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20 February 2017

Ms Jeanette Radcliffe
Committee Secretary
Senate Standing Committee on Community Affairs

Via online submission and email: community.affairs.sen@aph.gov.au

Dear Ms Radcliffe

**MIGA submission – Inquiry into the complaints mechanism administered under the
Health Practitioner Regulation National Law**

Thank you for your letter dated 15 December 2016.

MIGA welcomes the opportunity to provide a submission to the Committee's Inquiry into the complaints mechanism administered under the *Health Practitioner Regulation National Law*.

A copy of MIGA's submission is enclosed. The submission follows, and can be read in conjunction with, its submission to the Committee's recent inquiry into the medical complaints process in Australia.

As a medical defence organisation and medical indemnity insurer advising, assisting and educating medical practitioners, medical students, health care organisations and privately practising midwives throughout Australia in relation to complaints made under the National Law, MIGA has particular interest in, and significant contribution to make, to the issues raised by the Inquiry.

If either you or the Committee have any questions about MIGA's submission or require further information please contact me.

MIGA looks forward to engaging further on these issues.

Yours sincerely

Timothy Bowen
Senior Solicitor – Advocacy, Claims & Education



MIGA submission

Senate Standing Committee on Community Affairs References Committee

Inquiry into the complaints mechanism administered under the Health Practitioner Regulation National Law

February 2017

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MIGA submission

Senate Standing Committee on Community Affairs

Health Practitioner Regulation National Law Complaints Inquiry

February 2017

Executive Summary

1. As a medical defence organisation and medical indemnity insurer, MIGA is a significant stakeholder in the Australian health care complaints system and the provision of health care in Australia more generally.
2. Australia has well-intentioned and workable framework for health care complaints set up under the *Health Practitioner Regulation National Law* (**the National Law complaints system**).
3. There is scope for considerable improvement to the National Law complaints system around the following areas:
 - **culture / perception** – addressing the level of distrust and lack of confidence held by parts of the health care profession in regulators and complaint bodies, by working towards a system which all stakeholders see as dealing with complaints and notifications in a fair, appropriate and timely manner– key steps include reviewing each of the aims of the National Law complaints system, regulator and complaint body skill sets and their interactions with stakeholders, and professional and community education around regulator and complaint body roles and responsibilities
 - **national consistency** – the National Law complaints system operates differently in various Australian states and territories – without trying to adopt or support any one particular model, it is important to work out what works best in each model, and introduce it across Australia as far as possible and practical
 - **improving processes, consideration and outcomes** – through close examination of issues around complaint and notification assessment, investigation, consideration and determination, performance and health issues, and disciplinary processes and outcomes, to:
 - determine how complaints and notifications are best handled in a fair, appropriate and timely manner
 - assess how their outcomes contribute to the provision of health care
 - allow regulators to be responsive to their obligations to ensure public safety and to uphold professional standards
4. MIGA acknowledges that significant improvements have already been made to the National Law complaint system in the relatively short time since its introduction. The system has the capacity to be a world leader. This inquiry provides an important opportunity to examine closely where the system is at, where it should be and what needs to be done to achieve those aims.

MIGA's interest

5. MIGA is a medical defence organisation and medical indemnity insurer with a national footprint offering a range of insurance products and associated services to the health care profession across Australia.
6. It has represented the interests of the medical profession for more than 115 years.
7. Its members and policy holders include significant numbers of medical practitioners, health care companies, privately practising midwives and medical students working across a broad range of specialties and contexts in the Australian health care system.
8. MIGA's lawyers regularly advise and assist medical practitioners in responding to complaints and other issues involving the Medical Board of Australia (**the Board**), the Australian Health Practitioner Regulation Agency (**AHPRA**) and various state-based health complaint entities.
9. Its risk management and education program for its members and policy holders has a focus on understanding and minimising the causes of patient complaints.
10. MIGA has recently contributed to the Queensland Parliamentary inquiry into the performance of the Queensland Health Ombudsman's functions, which focuses on the health complaints system in that jurisdiction.

Culture and perception

11. In MIGA's experience, there is a significant level of distrust and lack of confidence amongst health care stakeholders and professionals in the National Law complaints system. It accepts that such distrust and lack of confidence is not always justified.
12. The aim of the National Law complaints system itself, and those working within it, is to deal with complaints and notifications in a fair, timely and appropriate manner.
13. Although the necessary framework and intent are present, it is the execution and implementation which can sometimes be found wanting.
14. The key issues which MIGA sees around culture and perception for the National Law complaints system are set out below.

(a) Perceptions of complaints and roles of various bodies

15. The National Law complaints system deals with each of:
 - patient dissatisfaction about their experience of health care
 - issues around the conduct, performance and health of health practitioners

16. Sometimes complaints and notifications involve both of these issues, but there are also times they involve dissatisfaction only, with nothing to bring the conduct, performance or health of a practitioner into question.
17. From the perspective of the health profession, it can sometimes seem that undue emphasis is placed on patient expectations, which can then be seen as suggestive of, or inferring, issues around a health practitioner's conduct, performance and / or health.
18. MIGA questions whether this issue arises out of the often broad scope in which health complaints entities can operate in various Australian states and territories.
19. Whilst AHPRA and the professional boards and councils have a clear focus on public protection and professional standards, the focus of health complaints entities can be broader, and extend to issues such as patient satisfaction and broader health policy considerations such as access, interactions, transparency and rights. To that extent, they can sometimes appear to be bodies dealing more with 'consumer satisfaction' than issues around the provision of health care.
20. MIGA does not suggest health complaints entities should not have different roles to AHPRA and the professional boards and councils. However, these entities interact and consult with AHPRA and the professional boards and councils to varying degrees, and in some jurisdictions have the 'casting vote' on how to handle a complaint or notification. Given the focus of these entities and their interactions with other regulatory bodies, it questions whether their multiplicity of roles can unintentionally influence how complaints and notifications are dealt with, particularly the degree of significance and action afforded to them.
21. MIGA recognises that health complaints entities do encourage direct resolution of complaints with health practitioners and organisations in various circumstances, and provide mechanisms for alternative dispute resolution. It believes there may be greater scope for these entities to focus on those functions. In addition, it considers they should look at how they may be able to more clearly separate, both in professional and community perceptions and in reality, their roles:
 - as 'honest brokers' of complaints not raising issues of practitioner performance, conduct or health
 - in liaising and consulting with AHPRA and the professional boards and councils in matters that do involve practitioner performance, conduct or health issues

This would include clarification of the aims of those entities in legislation, and clearer separation of complaints resolution functions on the one hand, and assessment, consultation and prosecution of complaints warranting a regulatory response, on the other.
22. Clearer and concise professional and community education on the roles of AHPRA, professional Boards and Councils, and health complaint entities may also be helpful.

(b) Timeframe parity

23. The time given to health practitioners to respond to complaints and notifications on one hand, and the time taken by each AHPRA, professional boards and councils, and health complaint entities on the other hand to deal with them, can be significantly unbalanced.
24. For example:
- a practitioner often face timeframes of between 7 and 21 days to respond to an initial complaint, whereas the responsible body has 60 days or more to deal with it – in reality this can take significantly longer
 - at the investigation stage, opportunities of between 14 to 28 days to respond are usually given to practitioners, but investigations themselves may take 1 to 2 years. This often occurs with no feedback to the practitioner regarding the progress of the investigation as required by the National Law
 - if a disciplinary prosecution occurs in a tribunal, practitioners can often face relatively short timeframes of between 4 and 6 weeks to respond to a prosecution case of significant complexity, whereas the prosecutorial body often has had many months or even a year or more to gather its evidence
25. MIGA questions whether a focus on meeting legislative timeframes and key performance indicators is contributing to timeframe disparity between opportunities for practitioners to respond on the one hand, and assessment, investigatory and prosecutorial processes on the other.
26. Greater scope to provide further time as fair and appropriate in circumstances of an individual case would be welcome. In addition, a focus on ensuring better parity of timeframes between expectations on practitioners to respond, and regulatory or other bodies to act, is warranted.

(c) Stakeholder engagement

27. There can be limited meaningful opportunities for stakeholder engagement with regulators and other bodies involved in the National Law complaints system.
28. Significant steps that have been taken towards better stakeholder engagement by each of AHPRA, the Medical Board of Australia and a number of state or territory professional boards and councils, and health complaint entities. However, the steps taken and efforts made have not been consistent across all relevant entities.
29. Of particular concern is the considerably less stakeholder engagement evinced by some health complaint entities.
30. MIGA acknowledges the concerns expressed by certain entities, particularly the Office of the Health Ombudsman (OHO) in Queensland, about perceptions of bias and the need to ensure independence. However, it believes meaningful stakeholder engagement can be achieved so

long as there is balanced opportunities for input from a variety of governmental, professional and community perspectives.

31. There is a need for focused efforts on the part of all regulatory and other bodies in the National Law complaints system, working in conjunction with professional and community stakeholders, to assess where ongoing consultation is helpful and appropriate.

(d) Clinical and investigatory perspectives

32. MIGA perceives a tension between those whose expertise is investigatory, and those whose expertise is clinical, within the health care complaints system.
33. Significant decisions are often made by, or in consultation with, clinical expertise. However, much of the system is driven by those with investigatory expertise, who often lack clinical experience or significant understanding of the Australian health care system.
34. Placement of clinical expertise at significant decision making points is critical and ensures balance within the National Law complaints system. However, in reality it is the investigatory perspectives which for the most part determine information to be put forward for consideration, and influence the way in which that information is interpreted.
35. MIGA acknowledges the committed and thorough work undertaken by those with investigatory expertise within the National Law complaints system. However, it is concerned that by its dominance and nature it can lead to an inquisitorial or prosecutorial approach instead of a clinical and professional regulatory approach. It is the latter approach which is preferable, is the aim of AHPRA and the professional boards and councils, and which is sought by the health care profession.
36. A review of the extent to which there is an appropriate balance between clinical and investigatory expertise within the National Law complaints system is required. It may be that this is best achieved through a variety of mechanisms, including rigorous research, qualitative review and targeted consultation with key stakeholders.

(e) Effect on practitioners involved in the health complaints system

37. MIGA's focus on doctors' health has shown it the significant and sometimes devastating effect that one or more complaints or notifications can have on a practitioner's personal health and well-being.
38. It recognises and commends the efforts of the Medical Board of Australia and other professional stakeholders to establish and support doctors' health services.
39. MIGA itself provides a variety of education and practical supports in the field of doctors' health.¹

¹ Such as its Doctors' health e-book, membership incentives for undertaking a health check, and practitioners' support services for doctors facing complaints or claims, involving medical and peer support - www.miga.com.au/content.aspx?e=209

40. It is time to focus on how the National Law complaints system itself can be triggers for such problems, particularly through perception and process. This can be achieved through using available information and experiences about the effects that complaints and notifications can have on health practitioners to inform where communications and processes can be improved to reduce the risk of such problems, whilst still preserving the integrity of the system.

National consistency

41. There is a *Health Practitioner Regulation National Law* in place in each Australian state and territory which provides for a system of complaints and other notifications.
42. The National Law complaints system also involves health complaint entities in each state and territory, established under separate legislation in those jurisdictions. These bodies interact to various degrees and in different ways with AHPRA, professional boards and councils.
43. Both New South Wales and Queensland have a 'co-regulatory' approach, different to that elsewhere in Australia. This provides a greater role for health complaint entities in assessment, investigation and prosecution.
44. Even within those two states, there are also significant differences between the roles of their health complaint entities. For example, consultation between professional councils and the Health Care Complaints Commission (HCCC) in New South Wales takes on more a collaborative model than that between equivalent bodies in Queensland, namely the professional boards and the OHO, which is more about informing different bodies of actions taken.
45. In New South Wales, matters involving a practitioner's professional performance, conduct or health not warranting disciplinary prosecution can managed quite differently than elsewhere in Australia.
46. For instance, throughout most of Australia matters involving departures from expected professional standards are dealt with by way of investigation and caution if required. By contrast, in New South Wales such matters are often dealt with via peer counselling and, if required, by either performance assessment or less formal hearings. Although the scope for performance assessment exists elsewhere in Australia, in MIGA's experience it tends to be used as an investigatory, rather than a performance improvement or educative, tool.
47. A further example is the different ways in which matters involving a practitioner's health are dealt with in New South Wales as compared with the rest of Australia.
48. Throughout Australia there are provisions under the National Law for dealing with health matters not warranting prosecution. However, in New South Wales the Medical Council has a well-developed health program, which has operated for almost 25 years, involving what MIGA sees as a better designed and more supportive process. It involves professional assessment, hearings and counselling. Whilst this program can be confronting for the practitioner involved, it is generally more supportive and helpful than the processes elsewhere in Australia. By contrast, these other processes provide for health assessment and the debriefing by the assessor, which could then lead to conditions on practice, but with much more limited support or other review mechanisms in place.

49. There has been considerable debate over whether a uniform approach towards health care complaints handling is warranted, including:

- whether AHPRA and the professional boards and councils should alone be responsible for the National Law complaints system
- what the roles of health complaints entities should be, particularly whether they should be focused on dealing with so-called 'consumer' issues involving patient satisfaction only
- how matters involving professional performance, conduct or health not warranting a disciplinary response should be dealt with
- whether a co-regulatory model as in New South Wales or Queensland should be adopted

50. Instead, MIGA believes that the focus should be on working out what are the best aspects of practice in different parties of Australia, and applying them where appropriate elsewhere. It is not necessary for there to be a uniform or even particular type of model to achieve this aim, and only relatively limited legislative amendment may be required.

51. Issues which MIGA believe warrant consideration for broader implementation include:

- types of complaints or notification which are best dealt with by professional boards / councils, and those best dealt with by health complaints entities
- adopting best practice consultation methods between professional boards and councils on the one hand, health complaints entities on the other, about dealing with complaints and notifications
- adopting best practice models for ensuring appropriate and timely clinical input at various stages of assessment, investigation and decision-making
- uniform and realistic timeframes for responses
- parity of timeframes within assessment, investigation and prosecution processes
- best practice ways of communicating with health practitioners, which themselves acknowledge the significant effects that these processes can have on practitioner health
- consideration to introducing a similar process to the NSW Medical Council performance program in other jurisdictions, with a view to reducing the use of cautions in performance matters and to make a more meaningful contribution to an individual practitioner's practice and development
- consideration to of introducing a similar process to the NSW Medical Council health program in other jurisdictions, given the level of support, oversight, protection and benefits it can offer to practitioners

Improving processes, consideration and outcomes

52. A number of the issues which warrant review and change in terms of improving processes, consideration and outcomes have already been outlined in this submission, including around timeframes, clinical involvement, consultation, performance and health matters.
53. Below a number of further matters warranting review and change are detailed.

(a) Natural justice and procedural fairness

54. Procedural fairness and natural justice are critical components of any complaints process.
55. Although the overriding focus of the National Law complaints system is, and should be, on protection of the public, this does not exclude the operation of procedural fairness and natural justice. It would only be in a limited number of circumstances in which protection of the public would not allow procedural fairness to operate.
56. At common law, the National Law complaints system is governed by procedural fairness as it features powers to adversely affect health practitioner's rights, interests and legitimate expectations.
57. Importantly, it appears to be common ground amongst National Law complaints system bodies that they are subject to considerations of procedural fairness.
58. MIGA acknowledges that:
- the National Law itself and various state and territory legislation enacting health complaints entities contain obligations and requirements consistent with procedural fairness
 - bodies within the system operate with a view to considering procedural fairness
59. The difficulty arises in determining what constitutes procedural fairness in a particular case. This can never be determined definitively, but more can be done to ensure procedural fairness operates appropriately wherever possible and practical.
60. The term procedural fairness is mentioned only in the New South Wales version of the National Law in relation to the joinder of complaints in Tribunal proceedings (s 165D). The similar term of 'natural justice' is only used in the National Law in other states and territories in relation to health panel procedures (s 185).
61. In legislation enacting health complaint entities, it is only Victoria, South Australia, Tasmania and the Northern Territory which provide overriding requirements for bodies to act in accordance

with considerations of procedural fairness or natural justice.² By contrast, these obligations are restricted to the certain exercise of functions in New South Wales,³ Victoria⁴ and Queensland.⁵

62. It is important that considerations of procedural fairness be forefront of the exercise of all powers and functions in the National Law complaints system. The best way to ensure this is to provide for overriding considerations of procedural fairness in legislation and practice.

63. MIGA proposes:

- inclusion of an explicit requirement of procedural fairness in the objects of the National Law
- outlining of the requirements of procedural fairness, put in their appropriate context with other considerations of public protection, upholding professional standards and maintaining public confidence, in the regulatory principles for AHPRA and the professional boards
- Australian states and territories should work towards having consistent reference to the requirements of procedural fairness in legislation enacting health complaints entities
- all bodies operating within the National Law complaints system should have clearly developed, and publicly available, policies on the application of procedural fairness in particular situations, where already not developed under the National Law or otherwise – these would benefit from input by professional and community interests

(b) Dealing with vexatious and frivolous complaints

64. In its submission to the Committee's Inquiry into the medical complaints process last year, MIGA outlined various issues around the operation of the National Law in relation to vexatious complaints involving elements bullying and harassment, particularly around professional culture and expertise, mandatory reporting, and both experience and perspectives of those involved in the complaints handling process.

65. As indicated in MIGA's earlier submission:

- the requirements in relation to making a mandatory notification based on significant departure from professional practice are not well understood, and AHPRA guidelines on this topic are not well known
- it has reservations about the expertise, experience and perspectives of those assessing complaints, particularly those who are not health professionals or lawyers working the area - it takes training and time for a health professional, lawyer or other professional involved in assessing complaints to develop judgement and experience to make good decisions (these issues are explored in further detail more generally above)

² See *Health and Community Services Complaints Act 2004* (SA) s 84; *Health Complaints Act 1995* (Tas) s 74 and *Health and Community Services Complaints Act* (NT) s 85

³ *Health Care Complaints Act 1993* (NSW) ss 16, 28 and 28A

⁴ *Health Complaints Act 2016* (Vic), s 59

⁵ *Health Ombudsman Act 2013* (Qld) ss 154 and 243

- it recommended consideration be given to the underlying training and experience required for those involved in the complaints handling process, both for employees of various bodies within the complaints system and those who serve on committees assessing complaints
66. The National Law and legislation enacting health complaints entities in various states and territories have frameworks to allow for frivolous or vexatious complaints to be dismissed. However, there needs to be a focus on whether those assessing complaints have the necessary experience and expertise to determine when complaints fall within this category.
67. MIGA acknowledges that there will always be complaints which are perceived by a health practitioner to be frivolous or vexatious, but which on an objective consideration are not within that category. However, it continues to see complaints which health practitioners are being asked to respond to which appear frivolous or vexatious, particularly given the nature of the complaint, its tenor or its inherent logic.
68. MIGA welcomes AHPRA's commissioning of research on vexatious complaints.
69. Given the Committee's concern in the earlier inquiry that AHPRA's processes may not be sufficient to identify vexatious complaints, it questions whether there should be further training for those involved in assessing complaints, and policies and procedures around dealing with complaints suspected to be frivolous or vexatious, such as through seeking further clinical input.

(c) Consistency in decision making and outcomes

70. In different Australian jurisdictions, or even in the same jurisdiction, there can sometimes be apparent inconsistencies between the decisions or outcomes in similar circumstances.
71. MIGA welcomes regulator reliance on appropriate clinical advice in reaching such decisions.
72. However, a clinical opinion does not necessarily determine the outcome, i.e. a sanction or conditions imposed. In addition, it will not necessarily be consistent in similar circumstances given the different views which can arise amongst practitioners in the same profession.
73. Although tribunal decisions involving disciplinary cases are published, this is only a very small sub-set of decisions and outcomes in the National Law complaints system. Many decisions and outcomes, particularly those where serious disciplinary action is not pursued and not publicly available. It is entirely appropriate, and necessary, that such decisions and outcomes remain confidential.
74. With a view towards consistency in decision-making and outcomes, there may be benefit in yearly publication of summaries in major specialties of issues that regulators have encountered over that year, and its response to them. Some of this does already take place through AHPRA, professional board and council newsletters, but in an inconsistent and piecemeal manner.
75. A clearer indication of regulator views on practices within particular specialities, kept at a general level and de-identified to ensure individual patients and practitioners cannot be identified, would be helpful in ensuring consistency in the system and in standards expected in the provision of health care more generally.

(d) Self-incrimination and use of evidence in other contexts

76. The limited availability of protections against self-incrimination and use of evidence in other contexts under the National Law is of considerable concern.
77. Although there are legislative and common law protections against self-incrimination, these are generally confined to court or tribunal proceedings. They do not usually apply to the provision of information, whether by written response, in the context of a board or council hearing or interview, or otherwise.
78. A practitioner can be left in the situation of having to choose between:
- providing information in the context of a health care complaint, but putting themselves at risk of sanction or proceedings in another context, or
 - declining to provide information to a health care complaint, but facing consequences which may not have occurred if the information could have been provided with appropriate protections against use elsewhere
79. Examples of these situations include:
- allegations of criminal conduct against a health practitioner
 - situations of clinical management where a health practitioner may be subject to a civil penalty, such as breaches of poisons legislation governing the medication prescription in various states and territories
 - use of material in subsequent civil damages claims
80. Given the interest of the National Law complaints system in protecting the public, and ensuring appropriate professional standards and public confidence, there is an interest in providing scope for full and frank information to be provided by practitioners. Considerations of procedural fairness suggests that protections similar to those available in a court or tribunal context should also be available in each of the assessment and investigatory contexts, and in professional board or council hearings and interviews.
81. MIGA supports appropriate protections against self-incrimination and the use in other contexts of evidence or other information provided by or on behalf of a health practitioner in respect of a complaint or other notification in the National Law complaints system.

(e) Treating practitioner mandatory reporting

82. Under the National Law, health practitioners who form a reasonable belief that another practitioner has placed the public at risk of substantial harm because of an impairment are required to make a mandatory notification to AHPRA (or in Queensland to the OHO).

83. Western Australian practitioners are not required to make a mandatory notification where their belief is formed in the course of providing health services to a health practitioner. This is often referred to as the treating practitioner exclusion.
84. Although there Queensland practitioners are excused from making a mandatory notification in relation to impairment in certain circumstances, this is when it is not thought the impairment would place the public at risk of substantial harm. Given the threshold for reporting is substantial harm under the National Law, this does not seem to be a meaningful exception.
85. Considerable attention has been given in recent times to whether the treating practitioner exemption should be implemented throughout Australia.
86. Its implementation was recommended as part of the 2014 Independent Review of the National Registration and Accreditation Scheme for Health Professionals. However, Australian health ministers deferred this recommendation pending further research. Since that time, 18 months have elapsed. The support amongst professional stakeholders for implementation of the treating practitioner exemption throughout Australia and consistent and striking.
87. MIGA has considered recent research published in the *British Medical Journal* on reporting of impaired health practitioners by treating practitioners.⁶
88. MIGA supports a number of the conclusions of that research, namely to:
- make greater efforts to educate practitioners about the scope of their duty under the law – as mentioned above and in MIGA’s submission to the Committee’s earlier inquiry, mandatory reporting obligations are not well understood and the AHPRA mandatory reporting guide not well-known – this education should be available in a variety of forms of platforms, including using interactive decision-making tools and apps
 - changing the reporting duty to exclude practitioners who voluntarily participate in an agreed treatment plan and take the necessary steps to protect patients from harm – although MIGA acknowledges the authors’ observation that the Medical Board of Australia does not see the reporting threshold triggered in situations where a practitioner is compliant with treatment and any risk to the public has been appropriately managed, it does not believe this has been well expressed in legislation or in the AHPRA guide - legislative clarification is warranted
 - various stakeholders, including regulators, practitioner health programmes, educators, insurers (such as MIGA) and professional bodies working together to ensure that mandatory reports result in a fair, sensitive and timely response – in particular, as set out above MIGA supports consideration being given to the implementation of the NSW Medical Council health program throughout Australia, and funding being given to research into the experiences of treating practitioners and their patient practitioners who are the subject of a mandatory report

⁶ Bismark MM Matthews B Morris JM, et al, views on mandatory reporting of impaired health practitioners by their treating practitioners: A qualitative study from Australia *BMJ Open* 2016;6:e011988. – Available at bmjopen.bmj.com/content/6/12/e011988.full