Chapter 5

Conclusions and recommendations

5.1 The safety of Australian health care consumers is of paramount importance. To ensure that all Australians continue to enjoy safe health care, the complaints mechanism needs to treat both health practitioners and notifiers respectfully.

5.2 This respect requires the Australian Health Practitioner Regulation Agency (AHPRA) to provide both notifiers and practitioners with clear explanations about what is happening at each stage of the complaints process, what information is being provided to the relevant board, what clinical advice is being provided and by whom, why that advice is being obtained and what the next steps in the process are. Once a board has made a decision, it is vital that AHPRA communicates that decision promptly, is able to explain why the board made that decision and that it acts swiftly to see that the decision is implemented.

5.3 The committee found that a failure to provide the information and transparency that both practitioners and notifiers deserve has led to a loss of confidence in the complaints process.

5.4 The committee considers that significant work needs to be done to regain the confidence of Australian health consumers and practitioners. The committee acknowledges that the 2017 amendments to the Health Practitioner Regulation National Law (National Law) are a start towards regaining that trust. The committee hopes that its recommendations—together with the second tranche of proposed amendments to the National Law—will help to expedite that process.

Notifier engagement

5.5 Patients and those close to them have a right to comment on the treatment they receive and they should be encouraged to do so where they have concerns about adverse incidents.

5.6 In this inquiry, the committee heard from a number of members of the public who were concerned about their health or the health of someone close to them. The committee notes that these people constitute the vast majority of notifiers.

5.7 The committee notes evidence from the health complaints entities, and others, such as Carers Victoria, that some notifiers continue to struggle to identify where complaints about health practitioners should be lodged.

5.8 Even if notifiers manage to find the correct entity, notifiers often struggled to have their concerns taken seriously or be rigorously investigated.

5.9 The committee acknowledges that health practitioner regulation can be a difficult area to navigate and that it can be difficult to understand what information a notifier should provide and what rights they have in the process.

5.10 The health complaints entities advised the committee that they were working with AHPRA to facilitate a smooth transition between the health complaints entities and AHPRA in cases that need it. The committee commends AHPRA and the health complaints entities on their efforts to improve the process for all potential notifiers.

5.11 Once notifiers reach the complaints process administered under the National Law, they appear to be entitled to little information or involvement. The committee notes that this apparent isolation from the complaints process is exacerbated in cases where notifiers consider that not all of the relevant information has been collected by AHPRA and submitted to the national board, leading to mistrust and a lack of confidence.

5.12 In Chapter 3, the committee recognised that there is a desire for notifiers to be better informed and be more involved in the complaints process. The 2017 amendments to the National Law will allow more information to be provided to notifiers about the status of matters and the rationale for board decisions.

5.13 Keeping notifiers informed of the progress of matters and allowing them to comment on that progress will allow greater transparency in the conduct of investigations and invite notifiers to have greater confidence that a thorough and fair assessment is being made of their notification.

Recommendation 1

5.14 The committee recommends that AHPRA review and amend the way it engages with notifiers throughout the process to ensure that all notifiers are aware of their rights and responsibilities and are informed about the progress and status of the notification.

Vexatious notifications

5.15 In Chapter 2 of this report, the committee noted that practitioners remain deeply concerned about the prevalence of vexatious notifications. Vexatious notifications were cited as a problem by a significant proportion of practitioners that submitted to the inquiry.

5.16 The committee notes that when vexatious notifications are accepted, there can be a disproportionate effect on the practitioners involved.

5.17 The committee accepts that some notifications are intentionally vexatious. In the committee's *Medical Complaints in Australia* inquiry (the previous inquiry) the committee recognised that the complaints process could be used by practitioners to bully or harass colleagues.[1]

5.18 Intentionally vexatious notifications, meaning those that are lodged primarily to bully or harass the practitioner subjected to it, are most often lodged by other health practitioners.

1 Senate Community Affairs References Committee, *Medical Complaints in Australia*, November 2016.

5.19 A distinction may be able to be made between two classes of notifiers: persons with an immediate interest in the health or wellbeing of the patient and those whose primary focus is the health or conduct of the practitioner.

5.20 In Chapter 3 the committee noted that there was support in the Snowball Review, and a consensus among witnesses, that notifiers who were personally affected by the notification should be treated differently to other notifiers.

5.21 The difference in treatment may be a restriction on the amount of information that is provided to a notifier where there are reasonable grounds to suspect that a notification may be intentionally vexatious.

5.22 In its previous inquiry, the committee identified that the national boards needed a process, method or criteria to identify vexatious complaints.[2] In that inquiry, the committee was advised that AHPRA was taking steps to address a number of the committee's concerns. The committee notes that AHPRA has since established an online complaints portal and that the portal may assist to manage future vexatious notifications.

5.23 During this inquiry, the Australian Commission on Safety and Quality in Health Care referred the committee to complaint handling policies currently in place in New South Wales. The New South Wales policy contains a clear statement of what constitutes a vexatious complaint.[3] The committee considers that having a framework for identifying vexatious complaints would be a useful tool in the management of vexatious complaints.

Recommendation 2

5.24 The committee recommends that AHPRA and the national boards develop and publish a framework for identifying and dealing with vexatious complaints.

5.25 The committee notes that legal proceedings can be costly for the parties involved. All parties should approach the complaints process with a view to concluding the matter as quickly as possible, having regard to the complexity of the issues and fairness to both the practitioner and the notifier.

5.26 The committee accepts that, in vexatious cases, health practitioners are required to expend considerable time, effort and money to defend the complaint.

5.27 In making this recommendation, it is not the committee's intention to deter individuals who wish to make a comment about care they have received.

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2 Senate Community Affairs References Committee, *Medical Complaints in Australia*, November 2016, p. 21.

3 NSW Health, *Complaint Management Policy*, additional information provided by the Australian Commission on Safety and Quality in Health Care, 31 March 2017 (received 31 March 2017), p. 16.

Recommendation 3

5.28 The committee recommends that the COAG Health Council consider whether recourse and compensation processes should be made available to health practitioners subjected to vexatious claims.

Clinical peer advice

5.29 The process of assessing complaints appears to be opaque. While AHPRA may have improved processes for including clinical peer input into the assessment of notifications, evidence to the committee suggests it remains unclear when clinical input is provided and who is asked to provide it.

5.30 In Chapters 2 and 3 the committee considered the issues of triaging and clinical peer input. The committee recognises that AHPRA and the national boards believe that appropriate clinical input is already obtained, or is able to be obtained, where it is necessary.

5.31 However, the evidence to this inquiry noted that providing clear clinical peer advice at the earliest possible point in the process could be a substantial investment in reducing any vexatious notifications and truncating the length of time it takes to perform assessments and investigations.

5.32 The committee understands that clinical peer advice is usually sought during the investigations stage. Noting that the investigation stage can extend for months and sometimes years, the committee considers that clinical peer advice should be provided at the earliest possible opportunity.

5.33 The committee recognises that it may be impractical for the membership of a board to cover all sub-specialties, but considers that in the interests of fairness to practitioners and increased timeliness, there is value in the relevant board keeping a list of peers that may be appointed to the board in their respective discipline or sub-discipline. When AHPRA becomes aware that a notification regarding a practitioner from a discipline not represented on the board will be assessed by the notifications committee at its next meeting, a peer from the same discipline as the practitioner under consideration may be asked to attend the initial notification committee meeting to ensure that the board can obtain the clinical peer input it needs at the earliest possible opportunity.

Recommendation 4

5.34 The committee recommends that AHPRA and the national boards institute mechanisms to ensure appropriate clinical peer advice is obtained at the earliest possible opportunity in the management of a notification.

5.35 In Chapter 3 the committee expressed its concern at the potential for conflicts of interest to emerge. Witnesses informed the committee of cases where they believe conflicts of interest had emerged between a member of the board and an aspect of the notification.

5.36 A conflict of interest, or the perception of a conflict of interest, has the potential to greatly undermine confidence in the complaints process. Conflicts that affect members of the board ought to be treated very seriously.

5.37 The committee asked representatives of AHPRA and the Medical Board of Australia about policies around conflicts of interest and the potential consequences for breaching them. The committee was informed that members of boards are expected to self-report conflicts and failure to do so may be grounds for their resignation from the board.

5.38 The committee is concerned that AHPRA's policy for declarations of conflicts of interest by board members is not sufficiently robust. The committee considers that AHPRA must take further steps to safeguard the process.

Recommendation 5

5.39 The committee recommends that AHPRA immediately strengthen its conflicts of interest policy for members of boards and that the Chair of the board should make active inquiries of the other decision makers about actual or potential conflicts of interest prior to consideration of a notification.

5.40 The committee was also informed that there may be conflicts of interest between external providers of advice and practitioners subject to notifications.

5.41 In confidential submissions, the committee was informed that external advice may sometimes be sought from a practitioner with whom the subject practitioner may be in commercial competition. In this circumstance the committee considers that the advice provider would have a conflict of interest and would be expected to return the brief. However, some submitters have suggested to the committee that this does not always occur.

5.42 It was also suggested to the committee that remuneration to provide a report may lead the advice provider to seek to confirm the suspicions of the board in the hope of obtaining future work. Submitters suggest that in this case the advice provided may indicate that the practitioner is a greater risk to the public than they actually are.

5.43 The committee has no way of knowing how prevalent either of these forms of conflict of interest is, but the confidence of some practitioners has been undermined because they believe it is an issue. The committee considers that developing a transparent method to determine when external advice is obtained, who it is obtained from and ensuring that it is free from conflicts of interest would be beneficial.

Recommendation 6

5.44 The committee recommends that AHPRA develop a transparent independent method of determining when external advice is obtained and who provides that advice.

5.45 The committee received some evidence that one of the challenges to obtaining adequate clinical peer advice was that it may not be financially viable for expert practitioners to act in that capacity.

5.46 Instead, the lesser remuneration available was more likely to attract retired or former practitioners, potentially with less current clinical practice, to provide advice to the board.

5.47 The committee considers that AHPRA should make a competitive level of funding available to an independent entity to strengthen the clinical peer review process to attract esteemed practitioners in their field to advise the board.

Recommendation 7

5.48 The committee recommends that AHPRA consider providing greater remuneration to practitioners called upon to provide clinical peer advice.

Using the process to support practitioners to manage their own risks

5.49 When adverse events occur, practitioners should be encouraged to admit their mistakes and identify how they, and their colleagues, can learn from them in the future.

5.50 The evidence the committee received from practitioners was that the current complaints process does not support this outcome.

5.51 To the extent that a cautious approach supports patient safety, it is to be encouraged. However, the committee also acknowledges that if a mistake is made and a notification follows, the practitioner should, to the greatest extent possible, be encouraged to learn from that mistake to ensure it does not happen again.

5.52 Practitioners do not consider that this is currently how the national boards work. The evidence the committee received indicates that even the boards' lightest touch response, a caution, can affect a practitioner for years to come.

5.53 This is especially the case where regulatory action is published.

5.54 Some witnesses suggested to the committee that education, mentoring and conciliation were all options that should be available to the national boards. The committee understands that these are already options that are available to national boards. The question is whether the options that are currently available are being harnessed to achieve the best possible outcome for the public and the practitioner involved.

5.55 The committee strongly supports protecting the public and taking strong regulatory action when the circumstances require it. However, the committee considers that in other circumstances, education and mentoring, together with a greater emphasis on conciliation could be used to manage risk to the public and educate practitioners.

Recommendation 8

5.56 The committee recommends that AHPRA formally induct and educate board members on the way the regulatory powers of the board can be used to achieve results that both manages risk to the public and educates practitioners.

Guidelines and policies

5.57 In Chapter 4 the committee has noted that questions were asked about the completeness of AHPRA employees' understanding of the policies AHPRA administers. In particular, chiropractors and single expert witness psychologists raised concerns about specific policies that impact on their work.

5.58 In the case of chiropractors, the committee received submissions that indicated that staff were not familiar with the detail of advertising guidelines.

5.59 Similarly, evidence received from single expert witness psychologists suggested that AHPRA officers were also unaware of the Psychology Board of Australia's policy on investigations into notifications about single expert witnesses or of other external policies, such as Standing Orders of the Family Court of Western Australia.

5.60 The committee accepts that not all staff members can be familiar with all policies. However, specialist staff members administering notifications should be familiar with the policies relevant to the profession.

Recommendation 9

5.61 The committee recommends that AHPRA conduct additional training with staff to ensure an appropriately broad understanding of the policies it administers and provide staff with ongoing professional development related to the undertaking of investigations.

5.62 In Chapter 4 the committee also noted its concerns about AHPRA progressing notifications against psychologists and psychiatrists who were acting as single expert witnesses in family law proceedings.

5.63 AHPRA assured the committee that AHPRA and the Psychology Board of Australia had always fully complied with the psychology board's policy that notifications about practitioners acting as a single expert witness are placed on hold until the conclusion of the proceedings or leave of the court was obtained. This was contested by groups representing practitioners.

5.64 This issue was one of a number of examples throughout the inquiry where AHPRA seemed unaware that practitioners held an alternate perspective. The committee found this to be concerning. However, the committee understands that AHPRA will meet with the groups representing the single expert witnesses to discuss the issue.

5.65 AHPRA and the Association of Family and Conciliation Courts (Australian Chapter) agree that it would be highly beneficial if all notifications regarding these practitioners were administered in accordance with the policy.

5.66 Reports from practitioners that notifications are being progressed, despite the policy, suggest that a stronger form of regulation may be required.

Recommendation 10

5.67 The committee recommends that the COAG Health Council consider amending the National Law to reflect the Psychology Board of Australia's policy on single expert witness psychologists acting in family law proceedings.

Appeals

5.68 Appeals processes are important to ensure that all decisions are made properly and according to law. In Chapter 4 the committee noted that the evidence to this inquiry indicated that further reform was needed in this area.

5.69 In this inquiry, practitioners revisited the issue, raised in the committee's previous inquiry, of whether a caution issued by the relevant board should be subject to an appeal. The committee notes that all other board decisions are subject to an appeal and supports treating cautions in a consistent manner to other decisions made by the national boards.

5.70 The committee recognises that while a caution represents the relevant national board's lightest touch regulatory response, it can still have a substantial effect on a practitioner for years to come. The committee reiterates the views it expressed in the previous inquiry—consideration should be given to making a caution an appellable decision.

Recommendation 11

5.71 The committee recommends that the COAG Health Council consider making a caution an appellable decision.

5.72 Considering the equities in rights to appeal, notifiers informed the committee that an inequity exists between the rights of practitioners and those of notifiers. Under current arrangements, notifiers can only approach the National Health Practitioner Ombudsman and Privacy Commissioner whilst practitioners may approach the relevant tribunal.

5.73 The committee considers that there is benefit in examining whether notifiers should be granted standing before tribunals.

Recommendation 12

5.74 The committee recommends that the COAG Health Council consider whether notifiers should be permitted to appeal board decisions to the relevant tribunal.

Timeliness

5.75 All witnesses to this inquiry agreed that the complaints mechanism administered under the National Law should be timely, clear and fair to both practitioners and notifiers.

5.76 In Chapter 4, the committee expressed its concerns about how long the process can take in some cases. The committee considers that taking weeks to send a letter after the board has made a decision, or years to conduct an investigation when there is a clear statutory requirement that the action be done as quickly as practicable, is simply unacceptable.

5.77 All organisations must work within their available resources, but the lack of timeliness to resolve some cases indicates that something must change.

5.78 The current process has now been in place for almost a decade. In that time AHPRA has been advised on multiple occasions that it must make shortening its timeframes for all cases a priority. Based on the evidence the committee received, AHPRA has failed to address these concerns.

5.79 The committee urges AHPRA to take all necessary action to shorten its timeframes, including whether it has the appropriate range of powers and adequate resources.

Recommendation 13

5.80 The committee recommends that AHPRA take all necessary steps to improve the timeliness of the complaints process and calls on the Australian Government to consider avenues for ensuring AHPRA has the necessary additional resources to ensure this occurs.

Recommendation 14

5.81 The committee recommends that AHPRA institute a practice of providing monthly updates to complainants and medical professionals whom are the subject of complaints.

Conclusion

5.82 This inquiry has revealed that practitioners and notifiers have lost confidence in the AHPRA administered process. The answer to restore confidence in Australia's complaints process lies in its administration.

5.83 It is not sufficient that AHPRA is confident that its processes are robust. Everyone who uses the complaints process must be able to have confidence that the system is fair, rigorous, transparent and timely.

5.84 The above recommendations are intended to assist AHPRA reorient the process to effectively manage risk while at the same time assisting and engaging notifiers and supporting practitioners into the future.