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To: Senate Community Affairs Reference Committee,
C/- Jeanette Radcliffe, Committee Secretary,
Senate Standing Committee on Community Affairs,
Parliament House,
Canberra.

November 8, 2016

Re. Inquiry into the medical complaints process in Australia

Dear Ms Radcliffe,

I write in response to the questions taken on notice during the Senate Community Affairs Reference Committee's public hearing held in Sydney 1 November 2016.

Thank you for the list of questions on notice sent yesterday.

I also note that I received notification yesterday that my submission, allocated number 94, has been accepted by the Committee as confidential. The material submitted today in response to the first question on notice is sensitive and confidential for obvious reasons (it names people, dates and places), and I ask the committee to treat it as confidential alongside my submission.

Of course, I am happy to confidentially assist with any matters which arise from this material, my initial submission, or my testimony at the Public Hearing.

In response to Question 1 (Hansard page reference 24)

Clarification

In my submission, I stated that
"I have observed failure of existing processes which prevent identification and correction of harassment and bullying, particularly when it involves individuals in senior roles. I observe this to invariably apply to medical staff in managerial roles, and non-medical staff in managerial roles with whom they collaborate."

Fundamentally, I have indicated to the Inquiry that in my view there are inherent structural conflicts of interest which create barriers to reporting and correcting bullying and harassment in Australia. These barriers are related to the corrupting influence of the non-medical bureaucracy as it currently operates which impairs the medical profession's ability to deal with bullying.

However, it does more than that. This bureaucracy currently empowers 'bad eggs' in the profession and protects them. The bureaucracy itself also rewards and promotes 'bad eggs' in the profession because they offer other things to it, such as income streams, status, control, workforce etc. Sometimes all they offer is turning a blind eye to ineptitude and wastage in the bureaucracy. They are mutually reinforcing by covering up each other unsatisfactory conduct.

Increasingly, these 'bad eggs' in the medical profession often take up a role in the bureaucracy themselves, and in so doing are identified with it. It provides them effectively with a government backing when there is resistance to them. Such roles may include clinical administrative roles such as unit, divisional or stream directors, or they may be in roles in the professional colleges, cosily interacting with the non-medical bureaucracy in the assessment of training or employment of doctors. This 'unholy hybrid' medical and non-medical bureaucracy manipulates the processes which exist around bullying and harassment to protect itself, thereby corrupting such processes.

These 'power' silos are not accountable to the people who matter in the case of bullying and harassment – those who are bullied and those who witness and report it. Since current and future employment, training accreditation, work performance and management of bullying are all in the hands of these people, no-one with concern for their future will report inappropriate conduct to them. And no senior doctor who values their employment will report them for fear of reprisals. This has been exacerbated dramatically in NSW because NSW Health has been increasingly substituting medical contractors who will not receive future work if they report or complain, rather than Staff Specialists. So, the bullies get away with it, and in my view, despite all the awareness of bullying, 'walking past' inappropriate behaviour is the norm today.

Consequently, this bureaucratic distortion promotes the medical culture in which I have argued there has been increasing bullying with impunity over time, a culture where senior doctors who are not part of the bureaucracy essentially disengage in disgust. There is no 'healing' of the victims in this culture amongst the 'healers' – just a hardened disengagement and distrust of governance structures. It would be wrong of the Inquiry to try to tease out the medical culture of bullying from the facilitating administrative culture which exists in health services around Australia because they are intimately enmeshed. They are mutually reinforcing.

In response to Question 2 (Hansard page reference 24)

I do not consider the following material in response to Question 2 to be confidential.

As stated during the hearing, I believe bullying and harassment in the medical profession is under-reported and under-recorded. We don't know it's prevalence.

In my view, AHPRA is the only national body which would be suitable for overseeing the management bullying and harassment in the medical profession, at a national level. However, I'm not convinced that AHPRA should be responsible for conducting the bullying and harassment processes. In my view AHPRA should :

1. set standards for these processes that should apply across Australia
2. oversee their proper conduct
3. Identify conflicts of interest in processes and recommend changes to avoid them
4. compile a de-identified national register so that we can know the actual prevalence of bullying and harassment in the medical profession.

My reasons are that :

1. It's current funding model would never sustain AHPRA managing bullying and harassment
2. It would place too much power into the hands of AHPRA
3. I believe AHPRA should focus on both the safety of patients and the safety of medical practitioners

These standards should be applicable nationally to all bodies and individuals who employ, contract or train doctors. However, harassment and bullying should be dealt with locally as much as possible, by health administrations, professional colleges and even by appropriate groups of individuals. The standards for the management of harassment and bullying should be set and audited by AHPRA.

The national law would have to be amended to give AHPRA this power and enforce compliance across the Commonwealth. What would need to be achieved is:

1. Separate the current conflict of interest that applies because the same doctors may have administrative positions in a health facility, be training assessors for a college, and recommend employment suitability at interviews
    a. Individual doctors should not be able to hold a concurrent administrative position in the health system and in a professional college responsible for training
    b. Individual doctors involved in assessing the training of doctors in the professional colleges should not be involved in committees which recommend workforce appointments.

2. Accurately assess the prevalence of bullying and harassment
    a. Develop and maintain a national register by AHPRA
        i. It would publish practitioner de-identified data
            1. Number of allegations
            2. How many were escalated
            3. How many were resolved
            4. Location by health facility, institution or practise-type
    b. Mandatory reporting criteria for bullying and harassment for all line managers (medical and non-medical) in the health system and in the professional training colleges when a formal or informal report of bullying is made by a doctor, whether by a victim, or a witness.
    c. Mandatory reporting format needs to be developed which will be sent to, and allow, AHPRA to keep a national register. I likened this to a 'witness statement' in my submission.
    d. Informal reporting be treated in the same manner as formal reporting

3. It is important to look after the health of the doctors who report
    a. Processes should mandate written notification by the health administration to the person who has made the report and this should also be sent to AHPRA for auditing.
    b. The outcome of any local assessment should be sent to the reporter
    c. The reporter should be able to request escalation to a higher assessment by a genuinely independent code of conduct committee if dissatisfied by the local assessment
    d. Record long term follow-up
    e. Pastorally sensitive time frames apply to completion of local assessments and assessment by truly independent Code of Conduct Committees (say 2 weeks and 2 months).

4. AHPRA should develop standards to be adhered whenever and wherever bullying is assessed in the health system.
    a. Standards for local assessment. For example :
        i. Reports of harassment and bullying should always be assessed under bullying and harassment policies. That is, management prerogative should be removed by law in regards to harassment and bullying in the medical profession
        ii. Bullying and Harassment Policies should contain minimum standards to achieve timely, fair local assessment of reports of bullying and harassment
        iii. Standards for feedback to the reporter
    b. AHPRA should also develop a minimal standard for escalation of any report or local assessment. For example, escalation should occur if:
        i. The reporter is not satisfied with the local assessment
        ii. The nature of the bullying and harassment is serious
        iii. The bullied individual is harmed
    c. The definition of a truly independent Code of Conduct committee. For example,
        i. No affiliation with anyone involved
        ii. Include at least 3 individuals
        iii. Include at least 2 doctors, who must not be medical administrators or officers of the medical training colleges
        iv. Must always be constituted by a majority of non-administrator, non-professional college medical practitioners.

5. AHPRA should define criteria which identify and prevent reprisals and
    a. Conduct audits for reprisals
    b. Follow-up reporters for 5 years
    c. Have powers to deal with reprisals, such as award simple compensation based on credible loss of workplace earnings

In summary, the most important changes to the national law is the requirement in each State and Commonwealth jurisdiction that there be mandatory reporting locally and to AHPRA, feedback to the reporter, and if a reporter of bullying and harassment is not satisfied with the outcome of any local assessment that a simple rejection of that assessment require assessment by a truly independent "Code of Conduct" committee. That the guidelines for these processes, oversight, the compilation of a national registry be an additional responsibility of AHPRA as part of a shift of it's role to include the safety of medical practitioners.

Yours sincerely,