10th January 2017

Dear Ms Stewart,

Thank you for the opportunity to talk with you on the phone this morning about my concerns in relation to this inquiry. You asked me to put my thoughts in writing.

I am a medical practitioner working in a single-handed practice in a small town about 30 Km north of Coffs Harbour on the NSW mid north coast. Recently I wrote to the editor of the latest AHPRA newsletter commenting on an article about the culture of bullying and intimidation within parts of the medical profession and wider health system that has recently gained prominence in the media. I wrote that in my opinion, the bodies that administer the health complaints mechanisms in both state and federal jurisdictions are also part of the problem of bullying and intimidation.

I received a cordial reply informing me of the current senate inquiry and suggesting that I make a submission to your enquiry. Interestingly, AHPRA did not request from me any further information which in itself is I think a symptom of the denial that is part of the whole system. Importantly, this was the first time that I had become aware of the current inquiry which to my knowledge has not been widely publicised by the many professional bodies associated with medical practice.

I then investigated the process by which I might make a submission and was interested to find that in your website, at the bottom of the page headed “Making a submission”, it states “If you write something critical of another person or organisation the committee will write to them and ask them to respond”. For those already intimidated by the system, this is very likely to discourage submissions.

I am fortunate that to this point I have not knowingly had a complaint made against me to any body but I know personally a number of practitioners who have been subject to complaints and have seen the devastating impact on them of the process. The widespread belief is that the processes of responding to complaints is deeply unfair, prejudicial to the practitioner from the outset, lacking in due process by not permitting them any opportunity to test the evidence and completely lacking in transparency.

Any complaint will evoke deep distress in any conscientious doctor rendering them barely able to practice. Where doctors have restrictions placed upon their practice, there is often massive impact on reputation from which it may be very difficult if not impossible to recover. In addition, there are huge financial costs, often in the hundreds of thousands of dollars, which might amount to months or years of lost income whilst at the same time the practitioner has to bear the cost of maintaining their professional rooms, staff and indemnity insurance as well as legal costs. To cap things off, complainants can be referred to the police who may naturally, under the

prejudicial circumstances, tend to assume (with the implied imprimatur of the complaints body) that the doctor is guilty. The legal ramifications and cost in such cases are horrendous and the small print of some medical indemnity policies (e.g. MIPS) explicitly excludes support for a practitioner once a criminal charge has been laid. All this may result from an administrative decision that lacks what in other jurisdictions would be regarded as any semblance of normal due process. Is there any wonder that many practitioners suffer deep depression and suicide as a result? In the latter case, the oft-held conclusion is then that the practitioner was guilty. The evidence is rarely ever tested!

Anyone seems to be in a position to make a complaint whatever their relationship to a particular patient or any other matter and the system appears to accord immediate credibility to every complainant. Even anonymous complaints appear to be given the same status. The impression is that the complaints system is totally stacked against the practitioner. Whatever the outcome, the practitioner has no redress whatever from the complainant who is totally unaccountable for what is set in train. Furthermore, the investigation process often amounts to a witch-hunt in that the practitioner is subject to an inquisition about every aspect of his/her practice far beyond the subject of the complaint itself. No professional person whose whole professional career is subject to such a process will come out completely without criticism however diligent he or she is in attempting to maintain high standards. The “retrospectoscope” is a potentially merciless instrument.

Certainly for me, the outcome of hearing of fellow practitioners’ experiences has been a deep questioning of whether I wanted to continue to practice medicine given the apparent complete lack of engagement in this matter by the professional colleges and other bodies that are meant to support the profession. I know that my feelings are widely shared by many professionals. I have discussed this issue with my daughter who is a final year medical student at the ANU who tells me that particularly the male students have very negative attitudes towards “intimate” history taking and physical examinations.

It has been reported that over the past year there has been an increase in the order of 15 to 20 percent in complaints against doctors. If this were to continue exponentially over the next 10 years then no doctor will be spared.

What has to be understood, and what is drummed into every first year medical student, is that good medicine only occurs when there is a healthy “doctor-patient alliance”. That means that the doctor forms a partnership with the patient in doing the best to deal with the presenting problem. The first and absolute prerequisite for this is that the patient can trust the doctor. This trust is established by the highly regulated system by which doctors are trained, the registration mechanisms that license doctors to practice and accountability processes that endeavor to maintain the highest level of practice possible within the bounds of human frailty and the imprecise nature of the science and practice of medicine.

In turn, the doctor must be able to trust the patient to have enough intelligence, integrity, emotional autonomy and capacity to set appropriate boundaries to engage in the diagnostic, treatment planning and therapeutic process agreed upon. Central to the tradition of medicine as practiced in Australia is the art and science by which the doctor conducts a careful, nuanced and appropriately targeted process of history taking. Under some circumstances, this may require a deep level of enquiry into what the patient might experience as very sensitive matters. The doctor cannot realistically be expected to have an in-depth knowledge of the life’s experiences of the patient and the particular attitudes that the patient might thereby ascribe to

certain bodily functions particularly those of a sexual nature. It is thus inevitable that at times the questions that doctors ask during history taking or things that doctors say to patients in other contexts will evoke discomfort in patients without that being the doctors intent however caring and empathetic. Such discomforts often appear to be the basis for complaints. During the process of history taking, the doctor will be considering certain diagnostic possibilities, gently probing through careful and often nuanced questions to eliminate the likelihood of certain diagnoses and support the likelihood of others. This process leads to the formulation of a “differential diagnosis” which will effectively create in the doctor’s mind a prioritised list of possible diagnostic possibilities.

The physical examination that would normally follow should be directed at further refining the differential diagnosis. When I was a student, we were taught that in more than half of all presentations, a careful and thorough history should accurately point to the actual diagnosis and that combined with careful physical examination should provide the diagnosis in some 80% or more of cases. The purpose then of blood tests, radiological and other special investigations is to confirm the diagnosis in the majority of cases and further refine the differential diagnosis in the remaining minority. As mentioned before, the history taking process may at times elicit emotional discomfort or distress in the patient and this is also true and even more possible in respect of the physical examination especially of what the patient might be considered of an intimate nature e.g. vaginal or rectal examination. It should be understood that what a doctor might conceptualise as the reproductive, genito-urinary or gastrointestinal system, a patient might conceptualise as something sexual. Sadly there will be always the potential for misinterpretation and misunderstanding. Doctors are taught to be mindful of the cultural and other factors that might influence what the patient might be experiencing but in the end no doctor can guess what is really going on deep within the patient’s psyche.

For example, an examination involving the breasts or lower part of the body might evoke distant memories of past sexual abuse which might have been deeply submerged in the patient’s unconscious and of which the doctor cannot have the slightest inkling or knowledge. Such may then ultimately lead to a complaint, the real essence of which might be diabolically difficult to evince in the way that complaints are investigated or defended by the crude nature of the current complaints system and the equally crude but somewhat more transparent processes of a criminal trial.

As more and more doctors are subject to complaints and as patients increasingly adopt the attitude of consumers rather than partners in the process of achieving wellbeing, the practice of thorough history taking and examination becomes more and more attenuated due to doctors’ fear of complaints and litigation. The result is exponentially increasing reliance on batteries of expensive and often invasive tests, increasing levels of dissatisfaction with the outcomes of medical endeavor, increasing levels of defensive medical practice, dramatically rising costs of health care and medical indemnity all of which ultimately become the burden of government and of the population as a whole. The only beneficiaries are the legal profession and the ever-expanding disease industry.

The medical complaints system is a critical driver of this destructive process accompanied by the manner in which civil litigation is ever more failing to recognise that medicine is an inexact science driving up people’s expectations of perfect outcomes and awarding massive compensation payouts. Such litigation often ends up in a resolution skewed in the direction of “where the money is” i.e. against the insured party. Nowhere in the system are patients being required to take an appropriate level of responsibility in maintaining their health and wellbeing in

partnership with their health care providers.

The complex responsibilities demanded of doctors should also be understood in the context of a fee system that makes other professionals blush. I am not trying to make a political point by saying that senators need to be reminded that the Medicare rebate for a consultation of up to 20 minutes duration by a vocationally registered GP is the grand sum of $37.05 (80% of consultations are bulk billed, non-VR GPs are paid even less) out of which all practice expenses have first to be deducted including thousands of dollars medical indemnity insurance premiums. I am reminded of the adage “if you pay peanuts, ……”

The situation has reached a catastrophic state in the US where many doctors have lost the art of talking a history or conducting a proper physical examination. Some 15% of the GDP in the US is spent on heath care yet the quality of that care falls far short of that of many nations that spend far less. The structure of their health system further diminishes the doctor-patient alliance in many cases (e.g. health maintenance organisations). In Australia, all medical students are required to achieve a very high standard in these skills but in practice they will observe them being not employed in the way that they are taught.

To add to this, the increasing development of “medical silos” through hyper-specialisation means that specialist doctors are increasingly reluctant or lack the capacity to view the patient as a whole person even though this is a central tenet of all current models of medical training. Despite being initially trained as comprehensive generalists with a holistic view of what constitutes good medical care and outcomes focussed on wellbeing and not just symptom relief, many specialists have become fearful of talking with patients about matters even slightly out of their designated area of specialty. General surgeons and physicians are becoming a rare breed and yet their holistic knowledge and approach is essential in dealing with those patients presenting with non-specific symptoms where the differential diagnosis will be extensive and encompass many if not all physiological and anatomical systems.

I have heard of experienced practitioners being disciplined for talking about matters entirely within the competence of a first year medical graduate, the most bizarre example being the orthopedic surgeon in Victoria who was admonished for discussing diet with his patients many of whom were diabetics whose legs he was being required to amputate. What kind of message does this send to our profession and to patients being pursued by “ambulance-chasing” lawyers?

I am passionate about this because the future of our quality health care is at stake. I am coming towards the end of a long career which has taken me into almost every branch of medicine. I am the author of three world best selling textbooks for medical students. More than anything, I am an ordinary doctor quite isolated in a small country town who deeply cares for my patients and my profession and all it is meant to accomplish. As an individual, I am virtually powerless to be heard.

I believe that the medical profession and the exhaustive methods by which medical students are vetted and the profession held accountable have worked pretty well until now in upholding very high standards. There will always be bad apples but the overwhelming majority of doctors are profoundly good people, some more skilled and committed than others as in all life’s endeavours. Let us not throw the baby out with the bathwater.

Sadly the profession as a whole has tended to bury it’s head in the sand and the colleges, universities and other medical bodies have failed to address this issue in a

comprehensive way, hoping that it will all go away. I have heard nothing from the three of which I am a fellow about this subject. I know submissions to your enquiry have been canvassed in general. I don't know if these bodies have been approached specifically. If not, I would suggest that every one of the learned colleges should be specifically asked to make submissions (such as those listed at the end of this submission) and others many of whom are known to AHPRA as credentialing bodies. The AMA, medical schools and other representative organisations should also be specifically asked for submissions as well as the medical protection organisations. Unless all these stakeholders are actively engaged, the outcome will be of little consequence.

In truth, I believe that nothing short of a Royal Commission is really required to deal with the complexity of these issues.

I would be very pleased to be a witness in-person at the senate inquiry should that be appropriate. I am confident that my daughter would speak of the contemporary medical student experience.

Yours faithfully

Professional Colleges that should be invited to make submissions (among others):

Royal Australian College of General Practitioners (RACGP)
Australian College of Rural and Remote Medicine
Royal Australian College of Physicians (RACP)
Royal Australian College of Surgeons (RACS)
Royal Australian and New Zealand College of Psychiatrists (RANZCP)
Royal College of Pathologists of Australasia (RAPA)
Royal Australian and New Zealand College of Radiologists (RANZCR)
Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
Royal Australian and New Zealand College of Ophthalmologists (RANZCO)
Royal Australasian College of Dental Surgeons (RACDS)
Royal Australasian College of Medical Administrators (RACMA)
Australian College for Emergency Medicine (ACEM)
Australian and New Zealand College of Anaesthetists (ANZCA)