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AUSTRALIAN DENTAL ASSOCIATION

13 May 2016

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

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

Re: Medical complaints process in Australia

Dear Committee Secretary,

The Australian Dental Association (ADA) welcomes the opportunity to participate in this inquiry, which seeks to concentrate on, medical complaints, with a particular focus on bullying and harassment, the roles of the Australian Health Practitioners Regulation Authority (AHPRA), and the operation of the National Registration and Accreditation Scheme ('NRAS', or 'the Scheme') under the Health Practitioners Regulation National Law Act 2009 (the National Law), as introduced in each state and territory.

In preparing this response, the ADA has confined its responses to Terms of Reference (ToR) a and d to f.[1]

The National Law is intended to be nationally consistent and applies to all registered health practitioners. It is therefore likely that any recommendations from the Senate Committee may have implications for Australia's entire registered health workforce. We urge the Senate Committee to consider this when developing recommendations.

ToR a. The prevalence of bullying and harassment in Australia's medical profession

This is the overarching issue under inquiry. The committee defines 'Australia's medical profession' as including both nurses/midwives and medical practitioners (doctors), as well as students for those professions.

Regrettably, bullying and harassment are not likely to be limited to the medical, nursing and midwifery health professions. The National Boards' Code of Conduct for registered health professionals includes a brief reference to this under section 4.4 stating that, "when working in a team, good practice involves: … (f) understanding the nature and consequences of bullying and harassment and seeking to avoid or eliminate such behaviour in the workplace,".

[1] http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Medical_Complaints/Terms_of_Reference accessed 3 May 2016.

Similar to Work Health and Safety obligations, the Code of Conduct for registered health professionals should be strengthened to reinforce the overall duty of care of health professionals, particularly those in employer positions, to ensure the safety of their colleagues, staff and patients. This duty would accordingly extend to preventing and managing instances of bullying and harassment. Unfortunately, the NRAS does not apply to non-practitioner employers such as corporate, private health insurers and other non-practitioner owners of dental practices. Some of these entities have been reported to ADA as engaging in bullying, including via vexatious use of the notification processes of the National Law. These complaints are sometimes made against competitor dentists in the same town or area.

Addressing issues of bullying and harassment in the registered health professions will require significant investment of time and resources, and consultation with all stakeholders. The ADA therefore urges the Committee to recommend a carefully planned and coordinated response, led by AHPRA and the National Boards, which results in the development of a framework and tools for all health professionals to prevent and manage workplace bullying. Undertaking such work will also require the allocation of a suitable amount of funding and careful consultation with all relevant parties.

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

Does the legal framework under which the relevant medical boards and AHPRA operate have appropriate safeguards against being used vexatiously for bullying or harassment?

Although NRAS was created to facilitate a nationally consistent registration and regulation framework, the National Law operates differently in some states. New South Wales and Queensland each have unique processes for handling complaints about registered health practitioners albeit that they work collaboratively with AHPRA and the National Boards. Where there are these different processes, a national registration scheme logically requires that there be a uniform process for handling complaints. The Senate Committee should consider recommending that over time those jurisdictions that have not adopted the national framework do so in full.

Nevertheless, at the moment each version of the National Law includes provisions to prevent vexatious complaints under the National Boards' Code of Conduct.[2] The ADA is not privy to specific data on how often the need arises to invoke this provision, but would suggest that AHPRA and other relevant health care complaints handling bodies should publicly provide this data to assist policy making. That situation notwithstanding, the following concerns have been raised directly with the ADA:

- The normal judicial system assumes innocence until proven guilty. However, under the current notification management system, there is almost a presumption of guilt upon a practitioner once a complaint is made. While the ADA recognises the importance of the safety of the public, some level of protection must be afforded to the practitioner until the complaint is established. As there is no consequence for complainants who make vexatious or unproven claims, practitioners can thus fall victim to these claims and due to the notification processes have their reputation tarnished until their name is cleared. Greater protection against this has to be afforded to practitioners

[2] Relevant section of the National Law:
151 When National Board may decide to take no further action
(1) A National Board may decide to take no further action in relation to a notification if—
(a) the Board reasonably believes the notification is frivolous, vexatious, misconceived or lacking in substance;
Section 1.2 of the National Boards' Guidelines for Mandatory Notifications states that:
"Practitioners should be aware that if they make notifications that are frivolous, vexatious or not in good faith, they may be subject to conduct action."

- 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.
- A need for improved expertise at the time of complaint. There should not be this cascading process of moving a notification from one AHPRA officer to another; it should go as soon as possible to the most appropriate and capable person. This means there should be a dental professional appointed as a 'gate keeper' at the beginning of the process. It should be acknowledged not all dental professionals have expertise in all situations. A panel of experts the dental 'gate keeper' can access may be required.

Any changes to the National Law would also need to take into consideration existing legislation and complaints handling processes in each state and territory. Naturally registered health professions and other stakeholders should be consulted in that process.

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

Has nationalising the registration and monitoring of medical practitioners improved medical care in Australia?

To effectively answer this question. an extensive analysis of a wide range of information is required. Agreement on which baseline health indicators can and should be measured needs to be established, and changes to these to be monitored over time. To the ADA's knowledge, there is no plan in place to use such indicators to measure the performance and effectiveness of NRAS when it comes to the improvement of medical care and outcomes in Australia. The cost effectiveness and efficiency review of NRAS performed in October 2014 only performed its assessment of the cost for AHPRA to operate per registered health practitioner rather than analysing its impact on medical care and outcomes for patients.[3]

AHPRA is just beginning to review the extensive complaints data it holds. At present, only limited evidence is available in several of the registered health professions to support that registration and monitoring of health practitioners has improved health care in Australia by:

- Facilitation of timely credentialling and recredentialling, using electronic AHPRA registration data exchange with hospitals;
- Ability to nationally monitor registered health professionals, and prevent those who are prohibited from practicing in one jurisdiction from doing so in another state or territory;
- Detection and prosecution of unregistered and unqualified persons who were claiming to be dentists;

[3] Centre for Health Service Economics & Organisation and the Professional Standards Authority, Cost-effectiveness and efficiency review of the Australian National Registration and Accreditation Scheme for health professionals Final report, October 2014.

- Assisting with the coordination and management of infection control breaches;
- Extensive work to respond to criticisms about the notifications handling process, to improve the experience of those who are involved and better manage any risks to the public.

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

Should there be stronger requirements for patient outcome specific data to be used both in lodging and investigating complaints?

Analysis of benchmarked complaints data does potentially offer substantial opportunities to identify areas where practitioner education and review are warranted. However, great care must be taken to benchmark complaints data. Careful and consistent classification of the types and categories of complaints must be undertaken.

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.

Similarly, any benchmarking activity will need to recognise that there are large variations in how individual complaints were categorised in historical data, both prior to the establishment of AHPRA, and after. There is also variation in the categorisation of complaints across jurisdictions, and probably between different categories of registered health practitioners.

The degree of complexity and the associated risk are individually variable; for example, some practitioners may be unfairly maligned because they take on much more complicated cases, for example oral maxillofacial surgery is likely to have more paranesthesia cases due to the fact that paranesthesia is more common to oral maxillofacial surgery. This will need to be adequately taken into account in any prospective tool or framework to assess complaints that may be developed. This work will be resource-intensive and requires further funding if the full benefits of these opportunities are to be realised for patients and health practitioners.

ToR g. The desirability of requiring complainants to sign a declaration that their complaint is being made in good faith;

Is there evidence to suggest vexatious complaints are being made, and if so, what systems could be put in place to reduce the prevalence?

The ADA questions the effectiveness of requiring a signed "declaration that their complaint is being made in good faith". If the objective of such a practice is to require a complainant to think twice before

complaining, this may not be achieved if there is no cost to making that complaint, and no consequence attached to making a misleading or false declaration.

The ADA has been informed by its state branches of a number of cases where members have had to respond to frivolous and vexatious complaints – which accordingly as a consequence generate much stress, anxiety, aggravation, time away from practice and general opportunity cost through lost production.

To counterbalance the risk of vexatious and frivolous complaints being made against health practitioners, it may be appropriate for complainants to have to make a payment when they lodge a complaint. The public policy shortcomings of providing no consequence/no cost complaint procedures are that complainants may strategically use the 'free' option first. They accordingly would not spend money towards retaining a lawyer until their grievance has adequately progressed through the 'free' complaint pathway. In the event the complaint is not upheld, no harm or cost accrues to the complainant but there is an enormous impact on the practitioner that is not redressed.

The Senate Committee should consider recommending that the Health Boards, AHPRA and other relevant organisations mirror the practice adopted by another statutory body – the New South Wales Civil and Administrative Tribunal. Patients making a complaint against a practitioner in the "General consumer of commercial proceedings" realm must, on lodging their application, pay a fee (ranging from $47 to $252 depending on the quantum of the financial redress they are seeking). The existence of such a fee helps to ameliorate the cost of providing such service as well as causing some to rethink their inclination to leap to a complaint as their first course of action.

Noting there may be public policy reasons for having minimal barriers for entry when it comes to costs to lodge a complaint, the Senate Committee should alternatively consider requiring that vexatious complainants will be penalised. Such penalties, including defamatory compensation may in the circumstances be appropriate.

ToR h. any related matters

Improved advice and assurances as to when AHRPA imposed conditions on a practitioner are to be removed from the register would provide greater certainty.

Should you require further comment regarding the ADA's feedback, please contact Mr Robert Boyd-Boland, CEO at .

Yours sincerely,

Dr Rick Olive AM RFD

President