AHPRA

Aboriginal and Torres Strait Islander health practice
Chinese medicine
Chiropractic
Dental
Medical
Medical radiation practice
Nursing and Midwifery
Occupational therapy
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

Australian Health Practitioner Regulation Agency

10 March 2017

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

By email: community.affairs.sen@aph.gov.au

Dear Committee Secretary

to the Senate Inquiry: Complaints mechanism administered under the Health Practitioner Regulation National Law

Thank you for the opportunity to provide feedback to the Committee on the complaints mechanism administered under the Health Practitioner Regulation National Law.

AHPRA established a Community Reference Group (CRG), which had its first meeting in June 2013, to work with AHPRA and the National Boards. This is the first time a national group of this kind, with a focus on health practitioner regulation, has been established in Australia.

The CRG has a number of duties, including providing feedback, information and advice on strategies for building better knowledge in the community about health practitioner regulation, as well as advising AHPRA on how to better understand, and most importantly, meet, community needs.

While the group is a conduit between communities and AHPRA/National Boards, it is not representative of particular communities. Rather, members of the group represent only themselves and share their opinions as individuals.

Please find the CRG submission in response to the Terms of Reference of the Inquiry attached.

Please contact me via email [redacted], if you would like any further information.

Kind regards

Mark Bodycoat

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Senate inquiry: Complaints mechanism administered under the Health Practitioner Regulation National Law

14 March 2017

Submission by the Community Reference Group to the Senate Community Affairs References Committee

Introduction

The Community Reference Group thanks the Committee for the opportunity to respond to this Inquiry and is available for further comment if required.

The CRG is also aware that the Australian Health Practitioner Regulation Agency and the Medical Board of Australia are providing a response to the Inquiry and will incorporate detailed information about complaint handling and the structure of complaint handling mechanisms under the Health Practitioner Regulation National Law. While the CRG wishes its submission to be treated independently from that made by AHPRA and the Medical Board, it nevertheless lends its support to the description of the National Registration and Accreditation Scheme and of complaint handling under that scheme.

Structure and Purpose of the Community Reference Group

In 2013, the Australian Health Practitioner Regulation Agency (AHPRA) established a Community Reference Group (CRG). Its first meeting was in June of the same year. The intent behind the creation of the CRG was to establish a body that could work with AHPRA and the National Boards that made up the National Registration and Accreditation Scheme (National Scheme) through a variety of initiatives and secure the ability to get community views and feedback in connection with those. This was the first time a national group of this kind, with a focus on health practitioner regulation, had been established in Australia.

The CRG has a number of roles, including providing feedback, information and advice on strategies for building better knowledge in the community about health practitioner regulation, but also advising AHPRA on how to better understand, and most importantly, meet, community needs. Its roles and responsibilities are set out in more detail in its terms of reference, a copy of which is at Attachment A to this submission.

While the CRG is a conduit between communities and AHPRA/National Boards, it is not representative of particular communities. Rather, members of the group bring a variety of experience and expertise as individual and independent community members. They represent only themselves and share their opinions as individuals.

Members are listed on the Community Reference Group Members page on the AHPRA website. Communiqués from CRG meetings are published on the Communiqués page.

The CRG has contributed to and provided feedback on a substantial range of AHPRA and National Board initiatives since its establishment, and is considered to play the important role of 'critical friend' in the development of AHPRA and Board projects. It is regularly consulted on the development and revision of codes of conduct and ethics, and on standards and guidelines under the National Law. It is an ongoing

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contributor and point of consultation in the development and refinement of publicly-focused processes and initiatives, including particularly the notifications process. Since its establishment, the CRG has attracted strong support from National Boards for its consultative inputs and has begun to attract interest from outside the National Scheme.

In preparing this submission the CRG sought individual input from each of its members. Their feedback is presented as general comment and in direct response to the Inquiry's Terms of Reference:

a. the implementation of the current complaints system under the National Law, including the role of the Australian Health Practitioner Regulation Agency (AHPRA) and the National Boards;

b. whether the existing regulatory framework, established by the National Law, contains adequate provision for addressing medical complaints;

c. the roles of AHPRA, the National Boards and professional organisations, such as the various Colleges, in addressing concerns within the medical profession with the complaints process;

d. the adequacy of the relationships between those bodies responsible for handling complaints;

e. whether amendments to the National Law, in relation to the complaints handling process, are required; and

f. other improvements that could assist in a fairer, quicker and more effective medical complaints process.

General Comment

The regulation of health professionals in the National Scheme is undertaken in accordance with the provisions of the Health Practitioner Regulation National Law (National Law) as in force in the various Australian jurisdictions. The fundamental objectives and guiding principles of the National Scheme are set out in section 3 of the National Law. Significant among these is the objective of providing for the protection of the public (section 3(2)(a)). In Queensland, these objectives and guiding principles are made more explicit by the addition of section 3A, which is in the following terms:

> *'The main principle for administering this Act is that the health and safety of the public are paramount.'*

Given the objectives and guiding principles set out in the National Law, there is a balance that is required between the needs of health practitioners and those of health consumers. The CRG is therefore concerned that the Terms of Reference of this inquiry do not explicitly reference 'health consumers' or 'public safety', but do explicitly reference a desire to investigate whether the concerns within the medical profession with the complaints process (Terms of Reference, clause c) are being addressed.

In the circumstances, the CRG is concerned that the Committee will receive more representations from health practitioners than from concerned health consumers, given both the content of the Terms of Reference and the limited level of resources available to health consumers, such consumers' knowledge of the complaints process, and their ability to advocate their points of view. The CRG urges the Committee to consider the issue of complaints against health practitioners in a balanced way, with full cognisance of the legitimate interests of health consumers, and of the principles behind the legislation that seek to protect public safety.

The Committee is also encouraged to recognise and, to the greatest practicable extent, investigate the under-reporting of serious complaints. There are many factors preventing the public and health practitioners from raising concerns about poorly-performing health practitioners. The CRG also has concerns that this in itself is a substantial impediment to achieving the objectives of the National Law.

The CRG further urges the Committee not to confuse the need to improve the way complaints are handled once they are received, with the need to reduce the number of complaints received in the first instance by imposing obstacles on potential complainants. The CRG is concerned by people and entities expressing concerns about the medical complaints system in Australia, speaking of poor treatment by complaints entities, and poor processes carried out by these entities, and then proposing that the solution is to discourage or punish complainants. Discouraging people from lodging complaints may or may not reduce

the instances of bad-faith complaints, but will almost certainly risk reducing protection for public safety by reducing the rate of well-founded complaints. On the other hand, improving the way in which complaints are handled once they are received has the potential to reduce the impact of bad-faith complaints while also furthering public safety by allowing more timely and effective action based on well-founded complaints.

Comment in response to the Terms of Reference

Given the insight fellow health practitioners have into the nature of their work and what constitutes good practice, it is important that health practitioners are involved in the complaints process, which has important components of peer review, and in assessing complaints made against other health practitioners. However, it would be extremely concerning for health consumers if only health practitioners were responsible for that review. The involvement in the complaints process of AHPRA staff, community representatives on health practitioner Boards, and the state-based Health Complaints Entities brings essential perspectives to the consideration of complaints about health professionals and is vital in ensuring complaints outcomes are in line with public expectations and the objectives of the National Law. Some further insight into the risks of not including these perspectives may be gained from considering the circumstances and impacts of two major and high-profile matters from the past:

- The 1980's Chelmsford Hospital 'Deep Sleep Therapy' ignited great public concern and commitment from state governments to introduce greater independent oversight of health practitioners.[1]

- deaths linked with Dr Patel in Queensland contributed to the impetus to set up a national registration and accreditation scheme, with national and state-based Health Practitioner Boards deciding on matters which AHPRA staff had investigated.

The role of non-practitioners on Health Practitioner Boards was also secured with the National Law specifying each Board must comprise a minimum number of 'community members'.

The involvement of non-practitioners in the registration and accreditation of health practitioners helps to ensure there is balance in the consideration of complaints, and that outcomes address and reflect community expectations. The recent consultation by the Australian Medical Board into the issue of medical practitioners and 'revalidation', for example, has provided survey research demonstrating the contrasting views between the standards which the public expect medical practitioners to meet to maintain their registration, and the standards medical practitioners expect.

Reports from people with 'eyes on the ground', including members of the public and patients, help healthcare regulation systems to function effectively. In a vast and complex health system, which includes over 650,000 registered practitioners, maintaining and monitoring minimum safety standards is difficult. An open and accessible system for reporting concerns to regulators allows all Australians to participate in monitoring healthcare safety, and to raise the alarm when patient or public safety is at risk. This is especially important for protecting patients in situations where practitioners engaging in unsafe practice work in a solo or unsupervised capacity, or where they work only with practitioners considered 'junior' to them, or whose jobs are reliant upon the unsafe practitioner. In some circumstances, the unsafe practitioner's colleagues may be more hesitant to raise their concerns than a patient or member of the public.

The role of safety surveillance and complaints by the public is also especially important in detecting certain types of problems which patients (and those close to them) are often better placed to notice than the practitioners' colleagues. Examples of these issues include financial exploitation, fraud, boundary violations, discriminatory refusal of service, breach of conditions (e.g. chaperone conditions), providing

[1] The Chelmsford Hospital 'Deep Sleep Therapy' involved treatment where psychiatric patients where sufficiently drugged to keep them unconscious for weeks at a time, only waking them up for electroconvulsive therapy. The Royal Commission into the events found that 24 patients died as a result, a number of other patients committed suicide and close to 1000 suffered brain damage. The New South Wales Medical Board was seen to be either powerless or unwilling to deal with the doctors concerned. As a result NSW introduced the first independent Health Complaints Commissioner, and other state and territories soon followed.

inadequate or misleading information about diagnosis or treatment to patients or carers, misrepresenting qualifications to patients and falsely representing oneself as a registered practitioner.

Any change to the ability to make complaints or register concerns about the practice of individual practitioners, or about the impacts on the public of aspects of the health care system, must address the risk of disadvantaging health consumers and denying the regulatory system valuable information about its functioning. It is important to distinguish between, on the one hand, the motivations of practitioners making inappropriate notifications, and, on the other, the motivations of the majority of 'lay complainants or notifiers' (members of the public, most commonly patients and those close to them).

The CRG is concerned that many of the concerns raised about inappropriate use of the complaints system (often called 'vexatious complaints') involve practitioners lodging complaints against other practitioners – for example in the course of a commercial dispute, workplace conflict or bullying, cartel behaviour, anti-competitive business practices or retaliation for raising concerns. In such cases, practitioners making inappropriate notifications may be motivated by potential financial, commercial or professional gain, including increased market share, career advancement and commercial 'patch protection'.

As the various components of the National Scheme do not provide dispute resolution or offer avenues for compensation or redress, lay complainants (for example patients who have experienced harm), gain little, either materially or personally, from engaging in the complaints process. Most are driven by quite different motivations than those of the small number of practitioners who may make inappropriate notifications.

Research has found that lay people who make complaints about health services have two main motivations for doing so: concerns about the safety and welfare of others: and the desire for information.[2, 3] Patients' most common motivations are wanting to prevent a similar problem or harm from affecting other patients, and wanting to receive an explanation or apology for what happened to them. Research also shows that, among patients harmed by healthcare who have a justifiable reason to complain, only a small proportion do so.[4] Commonly cited reasons for not raising their concerns include fear or repercussions for themselves or others, not having faith in the complaints system (especially if it involves 'self-regulation' by the profession), and thinking they will not be believed. Other barriers to making a well-founded complaint following harm in healthcare include social vulnerability (for example being elderly, a person with a disability or mental health issue, or a member of a racial minority), and problems with the accessibility of the complaints system (for example, low literacy).

The CRG understands that the vast majority of notifications under the National Scheme are made by members of the public, rather than practitioners' colleagues, employers or educators. Therefore, any moves to introduce blanket obstacles to or restrictions on notifications must first consider whether they will have a disproportionate effect on members of the public (and the notifications they lodge), as against health practitioners and other professionals. Thus, efforts to deter inappropriate notifications that are imposed on notifiers (for example, the threat of sanctions for 'unjustified' notifications) will also run the risk that they will deter members of the public from lodging notifications. Members of the public already face significant obstacles to raising safety concerns about healthcare. Further increasing these obstacles is an additional level of risk to patient safety, which is inconsistent with the fundamental objectives of the National Scheme and the National Law.

The CRG acknowledges that improvements in the timeliness and transparency of notification assessment, investigation and decision processes are desirable and necessary to improve the effectiveness of making a notification as a patient safety measure, while minimising the burden upon practitioners. However, any measures put in place that have the effect of discouraging members of the public from raising their concerns – whether that outcome is intended or not – pose an unacceptable risk to public safety. This includes, but is not limited to, any measures which threaten notifiers with sanctions, make the notification process less accessible, or cause notifiers to fear for their personal or legal safety.

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[2] Bismark M, Dauer E, Paterson R, Studdert D. Accountability sought by patients following adverse events from medical care: the New Zealand experience. *Canadian Medical Association Journal*. 2006;175(8):889-94.

[3] Bismark M, Dauer EA. Motivations for medico-legal action: lessons from New Zealand. *Journal of Legal Medicine*. 2006;27(1):55-70.

[4] Bismark MM, Brennan TA, Davis PB, Studdert DM. Claiming behaviour in a no-fault system of medical injury: a descriptive analysis of claimants and non-claimants. *Medical Journal of Australia*. 2006;185(4):203.

Research has shown that open, considered and respectful handling of adverse events and complaints by the practitioner or service involved substantially reduces the chance of a patient making a formal complaint.[5,6,7] In the CRG's view, practitioners and their employers must consider the role of improving their personal and internal institutional responses to adverse events and complaints if they wish to address the number of formal complaints made about them about issues they consider to be 'minor'.

The CRG has noted the repeated use of the term 'vexatious' to refer to complaints or notifications, or those who make them. However, the intended meaning of this term appears to vary widely within its usage by particular individuals and organisations, as well as between individuals and organisations. The members of the CRG have noted 'vexatious' being variously used to refer to complaints that:

- are factually incorrect
- involve differences in opinion or perspective
- are made in bad faith
- are motivated by the complainant's emotions
- are motivated by the complainant's personal experiences
- appear to involve conflicts of interest
- are personal in nature
- are repeated
- occur long after the events in question
- seem unlikely to lead to regulatory action
- fall below the perceived threshold for complaint or notification, or
- do not end in regulatory action.

Without a more considered and clear definition of what a 'vexatious' complaint is, any efforts to curb or prevent them run the risk of failing to achieve their stated aims, while also putting the public at risk by casting an unduly broad net that falsely or inappropriately labels (or threatens to label) legitimate concerns as 'vexatious'. Many well-founded complaints will have some of the above features, or will be perceived as having some of these features by the practitioner who is the subject of the notifications. The existence of some of the list of features above does not of itself invalidate a complaint or make it vexatious. For example, a person who has acquired a permanent disability as a result of harm in healthcare may make a complaint about their care in a state of severe emotional distress. However, neither their apparent 'emotional' motivations, nor the apparent 'personal' nature of such a complaint, renders their concerns invalid, nor are those features reason to disregard the other issues raised or to label the complainant as 'vexatious'.

The CRG further believes it is important to note that just because a National Scheme entity decides not to take action over a specific complaint, this does not necessarily mean that the complaint was factually incorrect, 'vexatious' or otherwise without merit. For example, National Scheme entities apply certain thresholds for regulatory action, which take into account the ongoing risk to public safety. A complaint may describe true events, and those events may have been unacceptable according to relevant standards. However, regulatory action may not have been taken because the issues raised were deemed unlikely to be ongoing, had already been addressed by the practitioner, or are difficult to prove to a sufficient degree.

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[5] Ibid.

[6] Wu AW, McCay L, Levinson W, Iedema R, Wallace G, Boyle DJ, et al. Disclosing adverse events to patients: international norms and trends. *Journal of Patient Safety*. 2014.

[7] Vincent C, Phillips A, Young M. Why do people sue doctors? A study of patients and relatives taking legal action. *The Lancet*. 1994;343(8913):1609-13.

For some, possibly many, lay people, it is difficult to navigate the medical complaints system, which does not have a single point of entry to assist complainants to raise their concerns with the correct entity. Some complaints are not progressed through National Scheme processes because they are better handled by a health complaints entity. Against this background, outcomes of complaints should not be confused with, nor simplistically taken as a proxy indicator of, the legitimacy or truth of the issues and events raised in notifications. Nor should complaint outcomes be confused with, nor simplistically taken as a proxy indicator of, the motivations of a complainant, or whether the complaint was justified or made in good faith. The CRG respectfully cautions against the practice, seen in several submissions to this inquiry, of labelling complaints vexatious or inappropriate solely on the grounds that they did not result in regulatory action.

The CRG does not have access to the detailed particulars of proceedings for the handling of individual complaints. It is nevertheless concerned that some practitioners defending themselves against or denying allegations may claim that the relevant complaint is false or 'vexatious'. This includes such claims from practitioners who are the subject of complaints which are well-founded, and which raise real and serious concerns. The CRG urges the committee to consider the real possibility that some practitioners who are the subject of complaints that result in eventual action by a Board or tribunal (and can therefore be considered both serious and well-founded) initially defend themselves by claiming that the complaint(s) was false or vexatious.

As one example, in January 2017, the Victorian Civil and Administrative Tribunal (VCAT) suspended the registration of Dr Hassan Alkazali (his registration has since been cancelled with effect from 1 May 2017). The Tribunal found that Dr Alkazali had promised to help a patient qualify for the Disability Support Pension on the basis of her having schizophrenia, including coaching her in what to say to a psychologist, despite having no reason to believe the patient had the condition. He then engaged in sexually inappropriate behaviour towards the patient. However, when initially questioned about the complaint, Dr Alkazali alleged that the sexual text messages presented as evidence had been edited, and claimed that the woman's claims arose from her having "another psychotic episode". These claims were eventually rejected by VCAT. In this case the patient did not have the alleged mental health condition that Dr Alkazali used in an attempt to discredit her report. This case highlights the high risk of people's concerns being dismissed as vexatious due to their actual, perceived or falsely attributed characteristics. There are other instances of practitioners similarly claiming delusion, or misunderstanding or 'vexatiousness'. Examples of characteristics that may be used against complainants in this way include sex and gender, disability, mental illness, age, socio-economic status, language group, race, immigration status, refugee status and education.

The CRG understands that there is limited empirical evidence regarding the extent of bad faith complaints against health practitioners. However, it is important to give due attention and weight to the empirical evidence that does exist about this issue. In particular, research by the University of Melbourne, that examined a sample of 850 notifications, found that only 6 appeared, on all available evidence, to be motivated by reasons other than concern about patient safety. This amounts to only 0.7% of the notifications.

Genuine instances of bad-faith complaints are important. However, this evidence suggests that any measures to prevent or address them need to be proportional to their apparent frequency or rarity, and must not create a public safety risk that outstrips any benefits for the small group of practitioners potentially affected by truly bad-faith complaints. in the light of this measure, the CRG is concerned that any methods that evoke fear of 'getting in trouble' among potential notifiers who are aware of serious safety problems (especially members of the public) is an excessive response to the perceived problem, especially as research has found that patients actually harmed by healthcare, and who are aware of genuine safety risks, may not speak up because they do not think they will believed, do not trust the system, or fear repercussions.[8] It is arguable that such as response will place the public at risk by giving people who are aware of serious risks to patient safety more reason to remain silent.

The CRG has similar concerns regarding the impact that the threat of sanctions may have on practitioners who may be considering whether to formally raise a serious safety issue. Research has repeatedly found that practitioners may not report serious safety concerns due to fear of repercussions, including harassment, bullying, loss of their job, career stagnation and professional stigma. In some cases, this is

[8] Bismark MM, Brennan TA, Davis PB, Studdert DM., loc. cit.

despite their awareness that patients are being harmed. Adding further risks of potential adverse impacts will likely increase the motivation to stay silent, again putting the public at risk.

The CRG supports strong working relationships between bodies responsible for handling complaints. This includes ensuring data collection is consistent and timely to support a national outlook on complaints handling and its analysis, and working towards a 'no wrong door' or 'single door' approach, where a person with a health practitioner-related complaint or concern can contact a single place to have it handled in a consistent and timely way (or, in the case of a 'no wrong door' approach, be transferred in a timely way to the most appropriate body for complaints handling).

The 2014 Independent Review of the National Registration and Accreditation Scheme for health professions provided many recommendations for improving the National Law and its implementation. There are further improvements health consumers have identified, which go beyond those recommendations and which remain under consideration.

The CRG notes that Health Ministers are in the process of settling and introducing Tranche One of amendments to the National Law. One of the most important changes for health consumers is that complainants can be provided with the reasons why a Board made the decision that it did about a health practitioner. Since the National Law began operation this sharing of information has not occurred, and its absence may have affected the confidence of complainants in the health care complaints system, most especially in those instances in which the relevant Board chose not to take any action against a health practitioner. The CRG also welcomes the amendment that will allow a non-practitioner community member of a health practitioner Board to become its Chair.

There remain, however, a number of complex issues that will be considered for inclusion in a second or subsequent tranche of amendments to the National Law. The CRG intends to make submissions and provide other input to the consideration of those issues as part of the further amendment process.

The CRG notes that there have been some suggestions that the medical complaints system should be returned to one more focused on self-regulation by the profession. It is concerned that a number of adverse events over several years have highlighted that the management of unsafe or unethical practitioners in the context of self-regulation alone does not fit with public expectations, nor ensure patient safety. Indeed, there is often a gap between what a profession deems acceptable, and public norms and expectations about the need to put patient safety first and enforce standards rigorously. Some relevant cases do not come to public attention. However, serious Australian cases that have been publicly reported, and preceded the creation of the National Scheme and the enactment of the National Law, include those of Dr Graeme Reeves, Dr Jayant Patel, Dr James Peters and Dr Roman Hasil. Several such cases, in which members of the medical professions and the authorities they led failed to act adequately in response to serious and repeated allegations against doctors, provide significant arguments in favour of creating the National Scheme in the form in which it currently stands. These failures led to death, disability, serious harm, trauma and assault for patients, some of which continued after other patients and practitioners had raised the alarm.

A recent study commissioned by the Royal Australasian College of Surgeons dealt with significant failures within the college to adequately address bullying, sexual harassment and discrimination among its own members (and resulting patient safety risks).[9] This report provides significant reason to question whether the adequacy of medical self-regulation has improved sufficiently to remove or weaken the safeguards provided by independent complaints oversight.

Although the matter remains under consideration by the courts in Canada, the CRG wishes to draw the Committee's attention to the matter of George Doodnaught[10], which it believes illustrates a number of the points that are central to its position on the matters being considered by this inquiry. These include:

[9] Royal Australasian College of Surgeons. Expert advisory group on discrimination, bullying and sexual harassment: report to RACS 2015 [Available from: http://www.surgeons.org/media/22045685/EAG-Report-to-RACS-Draft-08-Sept-2015.pdf.

[10] In the matter referred to, in 2014, it was alleged that Canadian anaesthesiologist George Doodnaught was sentenced to 10 years in prison for sexually assaulting 21 female patients over the course of four years. The practitioner was found by the court to have forced these patients to perform sexual acts on him during their surgeries,

- the potential for there to be a gulf between public expectations and the realities of self-regulation by the members of a profession
- the need for external scrutiny of complaints and patient safety, as distinct from a 'practitioners scrutinising practitioners' approach, and
- the ease with which practitioners under scrutiny can use their status and power to discredit multiple patients who make complaints, and how readily other practitioners may accept these explanations.

The final outcome of the case remains to be determined and some caution in relying on the details of the allegations made in the proceedings is required, but the allegations at the core of the case, which have been widely reported in Canadian media, illustrate the risks of a complaints system built upon the idea that practitioners are the best determinants of the feasibility of events described in complaints, or the best judges of how credible complaints and complainants are. It also illustrates how readily a patient making true and serious allegations can have their credibility undermined by a practitioner relying on their position of status and power. Several of the women who were assaulted continued to pursue their allegations after their complaints were dismissed. It is also of concern to the CRG that, had these women made their complaints in an environment where sanctions were imposed against complainants deemed vexatious, they would have faced the risk of being penalised for making the allegations in the first place, on top of the trauma of the assaults. Alternatively, because of the serious and bizarre nature of the allegations they had to make, they may have been too afraid to complain in the first instance, and the practitioner may have continued to offend. The CRG notes, however, that the matter remains under consideration on appeal in the Canadian courts.

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while hidden behind a surgical screen in a fully-staffed surgical theatre. During the attacks his patients were sedated, but conscious enough to know what was happening, and to remember the attacks afterwards.

The publicly reported allegations and the findings of the Canadian court included that:

- over several years, three formal complaints of sexual assault were made against Doodnaught by different women to senior medical staff at the same hospital
- these women were unknown to each other, and made strikingly similar allegations. However, their complaints were dismissed by medical staff
- another complaint to the police, made by another woman, was also dismissed
- the explanation offered by the practitioner himself, and echoed by senior hospital medical staff and the police who dismissed the women's complaints, was that the women had been hallucinating due to their sedation
- the practitioner also told at least one woman that it was she who had attacked him in her sedated state, and told her it was a common effect of the sedation
- the senior medical staff claimed that it was impossible for such crimes to be carried out in fully staffed surgical theatre, and believed the accusations were unfeasible
- 15 of the 21 assaults for which he was charged occurred in the six months prior to his arrest (long after the first complaints had been made), and
- four of the assaults occurred in the 10 days prior to his arrest.

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ATTACHMENT A

Community Reference Group

10 July 2015

Terms of reference

1. **Purpose**

The Community Reference Group will complement the role of community members of National Boards, by:

1.1 providing information and advice on strategies for building community knowledge and understanding of the role of AHPRA and National Boards in protecting the community and managing professional standards

1.2 providing information and advice to AHPRA and National Boards on strategies for consulting the community about issues relevant to their work

1.3 providing feedback and advice from a consumer and community perspective on National Board standards, codes, guidelines, policies, publications and other specific issues, as requested by National Boards, and

1.4 providing consumer and community perspectives and advice to the National Boards and AHPRA about issues relevant to the National Scheme.

2. **Accountability**

2.1 The Community Reference Group will have an advisory role to the AHPRA CEO. The advice of the Community Reference Group will be provided for information to the Agency Management Committee, National Boards and AHPRA's National Executive.

2.2 National Boards and AHPRA may choose to seek advice from the Community Reference Group through its Secretariat.

3. **Membership**

3.1 The Community Reference Group will have up to 10 members in addition to the Chair, selected through an expression of interest process and appointed by the CRG Steering Committee.

3.2 The following persons are ineligible for appointment:

3.2.1 anyone who has served as a member on an AHPRA National Board, Panel or Committee

3.2.2 anyone who has been involved in any official capacity in the National Registration and Accreditation Scheme, or

3.2.3 a currently registered health practitioner.

3.3 Members will be appointed for up to three years.

3.4 AHPRA staff may attend as observers at the discretion of the group.

4. **Chair**

4.1 The Community Reference Group will be chaired by a current community member of a National Board. This provides:

4.1.1 a clear connection to the National Boards

4.1.2 assurance that the operations and processes of the Community Reference Group are aligned with the National Boards, and

4.1.3 assurance that National Boards' strategic direction, projects and activities that impact or are of interest to the community are discussed at Community Reference Group meetings.

4.2 The Chair is selected through an expression of interest process and appointed by the CRG Steering Committee for up to three years.

4.3 When a Chair vacancy is unfilled the CRG Steering Committee can appoint a member of the Community Reference Group to act as interim Chair until a full expression of interest process to appoint a full-term Chair, as identified in Section 4.1 of the Terms of Reference, is completed.

5. **Meetings**

5.1 The Community Reference Group will meet face to face at least twice each year and by teleconference as required. The Group may also make decisions out-of-session electronically. Members will abide by their signed confidentiality agreement.

6. **Quorum**

6.1 The quorum is to be at least 50% of the group.

7. **Procedures**

7.1 The Community Reference Group will adopt procedures consistent with the National Boards, which will include declarations of any conflicts of interest.

8. **Communications**

8.1 The Community Reference Group will publish agreed Communiqués on the AHPRA website after each meeting.

8.2 The Secretariat, with authorisation from the CEO, will manage any external requests for comment made to the Chair or members.

9. **Terms of Reference review period**

9.1 The Community Reference Group Terms of Reference to be reviewed every two years.

10. **Remuneration**

10.1 The Community Reference Group will receive a sitting fee for attending meetings at the same rate as National Board members.

11. **Secretariat**

    11.1 The Secretariat will be provided by AHPRA.

12. **The Community Reference Steering Committee**

    12.1 The Community Reference Group Steering Committee advises on the ongoing functions of the Community Reference Group. The Steering Committee is responsible for:

    12.1.1 establishing the terms of reference for the Community Reference Group

    12.1.2 selecting the Community Reference Group Chair

    12.1.3 advising on the Community Reference Group membership configuration and meeting schedule, and

    12.1.4 advising on the selection recruitment and appointment process for members to the Community Reference Group.