even though the numbers are small, we recognise that the impact on the individuals involved can be significant.[33]

2.33 The Ombudsman also pointed to existing safeguards against the making of vexatious complaints; in addition to the provision authorising National Boards to take no further action on complaints it deems vexatious or frivolous:

> Other provisions include the requirement for a national board to undertake a show-cause process in some circumstances and the ability of a health

31 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 6.

32 National Health Practitioner Ombudsman and Privacy Commissioner, *Submission 12*, p. 13.

33 Mr Martin Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 1 November 2016, p. 3.

> practitioner to appeal most types of regulatory action to a tribunal or court.[34]

2.34 The Ombudsman further noted that even some vexatiously made complaints may raise issues of public safety and expressed its confidence in the notification assessment and investigative processes of AHPRA and the National Boards in ensuring the protection of the public.[35]

2.35 AHPRA noted in this context that soon after the completion of this inquiry, it will launch a portal for the lodging of complaints online, which will also '… invite a declaration from the notifier that the content of their complaint or concern is true and correct to the best of their knowledge and belief.' A corresponding change will be made to the hard copy complaint form at the same time.[36]

2.36 AHPRA further noted that it will monitor the impact of this addition to 'ensure there are no unintended consequences for people wanting to raise concerns about registered health practitioners'.[37]

2.37 Similarly, AHPRA explained that, to better identify and understand the problem, it will commission research into vexatious notifications:

> As we have previously advised the committee, the data we have and the available research indicate this is a very small problem, but we recognise it has a big impact when it happens. We will publish what we learn and act on it.[38]

2.38 Mr Fletcher further noted that a process is underway to more specifically prohibit the making of vexatious complaints by medical practitioners:

> … the Medical Board will toughen its code of conduct in relation to vexatious complaints. Establishing a clear benchmark will enable the board to take further action against a practitioner who makes complaints purely to damage another registered practitioner.[39]

Committee view

2.39 The committee recognises that vexatious complaints are not always readily apparent, but is not convinced that AHPRA's processes are adequate for the purpose of identifying complaints made vexatiously.

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34 Ms Samantha Gavel, National Health Practitioner Ombudsman and Privacy Commissioner, *Committee Hansard*, 1 November 2016, p. 2.

35 National Health Practitioner Ombudsman and Privacy Commissioner, *Submission 12*, p. 13.

36 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 10.

37 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 10.

38 Mr Martin Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 1 November 2016, pp 1–2.

39 Mr Martin Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 1 November 2016, p. 2.

Vexatious complaints as a form of bullying and harassment

2.40 The committee has received a considerable amount of confidential evidence suggesting that the complaints process can be used as a tool of bullying and harassment within Australia's medical profession.

2.41 A significant proportion of confidential submitters claim that vexatious complaints have been made against them either internally within the workplace or through the formal processes of AHPRA to bully or harass them. In particular, submitters allege that notifications were lodged against them in response to their own complaints of bullying and harassment.

2.42 Confidential submitters are concerned that there is no avenue for AHPRA to counsel complainants on false or misleading allegations and that there are no consequences for individuals who make vexatious complaints. Some confidential submitters consider it would be beneficial if a record of vexatious complainants was kept and suggest that legal action should be taken against people found to have submitted vexatious complaints.

2.43 Dr Don Kane, Chair of the advocacy group Health Practitioners Australia Reform Association (HPARA), argued that this is a substantial problem for medical practitioners:

> These people [those making vexatious complaints] are misusing AHPRA for their own personal reasons. It is very rare, if ever, that AHPRA have taken action against people who have lodged vexatious claims. There is an absolute abuse of the mandatory notification process. It was put in there in the guise of being in the public interest, but really it is in the interests of the people making the complaint.[40]

2.44 The Medical Board of Australia and AHPRA responded to this concern, arguing that their primary concern is in ensuring patient and public safety and that any weakening of the notification and investigation process would undermine that:

> It has been alleged that the way AHPRA and the boards deal with complaints is a form of bullying. We reject this allegation. We fully accept that it is our responsibility to make sure we deal with notifications fairly and efficiently. We have worked hard to improve the timeliness of our processes and to improve our communication with both notifiers and practitioners. We have streamlined how we work with other health complaints entities to make sure that the right body is managing the complaint from the outset.
>
> But our primary focus is patient safety. Notifications that raise serious issues must be dealt with rigorously, and we must take appropriate regulatory action where there is a risk to the public. The community comes to us with their concerns when they have had a bad experience or a bad

40 Dr Don Kane, Chair, Health Practitioners Australia Reform Association, *Committee Hansard*, 1 November 2016, p. 39.

> outcome. They want us to take their concerns seriously and to take action to ensure that whatever happened to them does not happen again.[41]

Concerns with AHPRA's complaints process

2.45 Many confidential submissions express concern about AHPRA's management of vexatious complaints, as those submitters are concerned that the complaints process is misused as a vehicle to bully and harass medical professionals.

2.46 Conversely, confidential submissions from family members of patients expressed concern that their genuine complaints had resulted in lenient consequences for the medical practitioners concerned.

2.47 The issue of the AHPRA complaints handling process, including the identification of vexatious complaints, was reviewed during the 2011 Finance and Public Administration References Committee Inquiry into AHPRA. The committee commented:

> The committee is concerned about inconsistency in the application of complaint processes, the prescriptiveness of the application form and the way in which vexatious complaints are handled. The committee considers that further development of the complaints process is urgently required.[42]

2.48 The committee recommended:

> [T]hat complaints processing within AHPRA be reviewed to ensure more accurate reporting of notifications and to reduce the impact of vexatious complaints on health practitioners.[43]

2.49 The Government response to the inquiry report did not provide any comments specific to this recommendation.[44]

2.50 Discussing that committee's findings and recommendations, the Ombudsman, Ms Samantha Gavel, noted that considerable improvements had been made in AHPRA's processes since 2011, when the National Scheme was still new:

> I think we all know that there were problems with the notification process in the first few years of the scheme. I certainly know that from the reading I have done, and I have had a look at some of those reports. Since I came into

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41 Dr Joanna Flynn, Chair, Medical Board of Australia, *Committee Hansard*, 1 November 2016, p. 54.

42 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. 93.

43 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.

44 Australian Government, *Response to the Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency*, http://www.aph.gov.au/~/media/wopapub/senate/committee/fapa_ctte/completed_inquiries/2010-13/health_practitioner_registration/government_response/gov_response.ashx (tabled 7 February 2012).

> the role, which was two years ago now, I have seen a big improvement in notification processes. […]
>
> I have seen a big improvement in all sorts of areas. They have put a number of new policies and processes in place. For example, they have done more training for their staff that take calls on the phone so that they are better able to talk people through the national law, the notifications process and what they can expect. They can keep them better informed about what is occurring. They are now providing far more detailed outcome letters, which is important so that people understand what the board has looked at and why they have come to the decisions that they have. They are some of the areas where I have seen improvements.[45]

2.51 Despite this, the committee is concerned by the proportion of submitters to this inquiry who identified serious concerns with AHPRA's management of the notification and investigation process, particularly when in relation to notifications lodged vexatiously, as a tool of bullying and harassment. This section will outline those concerns.

Timeliness

2.52 Confidential submitters complained of long timelines for AHPRA investigations to be completed, ranging from two to four years. The slow timeframes concerns both those who have made complaints and those who have had complaints made against them. The former want to see incompetent practitioners quickly dealt with in a manner that protects the public. The latter are concerned that competent doctors' time and energy is being wasted responding to false accusations.

2.53 As noted above, AHPRA's target is to complete each investigation within six months. Ms Kym Ayscough, the Acting Chief Executive Officer, noted that the agency is aware of concerns in this area and pointed to the median age of open notifications as being 137 days:

> In the material that we have to 30 June 2016, the median age of open notifications is 137 days, and that is a five-day reduction in median age from the same time last year. This has been a particular area of focus for us. We know there was a lot of criticism, in the early days, of the national scheme about the time frames, and we have continued to work diligently, both AHPRA and the boards, to bring those time frames within reasonable expectations.[46]

2.54 Organisations also commented on this aspect of the complaints process. For example, the Australian and New Zealand College of Anaesthetists argued that:

> In this area justice delayed is justice denied.

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45 Ms Samantha Gavel, National Health Practitioner Ombudsman and Privacy Commissioner, *Committee Hansard*, 1 November 2016, p. 4.

46 Ms Kym Ayscough, Acting Chief Executive Officer; Executive Director, Regulatory Operations, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 1 November 2016, p. 55.

> It is important for the health professional to have any concerns speedily dealt with; at the same time if the concerns are sustained, then it is important for public protection that appropriate action is taken, including changes to the registration status.[47]

2.55 Similarly, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) also argued that timeliness of investigation is both vital and frequently absent:

> Timely and necessary action in response to complaints is important in providing effective public protection and confidence in the National Law on the part of both practitioners and patients.
>
> An ongoing problem is the length of time it takes to investigate and resolve complaints. In recent years, investigations have taken far too long, causing unnecessary stress for both complainants and practitioners under investigation and leaving both in the dark as to the outcome.[48]

2.56 RANZCP further noted that AHPRA often does not communicate well and promptly with them regarding the investigation of RANZCP members.[49]

2.57 The Australian Dental Association (ADA) argued that the length of time investigations can take can have a deleterious effect on both notifier and practitioner:

> The ADA considers the time AHPRA takes to deal with all cases is generally excessive and so management of notifications must be improved. This creates a burden of uncertainty for both the complainant and the health practitioner in question. What the current processes inadequately recognise is the impact of the complaints process on health practitioners, particularly in cases where complaints are unfounded. Practitioners not only have to invest time in defending complaints, they correspondingly experience the personal burden of shame, humiliation & psychological stress. There should be greater effort on a need to support practitioners during the notifications process, such as outlining to them expectations as well as providing timely updates on what the next phase of the process would involve and when that would occur. We are aware that AHPRA is reviewing its processes in this regard.[50]

2.58 Conversely, some confidential submitters complained about onerous requirements to produce documents to the investigative team on short notice.

Committee view

2.59 The committee recognises that AHPRA has improved its processes and that the timeframe for the closing of notifications has decreased in recent years. However, given the importance to both notifier and practitioner of timely resolution to each case,

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47 Australian and New Zealand College of Anaesthetists, *Submission 5*, p. [3].

48 Royal Australian and New Zealand College of Psychiatrists, *Submission 19*, p. 2.

49 Royal Australian and New Zealand College of Psychiatrists, *Submission 19*, p. 2.

50 Australian Dental Association, *Submission 6*, [p. 3].

the committee considers this issue to be of the highest significance and an area for continued monitoring and review.

Transparency and communication

2.60 Many confidential submitters claim the investigative process lacks transparency and scrutiny. A few note unsuccessful attempts to be provided with all information in relation to an allegation against them or to seek clarification of the details of their case. Some claim evidence is taken on face value and that those accused are not given the opportunity to respond to claims made in the investigation.

2.61 One illustration of this point came from Dr Gary Fettke, who discussed the problems he faced when trying to respond during AHPRA's investigation of his practice:

> The AHPRA process has shifting goalposts for those under investigation. You answer one allegation and another one surfaces. Trying to defend one's position without knowing the evidence and its accuracy makes for a star chamber circus.[51]

2.62 AHPRA acknowledged that its management of notifications 'has not always met community expectations' and outlined its efforts to improve, particularly in relation to timeliness and communication:

- 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.

> Improvements have been made. However, complex matters will take time to investigate and not all matters can be finalised quickly. It is important that investigations are robust, as the implications for the practitioner being investigated and the notifier alike are significant.[52]

2.63 Dr Joanna Flynn, Chair of the Medical Board of Australia, further outlined steps that have been taken to improve communication with practitioners who are the subject of notifications, including a more concerted effort to communicate more often and giving practitioners a single point of contact with AHPRA:

> One of the clear concerns that was expressed, when we started this work, was the impersonal nature of the communication, the infrequent

51 Dr Gary Fettke, *Committee Hansard*, 1 November 2016, pp 14–15.

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

> communication and the feeling that practitioners were a bit at sea and did not understand what was happening. That goes back to the point I made earlier about how stressful it is and us recognising how stressful it is to be subject to a notification.
>
> We have done a lot of work to change the culture in the organisation and to change the method of communication so there is more verbal communication, there is more frequent communication and people are given an unidentified officer with whom they can follow up their concerns. We do have staff turnover at times and sometimes there is discontinuity but, wherever possible, we try give somebody one point of contact that they can follow up with, and we try to respond to things in a much more timely and helpful way. We do recognise it is stressful, and a lack of information about what is happening and the lack of a sense that you can speak to anybody about what is going on is one of the things that adds to that stress.[53]

Committee view

2.64 Alongside timeliness, the committee notes that the level and style of communication with both notifiers and practitioners has been one of the key concerns raised about AHPRA's management of complaints. The committee notes that AHPRA and the national boards have recognised that clear and frequent communication is a vital component of the notification process. For both the notifier and the practitioner, understanding the progress and likely outcomes will help reduce stress and uncertainty. Unfortunately, from the evidence the committee has received, there are ongoing issues with some cases. Many people have suggested there is a need for more change.

Adversarial nature of the notification process

2.65 Multiple witnesses identified that one concern with the medical complaints process in Australia is that it is based on adversarial and investigative systems rather than mediation or other options for resolving disputes.

2.66 The Australasian College of Emergency Medicine (ACEM) noted that the process discourages local investigation and solutions:

> … there is no gradual escalation of a complaint, rather the mandatory notification legislation recommends rapid referral to AHPRA. This process also denies the individual against whom the complaint has been made the opportunity to respond or attempt to locally resolve the complaint prior to its escalation to AHPRA.[54]

2.67 ANZCA similarly argued that the existing process is too heavily focused on adversarial and investigative principles, rather than on addressing the issues raised in the notification and the performance of the practitioner:

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53 Dr Joanna Flynn, Chair, Medical Board of Australia, *Committee Hansard*, 1 November 2016, p. 56.

54 Australasian College of Emergency Medicine, *Submission 4*, p. 3.

> Communication and support are vital. This is both for the public who have raised the concern and the practitioner about whom the concern is raised. These complaints are often devastating to both parties. Everything should be done to reduce this stress and the time over which any investigation lasts.
>
> There needs to be a substantial move from the adversarial and legally based system that is currently evident to one that is focused on conciliation and rapid resolution wherever possible. There is no doubt that the concerns, aggravation and angst of complaints are magnified enormously when delays are multiplied and the process becomes adversarial.[55]

2.68 Dr Michael Mansfield argued that the focus of AHPRA's processes is 'punitive rather than educational or rehabilitative', and that, where appropriate, face-to-face meetings or mediation may serve to resolve complaints less stressfully, more cheaply and more quickly:

> Facilitated face-to-face meetings of accused and accuser would be very beneficial, with regard to reducing the complexity and cost of unnecessary investigations, and it would facilitate a speedy resolution of breach issues.[56]

2.69 The Health Care Consumers' Association (HCCA) made a similar point from a patient's perspective, arguing that 'many consumers may want to make an informal comment rather than a formal complaint', but that the existing notifications system does not readily allow this. The HCCA therefore recommended that learning how to receive feedback should be a skill taught to all medical professionals.[57]

2.70 The HCCA notes a key problem is that medical complaints processes serve dual roles, one in relation to the practitioner and one in relation to the consumer, with the result that neither role is fully met:

> Medical complaints processes aim to discipline and regulate professionals and deliver fair process, while also responding to consumer concerns. In reality, complaints processes are often not 'fit for purpose' for these disparate aims and as a result fail to achieve either disciplinary/regulatory or consumer outcomes.[58]

2.71 To resolve this dichotomy, the HCCA recommended that the notifications process have a stronger patient focus in how it closes complaints, separate to any action that the National Board might take:

> The complaints handling system should be changed to ensure that a consumer who is seeking an apology, further information or a fair hearing has access to a process that can deliver these outcomes; regardless of

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55 Australian and New Zealand College of Anaesthetists, *Submission 5*, p. [3].

56 Dr Michael Mansfield, *Committee Hansard*, 1 November 2016, p. 12.

57 Health Care Consumers' Association, *Submission 16*, p. 9.

58 Health Care Consumers' Association, *Submission 16*, p. 14.

> whether or not the issue raised is also appropriately dealt with as a notification by APHRA or by other complaints-handling bodies.[59]

2.72 Asked about adopting a less adversarial, more conciliation-based approach to managing complaints, AHPRA argued that the National Law does not give them the scope to do so:

> We have considered that question before and I think it is relevant to point out that AHPRA and the national boards are part of the overall complaints management system, and there is also in each state and territory a health complaints entity. The health complaints entities do have the capacity to mediate or conciliate on complaints.[60]

2.73 Surgeon Professor Paddy Dewan, in discussing the 'adversarial, legalistic mechanisms' of formal complaints and investigation processes, noted that such systems could be improved by making medical professional staff welfare a performance criterion for organisations such as AHPRA and the Colleges.[61]

Committee view

2.74 The committee recognises that public safety is the most important consideration in managing complaints against medical practitioners. However, safety is not improved if the medical complaints process is viewed as unnecessarily adversarial or confronting for either the notifier or the practitioner. While recognising that AHPRA's capacity to respond to notifications is prescribed in the National Law, the committee is of the view that a less adversarial approach to managing notifications may lead to improved public safety and better outcomes for practitioners.

Conflict of interest

2.75 Some confidential submitters claim AHPRA's processes do not consider possible conflicts of interest when determining who conducts the investigation or can be a witness. For example, one submitter claims that an AHPRA board member involved in the investigation was also a colleague, whilst another states that a complainant (a relative of a deceased patient) was permitted to join the investigative team of the relevant state or territory board (now AHPRA). Another submitter claims one of AHPRA's expert witnesses in their investigation had financial interests in an industry that would benefit from a particular outcome.

2.76 Asked about AHPRA's processes for dealing with potential conflicts of interest, chief executive officer Mr Martin Fletcher responded:

> We have a number of arrangements. We have people on a panel who are available to do assessments. One of the benefits of being a national scheme is that we can go outside a state or territory if we need to get somebody who

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59 Health Care Consumers' Association, *Submission 16*, p. 16.

60 Ms Kym Ayscough, Acting Chief Executive Officer; Executive Director, Regulatory Operations, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 1 November 2016, p. 67.

61 Professor Paddy Dewan, *Submission 3*, p. [2].

> is not directly involved with a particular practitioner. The other area where we use independent experts is getting expert opinions. Often that might require us to get somebody who has quite a specialised area of knowledge—on a medical subspecialty, for example. Again, we would often seek advice from the relevant professional college or medical college about an appropriate expert to source. When we do that we do not disclose the name of the person, but, obviously, once we are approaching an individual to do the assessment or provide the expert opinion we do disclose the name, because we then need to establish that there is no conflict of interest that may mean that they are unable to do what we need them to do.[62]

Qualifications of investigators

2.77 A related concern expressed by medical practitioners is that the AHPRA officers who conduct investigations are not necessarily medically trained or qualified themselves, and therefore may lack understanding or appreciation of the medical situation involved.

2.78 This argument was summarised by Dr Michael Mansfield:

> The main problem, however, is that AHPRA—via its allowed misuse of mandatory reporting guidelines—is facilitating bulling [sic] on a level never before seen. This is because the investigators lack any medical expertise. They do not have the necessary perspective to judge serious versus vexatious claims, nor do they have the expertise to judge the merit of differing independent medical reports.[63]

2.79 Similarly, Dr Gary Fettke argued that AHPRA's 'flawed investigation process' is a consequence of investigators who are 'inadequately trained, supervised and audited'.[64] Dr Fettke went on to note that, while decisions are made by the medical boards – whose members do have medical understanding – not all the information collected during an investigation necessarily forms part of the advice to the board:

> I have asked for all of my material to be put to the board and have it all reviewed by the board, but that does not happen. It is only very select. So the gatekeepers in our investigations are the investigators not the Medical Board.[65]

2.80 Dr Don Kane of HPARA likewise argued that inexperienced or unqualified investigators are producing reports that are inaccurate or fail to take into account the complexity of medical practice:

> The impression I get is that they [AHPRA investigators] are not well qualified to be in the positions they are in, and the use of sham peer review

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62 Mr Martin Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 22 November 2016, p. 10.

63 Dr Michael Mansfield, *Committee Hansard*, 1 November 2016, p. 12.

64 Dr Gary Fettke, *Committee Hansard*, 1 November 2016, p. 14.

65 Dr Gary Fettke, *Committee Hansard*, 1 November 2016, p. 16.

> both by AHPRA and by people who lodge complaints to AHPRA, be they administrations or individuals, is quite a common practice, and it is very, very damaging. They do not seem to have the expertise to realise that a health service, whether it be in medicine, nursing or otherwise, is very complex, and if you have reviews done by people who are not actually expert in the work of the person that they are reviewing, you are very likely to get a review that is not as it should be, and AHPRA does not seem to have the wherewithal to recognise that.[66]

2.81 In response to these concerns, AHPRA outlined the backgrounds and qualifications of their investigators and emphasised that, for the past two years, a national standard training course had been delivered to all investigators:

> Across the national scheme we employ probably around 100 investigators. They come from a variety of backgrounds. When we are recruiting we are particularly looking for people who have the skills to gather information around a complaint, synthesise that information and write reports for the information of the boards, who are the decision makers in the matter. They come from a variety of backgrounds. Some of our investigators have clinical backgrounds; others have experience working with other regulatory agencies, with ombudsman's organisations and some have backgrounds from the police service.
>
> In terms of qualifications or credentialing, we have for the last two years been delivering a standard training program to all of our investigators based on the national certified investigator training program from the Council on Licensure, Enforcement and Regulation. That program has been running for more than 30 years and has trained over 19 000 investigators. We deliver that now as baseline training for all of our investigators.[67]

2.82 AHPRA also clarified that, while board members are presented with a report compiled by the investigator, they are also provided with a list of all other information received during the investigation and can ask for any of that material.[68]

Cautions made appealable

2.83 As outlined above, a National Board can caution a practitioner following assessment of a notification. A caution, AHPRA notes:

> … is like a written warning and is intended to act as a deterrent so that the practitioner does not repeat the conduct or behaviour.

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66 Dr Don Kane, Chair, Health Professionals Australia Reform Association, *Committee Hansard*, 1 November 2016, p. 37.

67 Ms Kym Ayscough, Acting Chief Executive Officer; Executive Director, Regulatory Operations, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 1 November 2016, p. 54.

68 Ms Kym Ayscough, Acting Chief Executive Officer; Executive Director, Regulatory Operations, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 1 November 2016, p. 55.

> A caution is not usually recorded on the public register but may be published on the national register of practitioners if the National Board considers it appropriate to do so.[69]

2.84 The Ombudsman, Ms Samantha Gavel, described a caution as 'the least action that AHPRA can take'.[70]

2.85 Ms Kym Ayscough of AHPRA noted that:

> Under the national law, the board has available to it a number of regulatory responses. They really are considered to be in an escalating scale of seriousness, to respond to the different levels of regulatory risk, and a caution is a response that is at the very low end of the regulatory response.[71]

2.86 While describing cautions as the 'low end' of possible responses, Ms Ayscough did confirm that all responses to notifications against a practitioner, including cautions, go to their employer.[72]

2.87 Several submitters and witnesses noted that cautions issued by the National Boards are, unlike every other action available to Boards, not subject to administrative appeal, although there is the option of judicial review. The committee heard that the process could be improved by amending the National Law in relation to cautions.

2.88 Dr Joanna Flynn of the Medical Board of Australia noted that, while practitioners cannot appeal the decision to caution them, they are able to put forward their case before the caution is issued:

> A caution is not imposed unless a practitioner has been given notice of the board's intention to impose a caution and given an opportunity to make a submission in relation to it. So the practitioner does have an opportunity to make a submission, but that is not the same as an appeal; I accept that.[73]

2.89 The argument for making cautions appealable was made by Dr Kerry Breen, who argued that the National Law is flawed in allowing Boards to issue a caution 'without the doctor being interviewed by a Board member or even by an AHPRA staff member'. Furthermore, Dr Breen argued:

> … under Section 199, such a caution is not open to appeal, contrary to all other Board decisions which universally are open to appeal. Section 206 of

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69 AHPRA website, 'Possible outcomes', http://www.ahpra.gov.au/Notifications/Find-out-about-the-complaints-process/Possible-outcomes.aspx, accessed 15 November 2016.

70 Ms Samantha Gavel, National Health Practitioner Ombudsman and Privacy Commissioner, *Committee Hansard*, 1 November 2016, p. 10.

71 Ms Kym Ayscough, Acting Chief Executive Officer; Executive Director, Regulatory Operations, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 1 November 2016, p. 64.

72 Ms Kym Ayscough, Acting Chief Executive Officer; Executive Director, Regulatory Operations, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 1 November 2016, p. 64.

73 Dr Joanna Flynn, Chair, Medical Board of Australia, *Committee Hansard*, 1 November 2016, p. 65.

> the legislation provides that any employer must be informed of the caution, thereby making the caution public and hence not a minor matter. Cautions of this type probably serve a useful purpose but there must be a mechanism for appeal.[74]

Committee view

2.90 The committee notes that, while a caution is the lowest level of action a Board can take in response to a complaint against a practitioner, that caution can affect a practitioner's career. As such, further consideration should be given to the option of allowing administrative review for cautions.

Recognition that bullying and harassment is a patient safety issue

2.91 A point made by some submitters to this inquiry was that bullying and harassment could be more effectively responded to if there was a greater recognition that these behaviours in the medical profession can affect patient safety. Submitters expressed concern that, as bullying and harassment is rarely seen as a patient safety issue, AHPRA has limited capacity to deal with complaints about these behaviours.

2.92 As an example, Mr John Ilott of the Australian and New Zealand College of Anaesthetists noted that issues with bullying and harassment are dealt with differently in New Zealand than they are in Australia:

> I think one of the things that we have noticed in the difference between the Medical Council of New Zealand and the Medical Board of Australia is that the Medical Council of New Zealand is more prepared to acknowledge that bullying discrimination is likely to constitute a patient safety issue.[75]

2.93 The HCCA discussed this issue from the patients' point of view, noting that recent research demonstrates that bullying and harassment has an impact beyond that of the direct recipient of it:

> There is now increasingly clear evidence that medical workplaces in which bullying and harassment are tolerated are unsafe for patients. The Joint Commission, an independent, not-for-profit organisation that accredits and certifies around 20,000 health care organisations and programs in the United States, reviewed behaviours that undermine a culture of safety and bullying and concluded that harassment featured prominently:
>
> > "Intimidating and disruptive behaviours can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety,

74 Dr Kerry Breen, *Submission 103*, p. 3.

75 Mr John Ilott, Chief Executive Officer, Australian and New Zealand College of Anaesthetists, *Committee Hansard*, 1 November 2016, p. 46.

> health care organizations must address the problem of behaviours that threaten the performance of the health care team."[76]

Committee view

2.94 The committee is concerned that bullying and harassment, identified as a prevalent issue in the medical profession, is not currently considered to have a substantial impact on patient safety. The committee is of the view that the entire medical profession needs to, as a matter of priority, recognise this significant impact and AHPRA should take it into account when investigating notifications against practitioners.

Vexatious complaints and a declaration of good faith

2.95 One of the terms of reference for this inquiry suggested, as a possible solution to concerns about the vexatious use of complaints against practitioners, that notifiers could be obliged to sign a declaration of good faith. On the whole, while all submitters agreed that the making of vexatious or frivolous complaints was an unacceptable practice and unfortunate consequence of the complaints process, there was limited support for the notion of requiring notifiers to make a declaration of good faith. This primarily rested on two arguments: that those intent on making a vexatious complaint as a way of harassing or bullying a medical practitioner would be unlikely to be concerned by this requirement, and that some people with genuine complaints to make might be deterred by this additional requirement.

2.96 For example, AHPRA's Community Reference Group argued:

> … it should also be considered that many complainants may wonder whether it is worth the personal and reputational risk to report a bad experience of healthcare, and that any requirement for complainants to sign a declaration 'that their complaint is being made in good faith' may not deter vexatious complainants, but may deter genuine complainants.[77]

2.97 The Australian Nursing and Midwifery Federation (ANMF) also argued against this requirement, referring both to the unlikelihood of it deterring those intent on making a complaint for a vexatious reason and the probability that genuine complaints would be affected:

> Such a declaration would unlikely prevent unnecessary notifications being made, however, it has the potential to serve as a deterrent to practitioners who are making a valid complaint for fear that it could be determined 'vexatious' and that they may suffer some kind of professional retribution if the complaint is not proven. Therefore, the ANMF does not support the introduction of a requirement for a declaration to be made.[78]

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76 Health Care Consumers' Association, *Submission 16*, p. 11.

77 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 25.

78 Australian Nursing and Midwifery Federation, *Submission 99*, p. 5.

2.98 Similarly, the Ombudsman argued that the inclusion of such a provision would be unlikely to prevent the lodging of vexatious complaints:

> … requiring that people who lodge a notification sign a declaration that they are acting in good faith is not likely to reduce the number of notifications made or the incidence of possibly vexatious notifications.[79]

2.99 The AMA was also against the inclusion of this requirement, arguing that since a majority of notifications are made by other health practitioners, the introduction of such a requirement would be 'effectively challenging the professionalism of these people'.[80] Further, the AMA argued, it would be unlikely to improve the process in any other way:

> Given the relative transparency of the notifications process the AMA questions how the inclusion of this requirement would improve the information available to AHPRA in making its assessment or have any material impact on the result.[81]

2.100 RANZCP also noted the possible effects of this step in deterring genuine complainants, while noting that the National Law includes a provision for the protection of complainants from civil, criminal and administrative liability if their complaint is made in good faith:

> A potential complainant – whether patient or health practitioner – may already be anxious about lodging a complaint with AHPRA in addition to feeling detrimentally affected or aggravated by the behaviour they are seeking to complain about. Therefore, requiring complainants to take an additional step of having to sign a declaration that their complaint is being made in good faith may make complainants feel that their integrity or honesty is being questioned and, in fact, deter them from ultimately making a complaint to AHPRA.[82]

2.101 Likewise, the HCCA argued that such a requirement would constitute a significant barrier for consumers, already suffering a power imbalance when dealing with the health system and individual practitioners, should they want to make a complaint:

> The focus of policy and practice change in relation to medical complaints should be to reduce barriers to consumer complaints, and to support both complaints and feedback as opportunities for healthcare improvement. Introducing a requirement to sign a declaration would constitute a significant additional barrier to complaints-making and as a result should not be considered.[83]

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79 National Health Practitioner Ombudsman and Privacy Commissioner, *Submission 12*, p. 4.

80 Australian Medical Association, *Submission 9*, p. 5.

81 Australian Medical Association, *Submission 9*, p. 6.

82 Royal Australian and New Zealand College of Psychiatrists, *Submission 19*, p. 5.

83 Health Care Consumers' Association, *Submission 16*, p. 18.

2.102 There were exceptions, however, to this broad agreement. The main argument for the inclusion of a requirement of a declaration of good faith was that vexatious complaints can have a major and detrimental effect on a practitioner's career and life, and therefore every effort should be made to minimise their incidence.

2.103 The ACEM noted that all complaints have an effect on the practitioner, even those which are later deemed to have been made vexatiously:

> Complaints can be particularly damaging for those who have been cleared of the complaint made against them, since the allegations have previously been made visible on the AHPRA website during the complaints process. ACEM therefore considers it vital that complainants or notifiers sign a declaration that their complaint is being made in good faith, acknowledging the psychological, financial and career-related impacts that their complaint could have upon the individual.[84]

2.104 The ADA agreed that a 'good faith' declaration requirement may not dissuade potential vexatious complaints, and argued that instead 'it may be appropriate for complainants to have to make a payment when they lodge a complaint', or alternatively, requiring that vexatious complainants should be penalised.[85]

2.105 This latter position was echoed by other submitters, who – whether or not they supported the idea of a mandatory declaration of good faith – argued that those found to have made false complaints should be subject to prosecution or other penalties.

2.106 Professor John Stokes suggested an alternative approach. Instead of requiring complainants to sign a declaration or introducing a cost barrier, the proportion of vexatious complaints from fellow practitioners could be reduced by including an undertaking in the professional codes of conduct:

> I think it would be important to overcome the objection to signing by putting a statement into the salient code of conduct for medical practitioners, in both section 4 and section 8 of those documents. Section 4 concerns working with other health professionals and section 8 is on professional behaviour. So a simple statement in there that it is part of professional behaviour not to make vexatious complaints would make it unnecessary for a mandatory notification. The guidelines from AHPRA are extremely loose. You could drive a truck through them. Such a statement would stop that.[86]

2.107 A similar suggestion was made by some confidential submitters, who argued that independent Code of Conduct committees would be an appropriate way of handling all forms of bullying and harassment.

2.108 Strengthening the codes of conduct for the various specialities within the medical profession could therefore take the form of not just discouraging bullying and

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84 Australasian College of Emergency Medicine, *Submission 4*, p. 4.

85 Australian Dental Association, *Submission 6,* p. [5].

86 Professor John Stokes, *Committee Hansard*, 1 November 2016, p. 13.

harassment, but specifically prohibiting the vexatious lodgement of notifications against colleagues.

Committee view

2.109 The committee is concerned that there are not currently sufficient deterrents against practitioners lodging a complaint for vexatious reasons and for that reason agrees that professional codes of conduct should be strengthened in this regard. Further, the committee agrees that imposing penalties upon those found to have made vexatious complaints would be a further deterrent to this form of bullying and harassment.

Benchmarking

2.110 'Benchmarking' refers to the practice of comparing complication rates for a particular procedure across practitioners. The complication rate of an individual practitioner can then be compared to that of other similarly qualified practitioners as part of an investigation or audit.[87]

2.111 AHPRA confirmed that benchmarking of complication rates may occur as part of an investigation:

> Analysis of complication rates and benchmarking (including as part of a performance assessment) may assist the MBA and/or its delegates to make an informed judgement as to the level of risk posed by the practice of the medical practitioner and appropriate actions to be taken by the MBA.
>
> Benchmarking is a complex undertaking that must consider factors such as the speciality of the field of medical practice and the patient cohort involved. It is, therefore, important to note that where benchmarking is undertaken, AHPRA seeks the opinion of an independent expert and does not undertake its own benchmarking.[88]

2.112 Some confidential submitters support benchmarking on the basis, as discussed above, that the investigative teams lack the medical knowledge to make educated judgements. Other confidential submitters voice concern that accurate benchmarking is difficult to determine and suggest it should only be used when it will improve outcomes.

2.113 While arguing that more data and reporting would be useful, the HCCA noted that there is a 'fundamental problem' with increased benchmarking:

> … the paucity of relevant and useful data in most areas of medicine upon which to base this kind of benchmarking data. While there are specialised registries in a limited number of areas, for example joint prostheses and

87 See: Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 10.

88 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 10.

> neo-natal intensive care, the capacity to produce benchmarks that are clinically meaningful across healthcare is at present very limited.[89]

2.114 The ACEM also noted that figures are not currently comprehensive enough for benchmarking to be meaningful.[90]

2.115 The AMA argued that a potential disadvantage of increased use of benchmarking might be to influence how practitioners treat patients, with an over-emphasis on concerns about benchmarking data:

> Benchmarking can be complex and lead to perverse outcomes such as providing a disincentive for doctors to try new treatments, or self-protective practices such as not performing higher risk procedures because of the potential effect on outcome measures.[91]

2.116 ANZCA also expressed concerns with the use of outcome data to benchmark complication rates, and made several points against the practice. ANZCA argued that the data at an individual level misrepresents the team-based nature of much of medical practice; may contribute to competitiveness and a lack of support between colleagues if they are overly concerned with individualised benchmarking data; and further often lacks the context necessary, since no two patients have identical experiences either before or after the medical intervention.[92]

2.117 The ADA made a similar point regarding the variability of procedures and the complexity that creates in benchmarking data:

> For example, any benchmarking of outcomes, regardless of the 'sameness' of the procedure, will need to consider the impact of practitioner ability and care as much as:
>
> - how easy or difficult the patient is to treat (behavioural concerns);
> - the complexity of the presentation case despite the procedure. It is often the case for example that specialists do more complicated cases, but the procedure is still classified the same;
> - the patient's particular medical history;
> - compliance with post-operative instructions on the part of the patient/family/carer;
> - compliance with post-operative instructions on the part of the health care facility (for in-patient procedures); and
> - the general quality of assistance available to the operator and patient at the time of the procedure and thereafter.[93]

89 Health Care Consumers' Association, *Submission 16*, p. 17.

90 Australasian College of Emergency Medicine, *Submission 4*, p. 4.

91 Australian Medical Association, *Submission 9*, p. 5.

92 Australian and New Zealand College of Anaesthetists, *Submission 5*, pp [4–5].

93 Australian Dental Association, *Submission 6*, p. [4].

Professional and personal consequences of investigations

2.118 Submitters note significant professional consequences from being investigated, where even minor findings against them have left a permanent mark on their record, affecting their employability. Submitters discussed the difficulty in applying for positions when it is standard practice to ask if the applicant has received a notification from AHPRA and noted that their employability has been negatively impacted by having an official record for 'trivial matters'.

2.119 Almost all confidential submitters who have been investigated by AHPRA discussed the personal toll of the stress incurred as a result of the investigations.

2.120 Professor John Stokes expanded on this and discussed the toll that being the subject of a vexatious complaint and subsequent AHPRA investigation can have on practitioners:

> Many practitioners are dissatisfied with the mechanism. That is because of the significant unintended consequences of vexatious reporting, which causes practitioner illness. It also causes severe financial hardship and, in a number of cases that we know about, has caused the suicide of very good doctors.[94]

2.121 Dr Gary Fettke also emphasised the wide-ranging effects of having a complaint made against him and an investigation launched:

> It has changed me as a person. I think we all go into medicine for all the right reasons: to try and make a difference. When you try and make that difference and you are hammered not only by your institution but then in the wider community, it changes you. I am more defensive about what I say to my patients. When you are under investigation, particularly for a vexatious claim, you think, 'Actually, I've done nothing wrong here; I'm helping people.' It becomes all-consuming. You lose sleep. My wife and I spend hours beyond normal work hours trying to sort this out. It has affected our children with a combination of anxiety, depression and becoming more introverted. What should be a pleasant experience of helping people is now something you question every day: 'Why do I keep doing this?'[95]

Committee view

2.122 The committee notes the large number of personal accounts it received from, or on behalf of, medical practitioners whose lives and careers had suffered as a consequence of a complaint made against them. Patient safety and an open medical complaints process cannot be compromised, and the committee is deeply concerned by the evidence it has received which suggests that these may have been misused for the sake of bullying and harassing medical practitioners.

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94 Professor John Stokes, *Committee Hansard*, 1 November 2016, p. 13.

95 Dr Gary Fettke, *Committee Hansard*, 1 November 2016, p. 21.

Conclusion and committee view

2.123 Patient safety is of paramount importance in the medical profession, and for that reason it is vital that all Australians can trust that concerns about individual practitioners are taken seriously. As such, supporting a robust medical complaints system that takes appropriate action to ensure public safety is a central responsibility of the body created to administer the National Registration and Accreditation Scheme.

2.124 Equally, however, it is important that the process is trusted by medical practitioners themselves and is used only for its purpose of protecting public safety. It is clear that in this regard, Australia's medical complaints process does not have the complete confidence of sections of Australia's medical profession. As this committee has heard, AHPRA's notification and investigation process is vulnerable to misuse by individuals. Medical professionals have identified that lodging a notification against a colleague or competitor can serve as a tool of bullying and harassment.

2.125 While it is difficult to establish the prevalence of this practice, and noting the statistics on notifications which suggest it is relatively rare, the committee is nonetheless deeply concerned about this form of bullying and harassment. As many of the medical practitioners who made submissions to this inquiry noted, the toll on any individual can be very high. Furthermore, concerns which undermine any aspect of Australia's medical complaints process will have a negative effect on the integrity of the entire system and can serve to decrease public safety.

2.126 The committee has also received evidence that, in addition to the possibility of using the medical complaints process as a tool of bullying and harassment, other concerns with the complaints process exist. These concerns are explored in chapter 4.