A submission to the Community Affairs Committee of the Senate

Investigating

Complaints mechanism administered under the Health Practitioner Regulation National Law

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Dear Community Affairs Committee

The principle problems with the current law governing AHPRA are:

1. AHPRA does not promote a collaborative collegiate patient centric mediation focused process of management of adverse events and complaint, thus enhancing a culture of conflict and fear.

2. The processes are legalistic and involve management by people with little or no clinical understanding.

3. There is no accountability of those involved in the management of the complaints.

4. The processes are not transparent and are not timely.

5. There are no rules of evidence for much of the process of handling complaints.

6. There is no appeal mechanism for the complainant.

7. AHPRA is part of the process of constructive dismissal.

I will make two submissions, both of which I am happy to have presented in the public domain, and both are presented in the interest of safer healthcare, to both protect the consumer and the rights of healthcare providers to be managed by good governance. One submission will be on the problems and solutions, the other is a story of system failure that has led to the public vilification of an individual determined to make medicine safer.

Could the committee also further consider my submission to the 44th parliament - http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Medical_Complaints/Submissions and the other submissions made to the 45th parliament, including all emails related to different scenarios.

The terms of reference to which my comments are directed are:

a. the implementation of the current complaints system under the National Law, including the role of the Australian Health Practitioner Regulation Authority (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.

From the perspective of a surgeon, the behaviour and governance of the following organisations should be considered in developing a SAFE complaints and adverse events system, all currently contributing to a negative impact on the quality agenda, noting there are many other organisations that are involved in complaints policy, most of which do not enable individual circumstances to be well managed; also, noting that there are differences between states:

1. Hospital management
2. AHPRA
3. The National Health Ombudsman
4. Administrative Tribunals
5. The Supreme court
6. The Health Services Commissions
7. Medical indemnity organisations
8. The Coronial process for medical cases
9. The Royal Australasian College of Surgeons
10. The Royal Australasian College of Medical Administrators

1. Hospital management

a. There is no uniform process for handling of complaints across hospitals.
b. A consumer liaison officer is not an appropriate person to deal with concerns about medical management by a medical practitioner.
c. There are no performance criteria for patient outcomes for the hospital management.
d. There are no external reviews of the performance of healthcare professionals, and little or no comparison of performance of practitioners across states and with other countries.
e. Audit mechanisms require self-reporting and usually do not have feedback loops.
f. Care-plans and adherence to them can be manipulated inappropriately.
g. There is no process for dealing with the exclusion of practitioners that identify inappropriate behaviour of management.
h. Hospital management use the report of staff to AHPRA as a mechanism of silencing dissent.
i. 457 visa provisions are used to enable dissenting staff to be replaced – one of the tools of the bully.
j. Unconscionable behaviour of hospital medical staff toward other healthcare professionals – bullying – is not addressed within the current law, nor by hospitals.
k. Mobbing of healthcare professionals – ie exclusion from the use of facilities - is not addressed.

2. AHPRA

a. Complaints staff do not have firm guidelines that enable all complaints of the same nature to be dealt with in the same manner.
b. The handling of complaints is not transparent.

c. Who is involved at all levels and their conflicts of interest does not appear to be managed.
d. Performance criteria for all staff and committees do not exist, or are meaningless.
e. Limited performance criteria for the organisation-in-general exist.
f. Accountability for the legal expenses is lacking.
g. Accountability for the performance of the legal advisers and prosecutors is lacking; for example, if a healthcare practitioner wins on appeal, who is investigated, and by what mechanism, to complete the accountability loop.
h. Vexatious complaints are not only possible, but are able to be facilitated, and AHPRA can be part of the "mobbing" process.
i. There are no actions against vexatious complainants.
j. There are not appeal mechanisms for those making complaints.
k. Complaints against AHPRA staff are not handled well.
l. THERE IS NO LIMITATION ON THE DURATION OF APPOINTMENTS OF BOARD MEMBERS.
m. There is no management of conflict of interest, so that:
    i. panel members can sit in judgement against a healthcare professional they have previous found against.
    ii. Those involved in the workplace of the accused may be involved in judging them.
n. Immediate action committee meetings are able to proceed with little or no factual information.
o. AHPRA is, and should not be all of the following:
    i. Registration body.
    ii. Investigator in a complaint case.
    iii. Prosecutor in a complaint case.
    iv. Responsible for enactment of any restrictions.
p. A complaint being laid is damaging to a health practitioners career, even when no fault is found – guilty until proven innocent.
q. When harm is caused by a healthcare provider that has resulted from inadequate actions by AHPRA, there seems to be no mechanism of sanctions against AHPRA or its staff.

3. The National Health Ombudsman

a. Has no ability to overturn the findings of AHPRA.
b. Has no accountability mechanism of staff involved in the review of a complaint outcome.
c. Does not have an adequate quality assurance related to the understanding of medical facts.
d. The process is not transparent.
e. Only review the process of AHPRA, not whether the truth has been determined.
f. Complaints officers are not medically trained; training that would assist in understanding the flaws in the AHPRA process.

4. Administrative Tribunals

a. Duration of appointments to panels are not established.
b. Conflicts of interest are not managed for those on the medical panels.
c. The medical facts are not tested by using hot-tubbing.
d. No accountability of:
    i. The expert witnesses– no adverse outcome for the experts whose evidence is not concurred with.
    ii. The panel members.
    iii. The panel chairs.
    iv. The legal teams arguing for AHPRA.

e. Access by the press results in trial by media and guilt by allegation.
f. Directions imposed on AHPRA have no follow-up mechanisms.

5. The Supreme court

In the Supreme Court, Administrative tribunal and coronial decisions ***can only be challenged on an error in law***, rather than an error of medical fact. The Azaria Chamberlain case is one of Australia's best examples of a failure of legal argument to find medical truth. Medicine and governance of medical care should be focused on the pursuit of medical truth.

Changing the law to allow for challenging of the facts, using hot-tubbing, and having accountability of the professionals involved in the process of giving evidence would help address some of the problem.

6. The Health Services Commissions

The Victorian HSC

a. only deals with the performance of institutions, not with the behaviour or performance of healthcare professionals.
b. More importantly, they have no power to force the participation of the hospital.
c. The process is protracted, difficult for the complainants, and legalistic.

7. Medical indemnity organisations

a. Have budgets to meet, not quality of outcome for the practitioner, healthcare and the patient as measures of success.
b. The target of vexatious complaints is further disadvantaged by the restrictive costs imposed by indemnity organisations.
c. The financial risk is the driver of medical indemnity organisations, not the medical quality risk, leading to potential appropriate advances in medicine being impeded by the failure of ***protection of those who outperform their colleagues***.

8. The Coronial process for MEDICAL cases

a. The process is not drive by medical facts in cases of concern, as highlighted by the Lindy Chamberlain case

b. Supreme court challenge is currently only available on the basis of an error in law, not an error in medical facts.
c. There are no performance criteria related to the outcome of cases for:
    i. The coroner.
    ii. The health information officers.
    iii. The police.
    iv. The pathologists.
    v. The expert witnesses.
d. Hot tubbing is only rarely used.
e. Conflicts of interest of experts are not tested.

9. The Royal Australasian College of Surgeons

a. The processes for dealing with complaints are not transparent.
b. Conflict of interest of those overseeing the process not managed within the process.
c. Different responses to different people occur – there can be prejudice against the complainant and the person complained about.
d. Who is responsible and what accountability mechanisms for the management of complaints about bullying or clinical performance is not identified.
e. The EAG investigation did not investigate individual cases and has made no substantive change to surgical workplace culture.
f. The measurements of outcomes of the complaint process are the number of complaints now being investigated and the outcome of the complaints management, but with no reflection on the quality of the process. Individuals who have complained about the behaviour of the College have become targets of the complaints process.

10. The Royal Australasian College of Medical Administrators

a. Complaints mechanisms are not robust, lacking transparency and a right of appeal.
b. Anti-Bullying rhetoric is not matched by performance in response to complaints.

I trust the Community Affairs committee will be assisted by this and the second submission I will make.

Paddy Dewan
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