

The Senate

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Community Affairs  
References Committee

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Medical complaints process in Australia

November 2016

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### Participating members for this inquiry

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Senator Peter Whish-Wilson	Tasmania, AG
Senator Nick Xenophon	South Australia, IND



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# ABBREVIATIONS

ACEM	Australasian College of Emergency Medicine
ADA	Australian Dental Association
AHPRA	Australian Health Practitioners Regulation Agency
AIDA	Australian Indigenous Doctors' Association
AMA	Australian Medical Association
AMSA	Australian Medical Students' Association
ANMF	Australian Nursing and Midwifery Federation
ANZCA	Australian and New Zealand College of Anaesthetists
COAG	Council of Australian Governments
committee	Community Affairs References Committee
CPMC	Committee of Presidents of Medical Colleges
Expert Advisory Group	Expert Advisory Group on discrimination, bullying and sexual harassment to the Royal Australasian College of Surgeons
HCCA	Health Care Consumers' Association
HPARA	Health Practitioners Australia Reform Association
MBA	Medical Board of Australia
National Law	<i>Health Practitioners Regulation National Law Act 2009 (Qld)</i>
Ombudsman or NHPOPC	National Health Practitioner Ombudsman and Privacy Commissioner
NMBA	Nursing and Midwifery Board of Australia
NRAS or National Scheme	National Registration and Accreditation Scheme
RACMA	Royal Australasian College of Medical Administrators
RACP	Royal Australasian College of Physicians
RACS	Royal Australasian College of Surgeons

RANZCP	Royal Australian and New Zealand College of Psychiatrists
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# **LIST OF RECOMMENDATIONS**

## **Recommendation 1**

**4.25** The committee recommends that all parties with responsibility for addressing bullying and harassment in the medical profession, including governments, hospitals, speciality colleges and universities:

- acknowledge that bullying and harassment remains prevalent within the profession, to the detriment of individual practitioners and patients alike;
- recognise that working together and addressing these issues in a collaborative way is the only solution; and
- commit to ongoing and sustained action and resources to eliminate these behaviours.

## **Recommendation 2**

**4.27** The committee recommends that all universities adopt a curriculum that incorporates compulsory education on bullying and harassment.

## **Recommendation 3**

**4.30** The committee recommends that all universities accept responsibility for their students while they are on placement and further adopt a procedure for dealing with complaints of bullying and harassment made by their students while on placement. This procedure should be clearly defined and a written copy provided to students prior to their placement commencing.

## **Recommendation 4**

**4.32** The committee recommends that all hospitals review their codes of conduct to ensure that they contain a provision that specifically states that bullying and harassment in the workplace is strictly not tolerated towards hospital staff, students and volunteers.

## **Recommendation 5**

**4.35** The committee recommends that all specialist training colleges publicly release an annual report detailing how many complaints of bullying and harassment their members and trainees have been subject to and how many sanctions the college has imposed as a result of those complaints.

## **Recommendation 6**

**4.37 The committee recommends that a new inquiry be established with terms of reference to address the following matters:**

- **the implementation of the current complaints system under the National Law, including role of AHPRA and the National Boards;**
- **whether the existing regulatory framework, established by the National Law, contains adequate provision for addressing medical complaints;**
- **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;**
- **the adequacy of the relationships between those bodies responsible for handling complaints;**
- **whether amendments to the National Law in relation to the complaints handling process are required; and**
- **other improvements that could assist in a fairer, quicker and more effective medical complaints process.**

# Chapter 1

## Introduction

### **Bullying and harassment in the Australian medical profession**

1.1 There has been considerable focus in the Australian community in recent years on the issue of workplace bullying and harassment in the medical profession. A series of reviews and reports have indicated that bullying and harassment is a significant problem across a wide range of practice types and regions.<sup>1</sup>

1.2 On 2 February 2016, the Senate referred the medical complaints process in Australia to the Community Affairs References Committee for inquiry and report, with the following terms of reference:

- (a) the prevalence of bullying and harassment in Australia's medical profession;
- (b) any barriers, whether real or perceived, to medical practitioners reporting bullying and harassment;
- (c) the roles of the Medical Board of Australia, the Australian Health Practitioners Regulation Agency and other relevant organisations in managing investigations into the professional conduct (including allegations of bullying and harassment), performance or health of a registered medical practitioner or student;
- (d) the operation of the *Health Practitioners Regulation National Law Act 2009* (the National Law), particularly as it relates to the complaints handling process;
- (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;
- (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;
- (g) the desirability of requiring complainants to sign a declaration that their complaint is being made in good faith; and

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1 See, for example: Victorian Auditor-General, *Bullying and Harassment in the Health Sector*, March 2016, p. x, [http://www.audit.vic.gov.au/reports\\_and\\_publications/latest\\_reports/2015-16/20160323-bullying.aspx](http://www.audit.vic.gov.au/reports_and_publications/latest_reports/2015-16/20160323-bullying.aspx) (accessed 9 November 2016); Askew, D.A. *et. al.*, 'Bullying in the Australian medical workforce: cross sectional data from an Australian e-Cohort study', *Australian Health Review*, vol. 36, no. 2, May 2012, pp 197–204, <http://search.proquest.com/docview/1022629267?pq-origsite=summon&http://search.proquest.com>

(h) any related matters.

### ***Guidance on terms of reference***

1.3 The committee subsequently published additional guidance on the inquiry's terms of reference, highlighting that the inquiry's focus was on the intersection between bullying and harassment in Australia's medical profession and the medical complaints process:

To guide the inquiry process, the committee would like to provide clarity on how it is interpreting the terms of reference (ToR). The overarching issue under inquiry is the prevalence of bullying and harassment within Australia's medical profession (ToR a).

The other ToR should be read according to how they relate to bullying and harassment within Australia's medical profession, and how such bullying and harassment may ultimately impact on individual medical practitioners and patient outcomes.<sup>2</sup>

1.4 That guidance further added the following additional notes on individual terms of reference:

ToR a 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.

ToR b Is there anything preventing medical practitioners from reporting bullying and harassment?

ToR c Are the complaints and investigation processes of the relevant medical boards, nursing and midwifery boards and AHPRA able to be used vexatiously for bullying or harassment, particularly by other medical professionals?

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

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

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

ToR g Is there evidence to suggest vexatious complaints are being made, and if so, what systems could be put in place to reduce the prevalence?<sup>3</sup>

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2 Available on the inquiry's Terms of Reference webpage, [http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/Medical\\_Complaints/Terms\\_of\\_Reference](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Medical_Complaints/Terms_of_Reference).

3 Available on the inquiry's Terms of Reference webpage, [http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/Medical\\_Complaints/Terms\\_of\\_Reference](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Medical_Complaints/Terms_of_Reference).

1.5 The issue of bullying and harassment in Australia's medical profession received concentrated public and media attention following a series of prominent doctors making public comments about the profession's culture. Most notably, vascular surgeon Dr Gabrielle McMullin described the sexual harassment of female doctors as rife within the profession<sup>4</sup>, and neurosurgeon Dr Charlie Teo noted that bullying is 'more extreme than you've been led to believe'.<sup>5</sup>

1.6 The committee notes there have been a number of recent inquiries into workplace bullying and harassment in Australia. Notably, the House of Representatives Standing Committee on Education and Employment inquiry into workplace bullying in 2012 highlighted that bullying was a significant issue across a range of industries and professions.<sup>6</sup>

1.7 A 2015 report by the Expert Advisory Group established by the Royal Australasian College of Surgeons (RACS) found that 'discrimination, bullying and sexual harassment are pervasive and serious problems in the practice of surgery in Australia and New Zealand'.<sup>7</sup>

1.8 The Australian Medical Association (AMA) suggests that the findings of the RACS survey are likely to be representative across the whole medical profession, suggesting 'anecdotal evidence and feedback from members would indicate that this experience is replicated in other medical specialties'.<sup>8</sup>

1.9 As the submission from mental health advocacy group Beyondblue notes, the effects of workplace bullying and harassment can be serious and wide-ranging, particularly in the medical profession:

Research shows a clear link between bullying and harassment and the experience of depression and anxiety conditions. These conditions are potentially disabling, and associated with a wide range of adverse outcomes for affected individuals, including the risk of premature death by suicide. These conditions also impact on family, friends, workplace colleagues, and on society more broadly.

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4 'Sexual harassment rife in medical profession, warns surgeon', *ABC Radio AM*, 7 March 2015, <http://www.abc.net.au/am/content/2015/s4193059.htm> (accessed 16 November 2016).

5 'Top Doc calls for royal commission into medical bullying', *Ten News*, 16 February 2016, <https://tenplay.com.au/news/national/february/top-doc-calls-for-royal-commission-into-medical-bullying> (accessed 16 November 2016).

6 House of Representatives Standing Committee on Education and Employment, *Workplace Bullying: We just want it to stop*, October 2012, pp 8–10, [http://www.aph.gov.au/Parliamentary\\_Business/Committees/House\\_of\\_Representatives\\_Committees?url=ee/bullying/report.htm](http://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=ee/bullying/report.htm) (accessed 15 November 2016).

7 Expert Advisory Group on discrimination, bullying and sexual harassment, *Report to the Royal Australasian College of Surgeons*, 28 September 2015, p. 4, <http://www.surgeons.org/about-respect/what-we-have-done/building-respect,-improving-patient-safety/expert-advisory-group/> (accessed 9 November 2016).

8 Australian Medical Association, *Submission 9*, p. 2.

Bullying can lead to poor health and low morale, engagement and productivity among workers who witness bullying. In the medical profession the negative impacts of bullying and harassment have the potential to impact on patient care.<sup>9</sup>

### **Focus of the inquiry**

1.10 This inquiry was established to investigate the role of the existing medical complaints process to deal with certain types of bullying and harassment. A focus for this inquiry was how the medical complaints process in Australia, overseen by AHPRA and the National Boards, has itself been misused by some medical practitioners as a form of bullying and harassment. The committee has also investigated broader questions of bullying and harassment within the profession, including its prevalence and barriers to the reporting of it.

1.11 Throughout this inquiry, the committee received examples of medical practitioners whose careers and lives have been affected by what they believe are vexatiously made complaints lodged against them by colleagues or competitors.

1.12 While concerned about the prevalence of a wide range of forms of bullying and harassment within Australia's medical profession – and the consequent effects that has on patient outcomes and public safety – the committee's focus in this inquiry has largely been on the misuse of the complaints process. The medical profession needs a robust, transparent and respected complaints process in order to ensure public safety.

### **National regulation and accreditation of medical practitioners**

1.13 Australia's medical complaints process is a consequence of the creation of a national scheme for the regulation and accreditation of medical practitioners. In 2006, the Productivity Commission recommended the establishment of a single national registration and accreditation scheme (NRAS) to enable the Australian health workforce to deal with shortages and associated pressures; to increase its flexibility, responsiveness, sustainability and mobility; and to reduce red tape.<sup>10</sup>

1.14 The Council of Australian Governments (COAG) agreed in 2006 to establish the NRAS, to ensure that all health professionals were 'registered against the same, high-quality national professional standards' and to allow 'doctors, nurses and other health professionals to practise across state and territory borders without having to re-register'.<sup>11</sup>

1.15 COAG signed the Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions in 2008. The scheme consisted of 'a Ministerial Council, an independent Australian Health Workforce Council, a national agency with an agency management committee, national profession-specific

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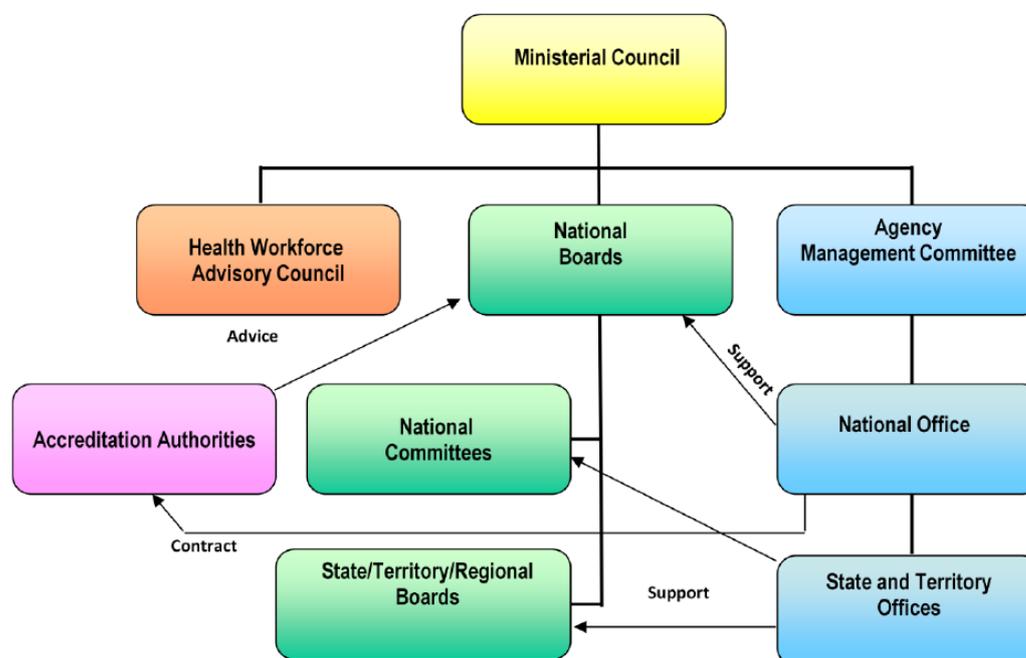
9 Beyondblue, *Submission 11*, p. 2.

10 Productivity Commission, *Australia's Health Workforce*, Research Report, January 2006.

11 COAG *Communique*, 13 April 2007, <http://webarchive.nla.gov.au/gov/20070830052604/http://www.coag.gov.au/meetings/130407/index.htm> (accessed 10 March 2016).

boards, committees of the boards, a national office to support the operations of the scheme, and at least one local presence in each state and territory' (see **Figure 1.1**).

**Figure 1.1 – National Registration and Accreditation Scheme**



Source: Australian Health Practitioner Regulation Agency.<sup>12</sup>

1.16 The Department of Health outlined the objectives of the National Scheme, as set out in the establishing legislation:

- to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered;
- to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction;
- to facilitate the provision of high quality education and training of health practitioners;
- to facilitate the rigorous and responsive assessment of overseas-trained health practitioners;
- to facilitate access to services provided by health practitioners in accordance with the public interest; and

12 Australian Health Practitioner Regulation Agency, *Submission 70*, p. 7, in Senate Finance and Public Administration References Committee, *Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA)*, [http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Finance\\_and\\_Public\\_Administration/Completed\\_inquiries/2010-13/healthpractitionerregistration/index](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Finance_and_Public_Administration/Completed_inquiries/2010-13/healthpractitionerregistration/index) (accessed 3 March 2016).

- to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.<sup>13</sup>

1.17 As the Commonwealth does not have the power to regulate health professionals, the legislative framework for implementation of the NRAS was enacted by the state and territory legislatures.

1.18 The *Health Practitioner Regulation National Law Act 2009* (Qld) (National Law) received Royal Assent on 3 November 2009. It details the substantive provisions for registration and accreditation. Other states and territories passed similar legislation to the National Law and jurisdiction-specific consequential and transitional provisions.<sup>14</sup> The NRAS legislation replaced 65 Acts across the jurisdictions and the bodies established replaced 80 state and territory boards. Several jurisdictions made amendments to the National Law, including New South Wales which opted for retaining its own complaints system. As the NRAS is based on state and territory legislation, the Commonwealth has limited capacity to modify complaints procedures.

1.19 The NRAS commenced on 1 July 2010 for all States and Territories except Western Australia, which joined the NRAS on 18 October 2010.

### ***Improving health outcomes and patient safety***

1.20 The NRAS was originally recommended as a productivity measure by the Productivity Commission.<sup>15</sup> However, in implementing the scheme, COAG emphasised the scheme's purpose in protecting health consumers and stated:

The new scheme will deliver many benefits to the Australian community including health consumers. National standards in each profession will mean stronger safety guarantees for the community. Patients will know that wherever the health professional is from, they are registered against the same, high-quality national professional standards.<sup>16</sup>

1.21 As the Department of Health noted, the NRAS is one element of Australia's health system, but it does have particular responsibility for the protection of the public:

This Scheme for the first time initiated nationally consistent standards for the registered professions, provided mobility for professionals to work across jurisdictions and allowed the development of a national public register of registered health professionals.<sup>17</sup>

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13 Department of Health, *Submission 13*, p. 9.

14 Australian Health Workforce Ministerial Council, *Submission 70*, p. 7, in Senate Finance and Public Administration References Committee, *Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA)*.

15 Productivity Commission, *Australia's Health Workforce*, Research Report, January 2006.

16 COAG *Communique*, 13 April 2007, <http://webarchive.nla.gov.au/gov/20070830052604/http://www.coag.gov.au/meetings/130407/index.htm> (accessed 10 March 2016).

17 Department of Health, *Submission 13*, p. 6.

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1.22 From the perspective of the Medical Board of Australia, the Nursing and Midwifery Board of Australia and the Australian Health Practitioner Regulation Authority one of the National Scheme's notable achievements is improved outcomes for patients via greater public protection:

... a national on-line register of practising practitioners and cancelled health practitioners which can be accessed by the public at any time, and prevents health practitioners who have committed misconduct and faced regulatory action to practise undetected in other states or territories.<sup>18</sup>

### ***Creation of the Australian Health Practitioner Regulation Agency***

1.23 The Australian Health Practitioner Regulation Agency (AHPRA) was established as the national agency responsible for implementation and ongoing management of the NRAS, and currently oversees 14 professions, including medical practitioners and nurses/midwives. The 14 National Boards currently part of the NRAS are:

- Aboriginal and Torres Strait Islander Health Practice Board of Australia;
- Chinese Medicine Board of Australia;
- Chiropractic Board of Australia;
- Dental Board of Australia;
- Medical Board of Australia;
- Medical Radiation Practice Board of Australia;
- Nursing and Midwifery Board of Australia;
- Occupational Therapy Board of Australia;
- Optometry Board of Australia;
- Osteopathy Board of Australia;
- Pharmacy Board of Australia;
- Physiotherapy Board of Australia;
- Podiatry Board of Australia; and
- Psychology Board of Australia.<sup>19</sup>

1.24 AHPRA has the following roles:

- maintaining up-to-date and publicly accessible national lists of accredited courses and registered practitioners with entries relating to individuals to include any conditions or restrictions on professional practice;

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18 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 8.

19 AHPRA website, <http://www.ahpra.gov.au/National-Boards.aspx> (accessed 19 October 2016).

- administering the resources of the scheme and ensure the scheme is as efficient as possible;
- acting in accordance with any policy directions from the Ministerial Council;
- reporting annually to the Ministerial Council;
- following agreement with the boards, setting fees, and where there is no agreement, referring this to the Ministerial Council;
- at its discretion, contracting or delegating functions, excluding registration and accreditation functions, with any delegations reported to the Ministerial Council;
- in consultation with the boards, developing and administering procedures and business rules for the efficient and quality operation of the registration and accreditation functions and the operation of the boards and their committees, consistent with ministerial policy direction and the objects of the legislation;
- in accordance with the objects of the legislation and any policy directions of health ministers, set frameworks and requirements for the development of registration, accreditation and practice standards by the national boards to ensure that good regulatory practice is followed;
- advising the Ministerial Council on issues relevant to the scheme; and
- establishing a national office.<sup>20</sup>

### ***National Boards and the regulation of individual practitioners***

1.25 There is a National Board for each of the 14 regulated health professions. National Board members are appointed by the Ministerial Council. At least half, but not more than two thirds of National Board members must be practitioner members and the remaining members are appointed as community members to ensure a degree of oversight from people outside the profession. Members of State and Territory Boards (Professional Boards) are appointed by the Minister for Health in each jurisdiction, with the same requirement for ratios of community members.

1.26 The functions of the Boards focus on protecting the public and guiding the professions. This includes responsibilities for registering health practitioners who meet the requirements of approved registration standards, investigating and managing concerns (known as notifications) about the performance, health or conduct of practitioners and developing standards, codes and guidelines. National Boards have delegated many functions to AHPRA and Board committees (national or State and Territory or regionally-based) to support the efficient functioning of the National Scheme. Registrations and complaints procedures are delegated from the National Board to the relevant state or territory Boards.

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20 Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions, pp 12–13, <https://www.ahpra.gov.au/About-AHPRA/Ministerial-Directives-and-Communiques.aspx> (accessed 19 October 2016).

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## **Reviews of the NRAS**

### *2011 Senate Finance and Public Administration References Committee inquiry*

1.27 In June 2011, just under a year after the NRAS took effect, the Senate Finance and Public Administration References Committee reported on its inquiry into the administration of health practitioner regulation by AHPRA. That report acknowledged the scale of the undertaking, but highlighted that implementation of the NRAS had been problematic.<sup>21</sup>

1.28 The committee wrote:

The committee points to the impact on patients and health service provision as yet another example of the serious implications of AHPRA's administrative failures. The committee notes that it has exacerbated patient waiting times, and compromised health service provision, particularly in rural and remote communities which are already particularly vulnerable.<sup>22</sup>

1.29 The committee made ten recommendations, including one relevant to this inquiry's focus:

#### **Recommendation 5**

The committee recommends that complaints processing within AHPRA be reviewed to ensure more accurate reporting of notifications and to reduce the impact of vexatious complaints on health practitioners.<sup>23</sup>

### *2014 Independent review*

1.30 In 2014, the National Scheme was reviewed by an Independent Reviewer, Mr Kim Snowball. The final report of this review was published in 2015 and made 33 recommendations. The Australian Health Workforce Ministerial Council accepted the two recommendations specifically related to AHPRA's notification and investigation process.<sup>24</sup>

1.31 The first of these, Recommendation 9, concerned increased and improved communication from AHPRA to both the notifier and the medical practitioner,

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21 Senate Finance and Public Administration References Committee, *Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency*, June 2011, p. 111.

22 Senate Finance and Public Administration References Committee, *Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency*, June 2011, p. 81.

23 Senate Finance and Public Administration References Committee, *Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency*, June 2011, p. xi.

24 Department of Health, *Submission 13*, p. 3; see also COAG Health Council, meeting as the Australian Health Workforce Ministerial Council, *The Independent Review of the National Registration and Accreditation Scheme for Health Professionals*, Communique, 7 August 2015, <http://www.coaghealthcouncil.gov.au/Announcements/ArtMID/527/ArticleID/71/Reissued-Communique-Final-Report-of-the-Independent-Review-on-the-National-Accreditation-Scheme-for-health-professionals> (accessed 2 November 2016).

including establishing the notifier's expectation for matters referred to a National Board. The Ministers asked AHPRA to 'action this recommendation as a matter of priority and provide a progress report by December 2015'.<sup>25</sup>

1.32 Recommendation 28 was that AHPRA should, in consultation with the National Boards, Tribunals and Panel members, conduct specific education and training programs for its investigators, with the aim of developing 'more consistent and appropriate investigative standards and approaches... including the primacy of public safety over other considerations within the matters'.<sup>26</sup> The ministerial council accepted this recommendation and requested a progress report from AHPRA by December 2015.<sup>27</sup>

1.33 In their submission, the Medical Board, Nursing and Midwifery Board and AHPRA recognised that:

... the management of notifications and complaints has not always met community expectations, including concerns about delays in the management of some notifications and confusion in roles with partners such as the health complaints entities.<sup>28</sup>

1.34 Consequentially, they have been working to improve the process, particularly in terms of timeliness and communication. They identified three main areas in which improvements were being made:

- implementing processes that deliver early triage of notifications and greater clinical input to ensure we continue to improve the timeliness of assessment of notifications;
- working with health complaints entities to ensure roles and processes are as clear as possible for notifiers and practitioners. A common assessment matrix has been developed and agreed to determine which entity is best placed to manage each matter and public information has also been produced; and
- correspondence with notifiers and practitioners has been reviewed and improved and more meaningful progress reports are now being provided to notifiers and practitioners during the course of investigations.<sup>29</sup>

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25 COAG Health Council, meeting as the Australian Health Workforce Ministerial Council, *The Independent Review of the National Registration and Accreditation Scheme for Health Professionals*, Communique, 7 August 2015, p. 4.

26 COAG Health Council, meeting as the Australian Health Workforce Ministerial Council, *The Independent Review of the National Registration and Accreditation Scheme for Health Professionals*, Communique, 7 August 2015, p. 6.

27 COAG Health Council, meeting as the Australian Health Workforce Ministerial Council, *The Independent Review of the National Registration and Accreditation Scheme for Health Professionals*, Communique, 7 August 2015, p. 6.

28 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 7.

29 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 7.

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## **Conduct of the inquiry**

1.35 The inquiry was referred to the committee on 2 February 2016, with a reporting date of 30 June 2016 set.<sup>30</sup> It lapsed with the dissolution of the 44<sup>th</sup> Parliament on Monday 9 May 2016 and was re-referred by the Senate on 15 September 2016.<sup>31</sup> A new reporting date of 16 November 2016 was set, but was subsequently extended until 30 November 2016.<sup>32</sup>

### ***Handling of submissions***

1.36 The committee invited submissions to be lodged by Friday 13 May 2016. Following the inquiry's lapse and re-referral, the committee decided not to formally call for further submissions but continued to accept submissions.

1.37 In total, the committee received 129 submissions from individuals and organisations. A list of submissions to the inquiry is available at Appendix 1.

1.38 The committee received a number of submissions from individual medical practitioners, as well as from family members or others on their behalf, discussing their personal experience of bullying and harassment, including via the complaints process. The majority of these submissions provided detailed accounts of individual cases.

1.39 To respect the privacy of those submitters, as well as of other medical practitioners, patients and employees of the health system, the committee decided to accept all such submissions in confidence. While individual cases and examples will not be referred to in this report, the committee acknowledges the concerns expressed by those who made submissions to this inquiry. These submissions assisted the committee to gain a firsthand understanding of the issues involved – the ways in which the complaints process has been implemented, concerns about AHPRA's management of the assessment and investigation process and the effects on practitioners' careers and lives as a result.

1.40 The committee also held two public hearings: one in Sydney on 1 November 2016 and a second in Canberra on 22 November 2016. Transcripts of those hearings are available on the committee's website and a list of witnesses who gave evidence is provided in Appendix 2. The committee acknowledges and thanks all those who contributed to this inquiry by providing written submissions or appearing at the public hearings.

### ***Structure of this report***

1.41 Following this introductory chapter, this report consists of three further chapters.

1.42 Chapter 2 outlines the medical complaints process in Australia, discussing the process of assessing and investigating complaints – known as notifications – lodged

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30 Journals of the Senate, *No. 135–2 February 2016*, pp 3661–3662.

31 Journals of the Senate, *No. 7–15 September 2016*, pp 224–225.

32 Journals of the Senate, *No. 15–10 November 2016*, p. 451.

against medical practitioners and how vexatious complaints are dealt with. It then discusses concerns with this process, specifically in relation to its relationship to bullying and harassment. In particular, this chapter draws on evidence the committee received which suggests that the complaints process – the making of a notification and the investigation by AHPRA and other bodies – can be itself used as a tool of bullying and harassment within the profession. The chapter then discusses the ramification of this, including its negative impacts on practitioners' careers and lives and consequences for patient safety.

1.43 Chapter 3 addresses broader questions of bullying and harassment in Australia's medical profession, including the responses to these made within the profession itself.

1.44 Chapter 4 discusses the broader context of this inquiry, noting that this inquiry into the intersection of the medical complaints process and the prevalence of bullying and harassment within the profession has drawn the committee's attention to systemic questions and concerns about the medical complaints process in Australia as a whole. The chapter outlines areas the committee considers to require further investigation that is beyond the scope of this inquiry's terms of reference.

## Chapter 2

### The complaints process as a tool of harassment

#### Introduction

2.1 A key focus of this inquiry was the ways in which the medical complaints process in Australia, particularly that run by the Australian Health Practitioner Regulation Agency (AHPRA) and the medical boards, may have been used as a tool of harassment within the medical profession. The committee received a considerable amount of evidence suggesting that one form of bullying and harassment within the medical profession is for one practitioner to lodge a notification against another with AHPRA, possibly leading to an investigation and findings against the latter.

2.2 This chapter will outline AHPRA's complaints process, identified by submitters as being vulnerable to be used for the purpose of bullying and harassment, and the option for the review of AHPRA's decisions through the National Health Practitioner Ombudsman and Privacy Commissioner. The chapter will then discuss the concerns with this process as identified by submitters and witnesses to this inquiry, including the lodging of vexatious complaints; timeliness; transparency and communication; conflicts of interest; qualifications of the investigators and the use of benchmarking.

#### Complaints procedures

2.3 Anyone can make a complaint (also called a notification) about a registered health practitioner's health, performance or conduct. The management of these notifications is a joint responsibility of AHPRA and the relevant National Board.<sup>1</sup> AHPRA is responsible for investigating registered health practitioners and providing information for the National Board to consider in making its decision.<sup>2</sup>

2.4 Different National Boards have delegated some of their decision-making to their State/Territory committees and AHPRA officers. There are a number of possible stages in the notifications process and they do not need to be completed in a linear sequence, nor does every notification go through all the possible stages. Many notifications are closed after assessment.

2.5 In New South Wales, complaints against health care practitioners are handled by the Health Care Complaints Commission. These complaints are handled in a process similar to those received by AHPRA.<sup>3</sup>

2.6 In Queensland, the Office of the Health Ombudsman is responsible for managing serious complaints relating to health practitioners, and determines which

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1 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 4.

2 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 4

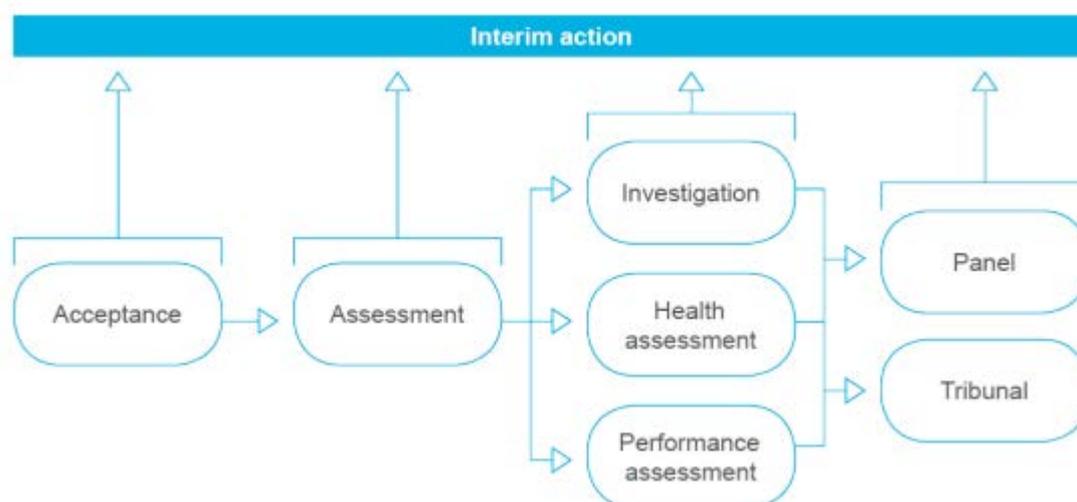
3 Department of Health, *Submission 13*, p. 3. See: <http://www.hccc.nsw.gov.au/>

complaints go to AHPRA and the National Boards after assessing their severity. AHPRA must then refer back to the Office of the Health Ombudsman any complaint where, during investigation, a suspicion of professional misconduct is developed.<sup>4</sup>

2.7 Decisions made at the state level in New South Wales and Queensland regarding a practitioner's conditions of practice or registration will be communicated to AHPRA for inclusion on the AHPRA public register of health practitioners.<sup>5</sup>

2.8 AHPRA's notification process can be seen illustrated in Figure 2.1, noting that interim or final action can be taken at any point in the process.

**Figure 2.1 – AHPRA notification process**



Source: Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 15.

2.9 In the Acceptance stage, the notification is received and a preliminary review is undertaken to confirm that the matter is grounds for notification, that it relates to a registered health practitioner (or student) and whether it could also be made to a health complaints entity.<sup>6</sup> Generally, at this point the practitioner about whom the notification has been made will be asked to respond, unless the issue relates to a matter that the Board cannot deal with or AHPRA is concerned that the notification

4 Department of Health, *Submission 13*, p. 3. See: <http://www.oho.qld.gov.au/>

5 Department of Health, *Submission 13*, p. 3.

6 Health complaints entities (HCE)s are state and territory-based bodies whose role is to investigate concerns about health service providers or systems. Regarding individual practitioners, HCEs can investigate specific concerns, primarily around fees and charges; they do not deal with issues relating to patient safety or practitioner registration. AHPRA and HCEs share information regarding complaints more relevant to the other, and sometimes will run a joint investigation. See: <http://www.ahpra.gov.au/Notifications/Further-information/Health-complaints-organisations.aspx>

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raises issues that might pose a serious risk to the public, in which case the relevant National Board can take immediate action to protect the public.<sup>7</sup>

2.10 Once a notification has been accepted, it enters the Assessment stage. AHPRA may ask for more information, and will usually send the relevant practitioner a copy of the notification unless it would prejudice the investigation or place a person at risk. AHPRA presents the information to the Board for consideration, and the Board can either close the notification with no further action taken, propose to take relevant action (such as cautioning the practitioner, imposing conditions on their registration or accepting undertakings from them),<sup>8</sup> or refer the matter to the next stage of Investigation, Health Assessment or Performance Assessment. AHPRA aims to complete the Assessment stage for each notification within 60 days. Proposing to take a relevant action, however, can extend that timeframe, since the practitioner will be given the chance to show cause as to why that action should not be taken.<sup>9</sup>

2.11 If the Board is not satisfied with the amount of information it has been provided with at the Assessment stage, it can refer the notification back to AHPRA for Investigation, Performance Assessment or a Health Assessment. Investigations are carried out by AHPRA officers and seek additional information to aid the Board in its decision making. This information can take many forms, including additional information from the notifier and/or practitioner, information from other health practitioners involved, independent expert opinions or other information such as Medicare data or police records. Once the investigation is complete, the Board seeks to form a reasonable belief as to whether the practitioner has behaved in a way that constitutes unsatisfactory professional performance, unprofessional conduct or professional misconduct, or if they have a health impairment. If the Board cannot make such a judgement, it may decide to take no further action. AHPRA's aim is to complete each investigation in six months, but it notes that complex investigations make take longer. At six, nine and twelve months, each investigation is audited to ensure that it is proceeding appropriately.<sup>10</sup>

2.12 A Health Assessment is undertaken if the practitioner's health is suspected to be impaired and impacting their professional performance, particularly as it relates to patient safety. Practitioners have the right to make submissions to the Board as part of the Health Assessment stage and the results of the assessment are discussed with

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7 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 16.

8 Examples of conditions that may be imposed include the completion of additional training, undertaking a period of supervised practice, managing their practice in a specified way or reporting at regular times on their practice. Undertakings are voluntary and relate to limitations on the practitioner's practice. Both conditions and undertakings are noted on the national register. See: <http://www.ahpra.gov.au/Support/Glossary.aspx>

9 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 17.

10 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, pp 18–19.

them. Boards have a range of options for action after undertaking a health assessment, including taking no further action; cautioning, accepting an undertaking from, or imposing conditions on, the practitioner; referring the matter to another entity; investigating further; requiring a Performance Assessment; or referring the matter for hearing by either a panel or tribunal.<sup>11</sup>

2.13 A Performance Assessment is carried out by one or more independent practitioners to assess the knowledge, skill, judgement and care demonstrated by the practitioner. As with a health assessment, the results are discussed with the practitioner, and the Board has the same range of options open to it at the assessment's completion.<sup>12</sup>

2.14 Matters relating to a notification about a health practitioner can also be referred by the Board to a panel – either a health panel if the practitioner is believed to have an impairment affecting their performance or a performance and professional standards panel if a Board believes that the practitioner's practice or professional conduct may be unsatisfactory. The panel then has the same powers of the Board and additionally can issue a reprimand of the practitioner. Reprimands, like conditions and undertakings, appear on the national public register of practitioners.<sup>13</sup>

2.15 If a Board finds that a practitioner's conduct amounts to professional misconduct, the matter must be referred to a Tribunal hearing. Tribunals are headed by a judge or magistrate and include at least one professional representative and one community representative.<sup>14</sup> Like panels, tribunals have broad powers, but can also cancel the registration of a practitioner.<sup>15</sup>

### ***Mandatory notifications***

2.16 Under the National Law, health practitioners, employers and education providers have mandatory reporting responsibilities to advise AHPRA or a National Board if they have formed a reasonable belief that a health practitioner has behaved in a way that constitutes notifiable conduct in relation to the practice of their profession.

2.17 Notifiable conduct by registered health practitioners is defined as:

- practising while intoxicated by alcohol or drugs;
- sexual misconduct in the practice of the profession;

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11 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 19.

12 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 20.

13 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 20.

14 The Tribunal is the relevant administrative review tribunal in the state or territory. See: <http://www.ahpra.gov.au/Notifications/Find-out-about-the-complaints-process/Tribunal-hearing.aspx>

15 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 21.

- placing the public at risk of substantial harm because of an impairment (health issue); or
- placing the public at risk because of a significant departure from accepted professional standards.<sup>16</sup>

2.18 Education providers have an obligation to make a mandatory notification about a student if the student has an impairment that may, either in the course of study or clinical training, place the public at substantial risk of harm.<sup>17</sup>

### ***Statistics on notifications***

2.19 AHPRA received 3 147 notifications about medical practitioners and 1435 about nurses and midwives in 2015-16. Of these:

- 369 (11.7%) of the notifications about medical practitioners were made by other medical practitioners and 620 (43.2%) of those about nurses and midwives were lodged by other nurses and midwives (these figures include self-disclosures);<sup>18</sup>
- 33 of the 3147 notifications about medical practitioners and 30 of the 1435 notifications about nurses and midwives identified bullying and harassment as a primary reason for the notification;<sup>19</sup>
- 32.5% of the notifications completed by AHPRA in 2015-16 received a full investigation or a specialised assessment. The remainder were closed following assessment;<sup>20</sup>
- 3.2% of complaints received by AHPRA in 2015–16 led to a panel hearing and 3.5% a tribunal hearing.<sup>21</sup>

2.20 These statistics demonstrate that the majority of notifications lodged—particularly against medical practitioners, less so regarding nurses and midwives—were from members of the public. Just under 12 per cent of the notifications lodged against medical professionals came from colleagues.

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16 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 14. Note: In Western Australia there is no legal requirement for treating practitioners to make mandatory notifications about patients (or clients) who are practitioners in one of the regulated health professions.

17 See: <http://www.ahpra.gov.au/Notifications/Who-can-make-a-notification/Mandatory-notifications.aspx>

18 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 6.

19 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 4.

20 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 5.

21 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 21.

2.21 While the proportion of notifications lodged to AHPRA regarding bullying and harassment was low, this should not be taken to suggest that bullying and harassment levels are low, but rather illustrates that AHPRA's primary purpose relates to public safety. Bullying and harassment allegations would, in most cases, be more relevant to investigate through the individual workplace or the relevant professional college.

### ***Review of decisions***

2.22 The National Health Practitioner Ombudsman and Privacy Commissioner (the Ombudsman) is an independent statutory agency created to provide ombudsman, privacy and freedom of information oversight of the agencies of the National Scheme, including AHPRA and the National Boards.<sup>22</sup> As such, the Ombudsman handles complaints from people dissatisfied with an AHPRA decision. The Ombudsman's submission outlines the actions of AHPRA or a National Board that may be the subject of a complaint:

- the actions taken by AHPRA to assess and investigate notifications or complaints made under the National Law;
- the actions of a National Board when making a decision in relation to matters raised as a result of a notification or complaint; and
- the actions of a National Board when making a decision to refuse registration or place conditions on the registration of a health practitioner.<sup>23</sup>

2.23 Ms Samantha Gavel, current (and first) Ombudsman, further outlined her responsibilities and powers, emphasising that the Ombudsman's office is focused on AHPRA's procedures, rather than the details of the original complaint:

It is important to note that the role of my office is not to review the conduct or performance of health practitioners; that is the role of the national boards. The role of my office is to consider the administrative actions of AHPRA and the board in relation to action that is subject of a complaint. We examine whether AHPRA and the board have acted consistently with applicable legislation, have complied with relevant policies and procedures and have taken relevant considerations into account. In particular, we look at whether AHPRA has gathered sufficient information during its investigation to inform the board's decision making and whether the board's decision is reasonable based on the information gathered by AHPRA.<sup>24</sup>

2.24 Actions open to the Ombudsman include recommending that AHPRA and the National Boards:

- reconsider a decision;
- review or change a policy or procedure;

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22 National Health Practitioner Ombudsman and Privacy Commissioner, *Submission 12*, p. 5.

23 National Health Practitioner Ombudsman and Privacy Commissioner, *Submission 12*, pp 6–7.

24 Ms Samantha Gavel, National Health Practitioner Ombudsman and Privacy Commissioner, *Committee Hansard*, 1 November 2016, p. 2.

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- offer an apology to an affected person;
  - expedite a delayed action; and
  - provide a better explanation to a person affected by a decision of AHPRA or a National Board.<sup>25</sup>

2.25 However the Ombudsman can only make those recommendations; it cannot overturn an AHPRA or National Board decision or force a review.<sup>26</sup> Further, in New South Wales, the Ombudsman has no jurisdiction to respond to complaints (complaints there are handled by the New South Wales Health Care Complaints Commission) and in Queensland can only respond if the matter is transferred from the Queensland Office of the Health Ombudsman.<sup>27</sup>

2.26 In 2014–15, the Ombudsman received a total of 75 complaints. The largest category of these (35 cases, or just under 47%) was from notifiers unhappy with the result of their notification about a practitioner; while 17 (or just under 23%) were from practitioners regarding the handling of a notification against them. The majority of the remainder was related to registration issues from individual practitioners.<sup>28</sup>

2.27 The 2015–16 figures showed 40 per cent of complaints came from members of the public concerned about the results of their notification against a health practitioner. A further 14 per cent were from health practitioners who had been the subject of a notification, and 34 per cent related to registration issues.<sup>29</sup> From 2014–15 to 2015–16, therefore, there was a slight drop in the proportion of complaints received by the Ombudsman from practitioners regarding the way a notification against them had been managed.

2.28 The Ombudsman also has a role in providing feedback to AHPRA and the National Boards about systemic issues identified from complaints received and helping those bodies to improve their processes.<sup>30</sup>

### ***Vexatious complaints handling***

2.29 One of the key issues identified in evidence received by this inquiry is that of vexatious complaints. Multiple witnesses argued that complaints are too often made for vexatious reasons, using the complaints process as a tool of bullying and harassment. In this section, AHPRA's process for identifying and handling vexatious complaints will be outlined.

2.30 Section 151 of the National Law authorises National Boards to take no further action on any notification if it reasonably believes it to be vexatious or frivolous.

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25 National Health Practitioner Ombudsman and Privacy Commissioner, *Submission 12*, p. 7.

26 National Health Practitioner Ombudsman and Privacy Commissioner, *Submission 12*, p. 7.

27 National Health Practitioner Ombudsman and Privacy Commissioner, *Submission 12*, p. 8.

28 National Health Practitioner Ombudsman and Privacy Commissioner, *Submission 12*, p. 9.

29 Ms Samantha Gavel, National Health Practitioner Ombudsman and Privacy Commissioner, *Committee Hansard*, 1 November 2016, p. 2.

30 Department of Health, *Submission 13*, p. 3.

Section 237 protects those who make a notification in good faith. However, as the joint submission from the Medical Board, Nursing and Midwifery Board and AHPRA notes, classifying notifications as vexatious is not straightforward:

However, determining that a notification is vexatious can be difficult, and hence data on vexatious complaints and notifications are difficult to quantify. For example, a complaint may relate to performance and risks to public safety but there may be elements of self interest from a notifier in relation to their professional or commercial interests.<sup>31</sup>

2.31 The Ombudsman noted that ready access to the complaints mechanism is important for public health and that, while complaints can be lodged vexatiously, there is limited evidence of this happening often:

... the NHPOPC's [National Health Practitioner Ombudsman and Privacy Commissioner] experience in handling complaints about the administrative actions of AHPRA and the National Boards does not suggest that there is a high incidence of people intentionally using notification processes for vexatious purposes.<sup>32</sup>

2.32 Mr Martin Fletcher, Chief Executive Officer of AHPRA, made a similar point, drawing on existing research:

What I am saying is that in all of the available data and research evidence that we have looked at there does not appear to be a big problem with vexatious complaints, and by 'vexatious' I mean a harmful intent on the part of the person making the complaint and no patient safety concern emerging when we look at the issue.

[...]

If I can give you one example, we have a research partnership with the University of Melbourne. They looked at 850 mandatory notifications over a 12-month period. They found fewer than six that they believed potentially met the criteria for a vexatious notification. The point I am also making is that, even though the numbers are small, we recognise that the impact on the individuals involved can be significant.<sup>33</sup>

2.33 The Ombudsman also pointed to existing safeguards against the making of vexatious complaints; in addition to the provision authorising National Boards to take no further action on complaints it deems vexatious or frivolous:

Other provisions include the requirement for a national board to undertake a show-cause process in some circumstances and the ability of a health

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31 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 6.

32 National Health Practitioner Ombudsman and Privacy Commissioner, *Submission 12*, p. 13.

33 Mr Martin Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 1 November 2016, p. 3.

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practitioner to appeal most types of regulatory action to a tribunal or court.<sup>34</sup>

2.34 The Ombudsman further noted that even some vexatiously made complaints may raise issues of public safety and expressed its confidence in the notification assessment and investigative processes of AHPRA and the National Boards in ensuring the protection of the public.<sup>35</sup>

2.35 AHPRA noted in this context that soon after the completion of this inquiry, it will launch a portal for the lodging of complaints online, which will also '... invite a declaration from the notifier that the content of their complaint or concern is true and correct to the best of their knowledge and belief.' A corresponding change will be made to the hard copy complaint form at the same time.<sup>36</sup>

2.36 AHPRA further noted that it will monitor the impact of this addition to 'ensure there are no unintended consequences for people wanting to raise concerns about registered health practitioners'.<sup>37</sup>

2.37 Similarly, AHPRA explained that, to better identify and understand the problem, it will commission research into vexatious notifications:

As we have previously advised the committee, the data we have and the available research indicate this is a very small problem, but we recognise it has a big impact when it happens. We will publish what we learn and act on it.<sup>38</sup>

2.38 Mr Fletcher further noted that a process is underway to more specifically prohibit the making of vexatious complaints by medical practitioners:

... the Medical Board will toughen its code of conduct in relation to vexatious complaints. Establishing a clear benchmark will enable the board to take further action against a practitioner who makes complaints purely to damage another registered practitioner.<sup>39</sup>

#### *Committee view*

2.39 The committee recognises that vexatious complaints are not always readily apparent, but is not convinced that AHPRA's processes are adequate for the purpose of identifying complaints made vexatiously.

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34 Ms Samantha Gavel, National Health Practitioner Ombudsman and Privacy Commissioner, *Committee Hansard*, 1 November 2016, p. 2.

35 National Health Practitioner Ombudsman and Privacy Commissioner, *Submission 12*, p. 13.

36 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 10.

37 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 10.

38 Mr Martin Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 1 November 2016, pp 1–2.

39 Mr Martin Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 1 November 2016, p. 2.

### **Vexatious complaints as a form of bullying and harassment**

2.40 The committee has received a considerable amount of confidential evidence suggesting that the complaints process can be used as a tool of bullying and harassment within Australia's medical profession.

2.41 A significant proportion of confidential submitters claim that vexatious complaints have been made against them either internally within the workplace or through the formal processes of AHPRA to bully or harass them. In particular, submitters allege that notifications were lodged against them in response to their own complaints of bullying and harassment.

2.42 Confidential submitters are concerned that there is no avenue for AHPRA to counsel complainants on false or misleading allegations and that there are no consequences for individuals who make vexatious complaints. Some confidential submitters consider it would be beneficial if a record of vexatious complainants was kept and suggest that legal action should be taken against people found to have submitted vexatious complaints.

2.43 Dr Don Kane, Chair of the advocacy group Health Practitioners Australia Reform Association (HPARA), argued that this is a substantial problem for medical practitioners:

These people [those making vexatious complaints] are misusing AHPRA for their own personal reasons. It is very rare, if ever, that AHPRA have taken action against people who have lodged vexatious claims. There is an absolute abuse of the mandatory notification process. It was put in there in the guise of being in the public interest, but really it is in the interests of the people making the complaint.<sup>40</sup>

2.44 The Medical Board of Australia and AHPRA responded to this concern, arguing that their primary concern is in ensuring patient and public safety and that any weakening of the notification and investigation process would undermine that:

It has been alleged that the way AHPRA and the boards deal with complaints is a form of bullying. We reject this allegation. We fully accept that it is our responsibility to make sure we deal with notifications fairly and efficiently. We have worked hard to improve the timeliness of our processes and to improve our communication with both notifiers and practitioners. We have streamlined how we work with other health complaints entities to make sure that the right body is managing the complaint from the outset.

But our primary focus is patient safety. Notifications that raise serious issues must be dealt with rigorously, and we must take appropriate regulatory action where there is a risk to the public. The community comes to us with their concerns when they have had a bad experience or a bad

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40 Dr Don Kane, Chair, Health Practitioners Australia Reform Association, *Committee Hansard*, 1 November 2016, p. 39.

outcome. They want us to take their concerns seriously and to take action to ensure that whatever happened to them does not happen again.<sup>41</sup>

### Concerns with AHPRA's complaints process

2.45 Many confidential submissions express concern about AHPRA's management of vexatious complaints, as those submitters are concerned that the complaints process is misused as a vehicle to bully and harass medical professionals.

2.46 Conversely, confidential submissions from family members of patients expressed concern that their genuine complaints had resulted in lenient consequences for the medical practitioners concerned.

2.47 The issue of the AHPRA complaints handling process, including the identification of vexatious complaints, was reviewed during the 2011 Finance and Public Administration References Committee Inquiry into AHPRA. The committee commented:

The committee is concerned about inconsistency in the application of complaint processes, the prescriptiveness of the application form and the way in which vexatious complaints are handled. The committee considers that further development of the complaints process is urgently required.<sup>42</sup>

2.48 The committee recommended:

[T]hat complaints processing within AHPRA be reviewed to ensure more accurate reporting of notifications and to reduce the impact of vexatious complaints on health practitioners.<sup>43</sup>

2.49 The Government response to the inquiry report did not provide any comments specific to this recommendation.<sup>44</sup>

2.50 Discussing that committee's findings and recommendations, the Ombudsman, Ms Samantha Gavel, noted that considerable improvements had been made in AHPRA's processes since 2011, when the National Scheme was still new:

I think we all know that there were problems with the notification process in the first few years of the scheme. I certainly know that from the reading I have done, and I have had a look at some of those reports. Since I came into

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41 Dr Joanna Flynn, Chair, Medical Board of Australia, *Committee Hansard*, 1 November 2016, p. 54.

42 Senate Finance and Public Administration References Committee, *Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency*, June 2011, p. 93.

43 Senate Finance and Public Administration References Committee, *Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency*, June 2011, p. xi.

44 Australian Government, *Response to the Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency*, [http://www.aph.gov.au/~media/wopapub/senate/committee/fapa\\_ctte/completed\\_inquiries/2010-13/health\\_practitioner\\_registration/government\\_response/gov\\_response.ashx](http://www.aph.gov.au/~media/wopapub/senate/committee/fapa_ctte/completed_inquiries/2010-13/health_practitioner_registration/government_response/gov_response.ashx) (tabled 7 February 2012).

the role, which was two years ago now, I have seen a big improvement in notification processes. [...]

I have seen a big improvement in all sorts of areas. They have put a number of new policies and processes in place. For example, they have done more training for their staff that take calls on the phone so that they are better able to talk people through the national law, the notifications process and what they can expect. They can keep them better informed about what is occurring. They are now providing far more detailed outcome letters, which is important so that people understand what the board has looked at and why they have come to the decisions that they have. They are some of the areas where I have seen improvements.<sup>45</sup>

2.51 Despite this, the committee is concerned by the proportion of submitters to this inquiry who identified serious concerns with AHPRA's management of the notification and investigation process, particularly when in relation to notifications lodged vexatiously, as a tool of bullying and harassment. This section will outline those concerns.

### ***Timeliness***

2.52 Confidential submitters complained of long timelines for AHPRA investigations to be completed, ranging from two to four years. The slow timeframes concerns both those who have made complaints and those who have had complaints made against them. The former want to see incompetent practitioners quickly dealt with in a manner that protects the public. The latter are concerned that competent doctors' time and energy is being wasted responding to false accusations.

2.53 As noted above, AHPRA's target is to complete each investigation within six months. Ms Kym Ayscough, the Acting Chief Executive Officer, noted that the agency is aware of concerns in this area and pointed to the median age of open notifications as being 137 days:

In the material that we have to 30 June 2016, the median age of open notifications is 137 days, and that is a five-day reduction in median age from the same time last year. This has been a particular area of focus for us. We know there was a lot of criticism, in the early days, of the national scheme about the time frames, and we have continued to work diligently, both AHPRA and the boards, to bring those time frames within reasonable expectations.<sup>46</sup>

2.54 Organisations also commented on this aspect of the complaints process. For example, the Australian and New Zealand College of Anaesthetists argued that:

In this area justice delayed is justice denied.

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45 Ms Samantha Gavel, National Health Practitioner Ombudsman and Privacy Commissioner, *Committee Hansard*, 1 November 2016, p. 4.

46 Ms Kym Ayscough, Acting Chief Executive Officer; Executive Director, Regulatory Operations, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 1 November 2016, p. 55.

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It is important for the health professional to have any concerns speedily dealt with; at the same time if the concerns are sustained, then it is important for public protection that appropriate action is taken, including changes to the registration status.<sup>47</sup>

2.55 Similarly, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) also argued that timeliness of investigation is both vital and frequently absent:

Timely and necessary action in response to complaints is important in providing effective public protection and confidence in the National Law on the part of both practitioners and patients.

An ongoing problem is the length of time it takes to investigate and resolve complaints. In recent years, investigations have taken far too long, causing unnecessary stress for both complainants and practitioners under investigation and leaving both in the dark as to the outcome.<sup>48</sup>

2.56 RANZCP further noted that AHPRA often does not communicate well and promptly with them regarding the investigation of RANZCP members.<sup>49</sup>

2.57 The Australian Dental Association (ADA) argued that the length of time investigations can take can have a deleterious effect on both notifier and practitioner:

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.<sup>50</sup>

2.58 Conversely, some confidential submitters complained about onerous requirements to produce documents to the investigative team on short notice.

#### *Committee view*

2.59 The committee recognises that AHPRA has improved its processes and that the timeframe for the closing of notifications has decreased in recent years. However, given the importance to both notifier and practitioner of timely resolution to each case,

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47 Australian and New Zealand College of Anaesthetists, *Submission 5*, p. [3].

48 Royal Australian and New Zealand College of Psychiatrists, *Submission 19*, p. 2.

49 Royal Australian and New Zealand College of Psychiatrists, *Submission 19*, p. 2.

50 Australian Dental Association, *Submission 6*, [p. 3].

the committee considers this issue to be of the highest significance and an area for continued monitoring and review.

### ***Transparency and communication***

2.60 Many confidential submitters claim the investigative process lacks transparency and scrutiny. A few note unsuccessful attempts to be provided with all information in relation to an allegation against them or to seek clarification of the details of their case. Some claim evidence is taken on face value and that those accused are not given the opportunity to respond to claims made in the investigation.

2.61 One illustration of this point came from Dr Gary Fettke, who discussed the problems he faced when trying to respond during AHPRA's investigation of his practice:

The AHPRA process has shifting goalposts for those under investigation. You answer one allegation and another one surfaces. Trying to defend one's position without knowing the evidence and its accuracy makes for a star chamber circus.<sup>51</sup>

2.62 AHPRA acknowledged that its management of notifications 'has not always met community expectations' and outlined its efforts to improve, particularly in relation to timeliness and communication:

- implementing processes that deliver early triage of notifications and greater clinical input to ensure we continue to improve the timeliness of assessment of notifications;
- working with health complaints entities to ensure roles and processes are as clear as possible for notifiers and practitioners. A common assessment matrix has been developed and agreed to determine which entity is best placed to manage each matter and public information has also been produced; and
- correspondence with notifiers and practitioners has been reviewed and improved and more meaningful progress reports are now being provided to notifiers and practitioners during the course of investigations.

Improvements have been made. However, complex matters will take time to investigate and not all matters can be finalised quickly. It is important that investigations are robust, as the implications for the practitioner being investigated and the notifier alike are significant.<sup>52</sup>

2.63 Dr Joanna Flynn, Chair of the Medical Board of Australia, further outlined steps that have been taken to improve communication with practitioners who are the subject of notifications, including a more concerted effort to communicate more often and giving practitioners a single point of contact with AHPRA:

One of the clear concerns that was expressed, when we started this work, was the impersonal nature of the communication, the infrequent

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51 Dr Gary Fettke, *Committee Hansard*, 1 November 2016, pp 14–15.

52 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 7.

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communication and the feeling that practitioners were a bit at sea and did not understand what was happening. That goes back to the point I made earlier about how stressful it is and us recognising how stressful it is to be subject to a notification.

We have done a lot of work to change the culture in the organisation and to change the method of communication so there is more verbal communication, there is more frequent communication and people are given an unidentified officer with whom they can follow up their concerns. We do have staff turnover at times and sometimes there is discontinuity but, wherever possible, we try give somebody one point of contact that they can follow up with, and we try to respond to things in a much more timely and helpful way. We do recognise it is stressful, and a lack of information about what is happening and the lack of a sense that you can speak to anybody about what is going on is one of the things that adds to that stress.<sup>53</sup>

#### *Committee view*

2.64 Alongside timeliness, the committee notes that the level and style of communication with both notifiers and practitioners has been one of the key concerns raised about AHPRA's management of complaints. The committee notes that AHPRA and the national boards have recognised that clear and frequent communication is a vital component of the notification process. For both the notifier and the practitioner, understanding the progress and likely outcomes will help reduce stress and uncertainty. Unfortunately, from the evidence the committee has received, there are ongoing issues with some cases. Many people have suggested there is a need for more change.

#### *Adversarial nature of the notification process*

2.65 Multiple witnesses identified that one concern with the medical complaints process in Australia is that it is based on adversarial and investigative systems rather than mediation or other options for resolving disputes.

2.66 The Australasian College of Emergency Medicine (ACEM) noted that the process discourages local investigation and solutions:

... there is no gradual escalation of a complaint, rather the mandatory notification legislation recommends rapid referral to AHPRA. This process also denies the individual against whom the complaint has been made the opportunity to respond or attempt to locally resolve the complaint prior to its escalation to AHPRA.<sup>54</sup>

2.67 ANZCA similarly argued that the existing process is too heavily focused on adversarial and investigative principles, rather than on addressing the issues raised in the notification and the performance of the practitioner:

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53 Dr Joanna Flynn, Chair, Medical Board of Australia, *Committee Hansard*, 1 November 2016, p. 56.

54 Australasian College of Emergency Medicine, *Submission 4*, p. 3.

Communication and support are vital. This is both for the public who have raised the concern and the practitioner about whom the concern is raised. These complaints are often devastating to both parties. Everything should be done to reduce this stress and the time over which any investigation lasts.

There needs to be a substantial move from the adversarial and legally based system that is currently evident to one that is focused on conciliation and rapid resolution wherever possible. There is no doubt that the concerns, aggravation and angst of complaints are magnified enormously when delays are multiplied and the process becomes adversarial.<sup>55</sup>

2.68 Dr Michael Mansfield argued that the focus of AHPRA's processes is 'punitive rather than educational or rehabilitative', and that, where appropriate, face-to-face meetings or mediation may serve to resolve complaints less stressfully, more cheaply and more quickly:

Facilitated face-to-face meetings of accused and accuser would be very beneficial, with regard to reducing the complexity and cost of unnecessary investigations, and it would facilitate a speedy resolution of breach issues.<sup>56</sup>

2.69 The Health Care Consumers' Association (HCCA) made a similar point from a patient's perspective, arguing that 'many consumers may want to make an informal comment rather than a formal complaint', but that the existing notifications system does not readily allow this. The HCCA therefore recommended that learning how to receive feedback should be a skill taught to all medical professionals.<sup>57</sup>

2.70 The HCCA notes a key problem is that medical complaints processes serve dual roles, one in relation to the practitioner and one in relation to the consumer, with the result that neither role is fully met:

Medical complaints processes aim to discipline and regulate professionals and deliver fair process, while also responding to consumer concerns. In reality, complaints processes are often not 'fit for purpose' for these disparate aims and as a result fail to achieve either disciplinary/regulatory or consumer outcomes.<sup>58</sup>

2.71 To resolve this dichotomy, the HCCA recommended that the notifications process have a stronger patient focus in how it closes complaints, separate to any action that the National Board might take:

The complaints handling system should be changed to ensure that a consumer who is seeking an apology, further information or a fair hearing has access to a process that can deliver these outcomes; regardless of

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55 Australian and New Zealand College of Anaesthetists, *Submission 5*, p. [3].

56 Dr Michael Mansfield, *Committee Hansard*, 1 November 2016, p. 12.

57 Health Care Consumers' Association, *Submission 16*, p. 9.

58 Health Care Consumers' Association, *Submission 16*, p. 14.

whether or not the issue raised is also appropriately dealt with as a notification by APHRA or by other complaints-handling bodies.<sup>59</sup>

2.72 Asked about adopting a less adversarial, more conciliation-based approach to managing complaints, AHPRA argued that the National Law does not give them the scope to do so:

We have considered that question before and I think it is relevant to point out that AHPRA and the national boards are part of the overall complaints management system, and there is also in each state and territory a health complaints entity. The health complaints entities do have the capacity to mediate or conciliate on complaints.<sup>60</sup>

2.73 Surgeon Professor Paddy Dewan, in discussing the 'adversarial, legalistic mechanisms' of formal complaints and investigation processes, noted that such systems could be improved by making medical professional staff welfare a performance criterion for organisations such as AHPRA and the Colleges.<sup>61</sup>

#### *Committee view*

2.74 The committee recognises that public safety is the most important consideration in managing complaints against medical practitioners. However, safety is not improved if the medical complaints process is viewed as unnecessarily adversarial or confronting for either the notifier or the practitioner. While recognising that AHPRA's capacity to respond to notifications is prescribed in the National Law, the committee is of the view that a less adversarial approach to managing notifications may lead to improved public safety and better outcomes for practitioners.

#### ***Conflict of interest***

2.75 Some confidential submitters claim AHPRA's processes do not consider possible conflicts of interest when determining who conducts the investigation or can be a witness. For example, one submitter claims that an AHPRA board member involved in the investigation was also a colleague, whilst another states that a complainant (a relative of a deceased patient) was permitted to join the investigative team of the relevant state or territory board (now AHPRA). Another submitter claims one of AHPRA's expert witnesses in their investigation had financial interests in an industry that would benefit from a particular outcome.

2.76 Asked about AHPRA's processes for dealing with potential conflicts of interest, chief executive officer Mr Martin Fletcher responded:

We have a number of arrangements. We have people on a panel who are available to do assessments. One of the benefits of being a national scheme is that we can go outside a state or territory if we need to get somebody who

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59 Health Care Consumers' Association, *Submission 16*, p. 16.

60 Ms Kym Ayscough, Acting Chief Executive Officer; Executive Director, Regulatory Operations, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 1 November 2016, p. 67.

61 Professor Paddy Dewan, *Submission 3*, p. [2].

is not directly involved with a particular practitioner. The other area where we use independent experts is getting expert opinions. Often that might require us to get somebody who has quite a specialised area of knowledge—on a medical subspecialty, for example. Again, we would often seek advice from the relevant professional college or medical college about an appropriate expert to source. When we do that we do not disclose the name of the person, but, obviously, once we are approaching an individual to do the assessment or provide the expert opinion we do disclose the name, because we then need to establish that there is no conflict of interest that may mean that they are unable to do what we need them to do.<sup>62</sup>

### *Qualifications of investigators*

2.77 A related concern expressed by medical practitioners is that the AHPRA officers who conduct investigations are not necessarily medically trained or qualified themselves, and therefore may lack understanding or appreciation of the medical situation involved.

2.78 This argument was summarised by Dr Michael Mansfield:

The main problem, however, is that AHPRA—via its allowed misuse of mandatory reporting guidelines—is facilitating bullying [sic] on a level never before seen. This is because the investigators lack any medical expertise. They do not have the necessary perspective to judge serious versus vexatious claims, nor do they have the expertise to judge the merit of differing independent medical reports.<sup>63</sup>

2.79 Similarly, Dr Gary Fettke argued that AHPRA's 'flawed investigation process' is a consequence of investigators who are 'inadequately trained, supervised and audited'.<sup>64</sup> Dr Fettke went on to note that, while decisions are made by the medical boards – whose members do have medical understanding – not all the information collected during an investigation necessarily forms part of the advice to the board:

I have asked for all of my material to be put to the board and have it all reviewed by the board, but that does not happen. It is only very select. So the gatekeepers in our investigations are the investigators not the Medical Board.<sup>65</sup>

2.80 Dr Don Kane of HPARA likewise argued that inexperienced or unqualified investigators are producing reports that are inaccurate or fail to take into account the complexity of medical practice:

The impression I get is that they [AHPRA investigators] are not well qualified to be in the positions they are in, and the use of sham peer review

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62 Mr Martin Fletcher, Chief Executive Officer, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 22 November 2016, p. 10.

63 Dr Michael Mansfield, *Committee Hansard*, 1 November 2016, p. 12.

64 Dr Gary Fettke, *Committee Hansard*, 1 November 2016, p. 14.

65 Dr Gary Fettke, *Committee Hansard*, 1 November 2016, p. 16.

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both by AHPRA and by people who lodge complaints to AHPRA, be they administrations or individuals, is quite a common practice, and it is very, very damaging. They do not seem to have the expertise to realise that a health service, whether it be in medicine, nursing or otherwise, is very complex, and if you have reviews done by people who are not actually expert in the work of the person that they are reviewing, you are very likely to get a review that is not as it should be, and AHPRA does not seem to have the wherewithal to recognise that.<sup>66</sup>

2.81 In response to these concerns, AHPRA outlined the backgrounds and qualifications of their investigators and emphasised that, for the past two years, a national standard training course had been delivered to all investigators:

Across the national scheme we employ probably around 100 investigators. They come from a variety of backgrounds. When we are recruiting we are particularly looking for people who have the skills to gather information around a complaint, synthesise that information and write reports for the information of the boards, who are the decision makers in the matter. They come from a variety of backgrounds. Some of our investigators have clinical backgrounds; others have experience working with other regulatory agencies, with ombudsman's organisations and some have backgrounds from the police service.

In terms of qualifications or credentialing, we have for the last two years been delivering a standard training program to all of our investigators based on the national certified investigator training program from the Council on Licensure, Enforcement and Regulation. That program has been running for more than 30 years and has trained over 19 000 investigators. We deliver that now as baseline training for all of our investigators.<sup>67</sup>

2.82 AHPRA also clarified that, while board members are presented with a report compiled by the investigator, they are also provided with a list of all other information received during the investigation and can ask for any of that material.<sup>68</sup>

### ***Cautions made appealable***

2.83 As outlined above, a National Board can caution a practitioner following assessment of a notification. A caution, AHPRA notes:

... is like a written warning and is intended to act as a deterrent so that the practitioner does not repeat the conduct or behaviour.

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66 Dr Don Kane, Chair, Health Professionals Australia Reform Association, *Committee Hansard*, 1 November 2016, p. 37.

67 Ms Kym Ayscough, Acting Chief Executive Officer; Executive Director, Regulatory Operations, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 1 November 2016, p. 54.

68 Ms Kym Ayscough, Acting Chief Executive Officer; Executive Director, Regulatory Operations, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 1 November 2016, p. 55.

A caution is not usually recorded on the public register but may be published on the national register of practitioners if the National Board considers it appropriate to do so.<sup>69</sup>

2.84 The Ombudsman, Ms Samantha Gavel, described a caution as 'the least action that AHPRA can take'.<sup>70</sup>

2.85 Ms Kym Ayscough of AHPRA noted that:

Under the national law, the board has available to it a number of regulatory responses. They really are considered to be in an escalating scale of seriousness, to respond to the different levels of regulatory risk, and a caution is a response that is at the very low end of the regulatory response.<sup>71</sup>

2.86 While describing cautions as the 'low end' of possible responses, Ms Ayscough did confirm that all responses to notifications against a practitioner, including cautions, go to their employer.<sup>72</sup>

2.87 Several submitters and witnesses noted that cautions issued by the National Boards are, unlike every other action available to Boards, not subject to administrative appeal, although there is the option of judicial review. The committee heard that the process could be improved by amending the National Law in relation to cautions.

2.88 Dr Joanna Flynn of the Medical Board of Australia noted that, while practitioners cannot appeal the decision to caution them, they are able to put forward their case before the caution is issued:

A caution is not imposed unless a practitioner has been given notice of the board's intention to impose a caution and given an opportunity to make a submission in relation to it. So the practitioner does have an opportunity to make a submission, but that is not the same as an appeal; I accept that.<sup>73</sup>

2.89 The argument for making cautions appealable was made by Dr Kerry Breen, who argued that the National Law is flawed in allowing Boards to issue a caution 'without the doctor being interviewed by a Board member or even by an AHPRA staff member'. Furthermore, Dr Breen argued:

... under Section 199, such a caution is not open to appeal, contrary to all other Board decisions which universally are open to appeal. Section 206 of

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69 AHPRA website, 'Possible outcomes', <http://www.ahpra.gov.au/Notifications/Find-out-about-the-complaints-process/Possible-outcomes.aspx>, accessed 15 November 2016.

70 Ms Samantha Gavel, National Health Practitioner Ombudsman and Privacy Commissioner, *Committee Hansard*, 1 November 2016, p. 10.

71 Ms Kym Ayscough, Acting Chief Executive Officer; Executive Director, Regulatory Operations, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 1 November 2016, p. 64.

72 Ms Kym Ayscough, Acting Chief Executive Officer; Executive Director, Regulatory Operations, Australian Health Practitioner Regulation Agency, *Committee Hansard*, 1 November 2016, p. 64.

73 Dr Joanna Flynn, Chair, Medical Board of Australia, *Committee Hansard*, 1 November 2016, p. 65.

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the legislation provides that any employer must be informed of the caution, thereby making the caution public and hence not a minor matter. Cautions of this type probably serve a useful purpose but there must be a mechanism for appeal.<sup>74</sup>

*Committee view*

2.90 The committee notes that, while a caution is the lowest level of action a Board can take in response to a complaint against a practitioner, that caution can affect a practitioner's career. As such, further consideration should be given to the option of allowing administrative review for cautions.

***Recognition that bullying and harassment is a patient safety issue***

2.91 A point made by some submitters to this inquiry was that bullying and harassment could be more effectively responded to if there was a greater recognition that these behaviours in the medical profession can affect patient safety. Submitters expressed concern that, as bullying and harassment is rarely seen as a patient safety issue, AHPRA has limited capacity to deal with complaints about these behaviours.

2.92 As an example, Mr John Ilott of the Australian and New Zealand College of Anaesthetists noted that issues with bullying and harassment are dealt with differently in New Zealand than they are in Australia:

I think one of the things that we have noticed in the difference between the Medical Council of New Zealand and the Medical Board of Australia is that the Medical Council of New Zealand is more prepared to acknowledge that bullying discrimination is likely to constitute a patient safety issue.<sup>75</sup>

2.93 The HCCA discussed this issue from the patients' point of view, noting that recent research demonstrates that bullying and harassment has an impact beyond that of the direct recipient of it:

There is now increasingly clear evidence that medical workplaces in which bullying and harassment are tolerated are unsafe for patients. The Joint Commission, an independent, not-for-profit organisation that accredits and certifies around 20,000 health care organisations and programs in the United States, reviewed behaviours that undermine a culture of safety and bullying and concluded that harassment featured prominently:

"Intimidating and disruptive behaviours can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety,

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74 Dr Kerry Breen, *Submission 103*, p. 3.

75 Mr John Ilott, Chief Executive Officer, Australian and New Zealand College of Anaesthetists, *Committee Hansard*, 1 November 2016, p. 46.

health care organizations must address the problem of behaviours that threaten the performance of the health care team."<sup>76</sup>

*Committee view*

2.94 The committee is concerned that bullying and harassment, identified as a prevalent issue in the medical profession, is not currently considered to have a substantial impact on patient safety. The committee is of the view that the entire medical profession needs to, as a matter of priority, recognise this significant impact and AHPRA should take it into account when investigating notifications against practitioners.

***Vexatious complaints and a declaration of good faith***

2.95 One of the terms of reference for this inquiry suggested, as a possible solution to concerns about the vexatious use of complaints against practitioners, that notifiers could be obliged to sign a declaration of good faith. On the whole, while all submitters agreed that the making of vexatious or frivolous complaints was an unacceptable practice and unfortunate consequence of the complaints process, there was limited support for the notion of requiring notifiers to make a declaration of good faith. This primarily rested on two arguments: that those intent on making a vexatious complaint as a way of harassing or bullying a medical practitioner would be unlikely to be concerned by this requirement, and that some people with genuine complaints to make might be deterred by this additional requirement.

2.96 For example, AHPRA's Community Reference Group argued:

... it should also be considered that many complainants may wonder whether it is worth the personal and reputational risk to report a bad experience of healthcare, and that any requirement for complainants to sign a declaration 'that their complaint is being made in good faith' may not deter vexatious complainants, but may deter genuine complainants.<sup>77</sup>

2.97 The Australian Nursing and Midwifery Federation (ANMF) also argued against this requirement, referring both to the unlikelihood of it deterring those intent on making a complaint for a vexatious reason and the probability that genuine complaints would be affected:

Such a declaration would unlikely prevent unnecessary notifications being made, however, it has the potential to serve as a deterrent to practitioners who are making a valid complaint for fear that it could be determined 'vexatious' and that they may suffer some kind of professional retribution if the complaint is not proven. Therefore, the ANMF does not support the introduction of a requirement for a declaration to be made.<sup>78</sup>

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76 Health Care Consumers' Association, *Submission 16*, p. 11.

77 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 25.

78 Australian Nursing and Midwifery Federation, *Submission 99*, p. 5.

2.98 Similarly, the Ombudsman argued that the inclusion of such a provision would be unlikely to prevent the lodging of vexatious complaints:

... requiring that people who lodge a notification sign a declaration that they are acting in good faith is not likely to reduce the number of notifications made or the incidence of possibly vexatious notifications.<sup>79</sup>

2.99 The AMA was also against the inclusion of this requirement, arguing that since a majority of notifications are made by other health practitioners, the introduction of such a requirement would be 'effectively challenging the professionalism of these people'.<sup>80</sup> Further, the AMA argued, it would be unlikely to improve the process in any other way:

Given the relative transparency of the notifications process the AMA questions how the inclusion of this requirement would improve the information available to AHPRA in making its assessment or have any material impact on the result.<sup>81</sup>

2.100 RANZCP also noted the possible effects of this step in deterring genuine complainants, while noting that the National Law includes a provision for the protection of complainants from civil, criminal and administrative liability if their complaint is made in good faith:

A potential complainant – whether patient or health practitioner – may already be anxious about lodging a complaint with AHPRA in addition to feeling detrimentally affected or aggravated by the behaviour they are seeking to complain about. Therefore, requiring complainants to take an additional step of having to sign a declaration that their complaint is being made in good faith may make complainants feel that their integrity or honesty is being questioned and, in fact, deter them from ultimately making a complaint to AHPRA.<sup>82</sup>

2.101 Likewise, the HCCA argued that such a requirement would constitute a significant barrier for consumers, already suffering a power imbalance when dealing with the health system and individual practitioners, should they want to make a complaint:

The focus of policy and practice change in relation to medical complaints should be to reduce barriers to consumer complaints, and to support both complaints and feedback as opportunities for healthcare improvement. Introducing a requirement to sign a declaration would constitute a significant additional barrier to complaints-making and as a result should not be considered.<sup>83</sup>

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79 National Health Practitioner Ombudsman and Privacy Commissioner, *Submission 12*, p. 4.

80 Australian Medical Association, *Submission 9*, p. 5.

81 Australian Medical Association, *Submission 9*, p. 6.

82 Royal Australian and New Zealand College of Psychiatrists, *Submission 19*, p. 5.

83 Health Care Consumers' Association, *Submission 16*, p. 18.

2.102 There were exceptions, however, to this broad agreement. The main argument for the inclusion of a requirement of a declaration of good faith was that vexatious complaints can have a major and detrimental effect on a practitioner's career and life, and therefore every effort should be made to minimise their incidence.

2.103 The ACEM noted that all complaints have an effect on the practitioner, even those which are later deemed to have been made vexatiously:

Complaints can be particularly damaging for those who have been cleared of the complaint made against them, since the allegations have previously been made visible on the AHPRA website during the complaints process. ACEM therefore considers it vital that complainants or notifiers sign a declaration that their complaint is being made in good faith, acknowledging the psychological, financial and career-related impacts that their complaint could have upon the individual.<sup>84</sup>

2.104 The ADA agreed that a 'good faith' declaration requirement may not dissuade potential vexatious complaints, and argued that instead 'it may be appropriate for complainants to have to make a payment when they lodge a complaint', or alternatively, requiring that vexatious complainants should be penalised.<sup>85</sup>

2.105 This latter position was echoed by other submitters, who – whether or not they supported the idea of a mandatory declaration of good faith – argued that those found to have made false complaints should be subject to prosecution or other penalties.

2.106 Professor John Stokes suggested an alternative approach. Instead of requiring complainants to sign a declaration or introducing a cost barrier, the proportion of vexatious complaints from fellow practitioners could be reduced by including an undertaking in the professional codes of conduct:

I think it would be important to overcome the objection to signing by putting a statement into the salient code of conduct for medical practitioners, in both section 4 and section 8 of those documents. Section 4 concerns working with other health professionals and section 8 is on professional behaviour. So a simple statement in there that it is part of professional behaviour not to make vexatious complaints would make it unnecessary for a mandatory notification. The guidelines from AHPRA are extremely loose. You could drive a truck through them. Such a statement would stop that.<sup>86</sup>

2.107 A similar suggestion was made by some confidential submitters, who argued that independent Code of Conduct committees would be an appropriate way of handling all forms of bullying and harassment.

2.108 Strengthening the codes of conduct for the various specialities within the medical profession could therefore take the form of not just discouraging bullying and

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84 Australasian College of Emergency Medicine, *Submission 4*, p. 4.

85 Australian Dental Association, *Submission 6*, p. [5].

86 Professor John Stokes, *Committee Hansard*, 1 November 2016, p. 13.

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harassment, but specifically prohibiting the vexatious lodgement of notifications against colleagues.

*Committee view*

2.109 The committee is concerned that there are not currently sufficient deterrents against practitioners lodging a complaint for vexatious reasons and for that reason agrees that professional codes of conduct should be strengthened in this regard. Further, the committee agrees that imposing penalties upon those found to have made vexatious complaints would be a further deterrent to this form of bullying and harassment.

***Benchmarking***

2.110 'Benchmarking' refers to the practice of comparing complication rates for a particular procedure across practitioners. The complication rate of an individual practitioner can then be compared to that of other similarly qualified practitioners as part of an investigation or audit.<sup>87</sup>

2.111 AHPRA confirmed that benchmarking of complication rates may occur as part of an investigation:

Analysis of complication rates and benchmarking (including as part of a performance assessment) may assist the MBA and/or its delegates to make an informed judgement as to the level of risk posed by the practice of the medical practitioner and appropriate actions to be taken by the MBA.

Benchmarking is a complex undertaking that must consider factors such as the speciality of the field of medical practice and the patient cohort involved. It is, therefore, important to note that where benchmarking is undertaken, AHPRA seeks the opinion of an independent expert and does not undertake its own benchmarking.<sup>88</sup>

2.112 Some confidential submitters support benchmarking on the basis, as discussed above, that the investigative teams lack the medical knowledge to make educated judgements. Other confidential submitters voice concern that accurate benchmarking is difficult to determine and suggest it should only be used when it will improve outcomes.

2.113 While arguing that more data and reporting would be useful, the HCCA noted that there is a 'fundamental problem' with increased benchmarking:

... the paucity of relevant and useful data in most areas of medicine upon which to base this kind of benchmarking data. While there are specialised registries in a limited number of areas, for example joint prostheses and

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87 See: Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 10.

88 Medical Board of Australia, Nursing and Midwifery Board of Australia and AHPRA, *Submission 21*, p. 10.

neo-natal intensive care, the capacity to produce benchmarks that are clinically meaningful across healthcare is at present very limited.<sup>89</sup>

2.114 The ACEM also noted that figures are not currently comprehensive enough for benchmarking to be meaningful.<sup>90</sup>

2.115 The AMA argued that a potential disadvantage of increased use of benchmarking might be to influence how practitioners treat patients, with an over-emphasis on concerns about benchmarking data:

Benchmarking can be complex and lead to perverse outcomes such as providing a disincentive for doctors to try new treatments, or self-protective practices such as not performing higher risk procedures because of the potential effect on outcome measures.<sup>91</sup>

2.116 ANZCA also expressed concerns with the use of outcome data to benchmark complication rates, and made several points against the practice. ANZCA argued that the data at an individual level misrepresents the team-based nature of much of medical practice; may contribute to competitiveness and a lack of support between colleagues if they are overly concerned with individualised benchmarking data; and further often lacks the context necessary, since no two patients have identical experiences either before or after the medical intervention.<sup>92</sup>

2.117 The ADA made a similar point regarding the variability of procedures and the complexity that creates in benchmarking data:

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.<sup>93</sup>

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89 Health Care Consumers' Association, *Submission 16*, p. 17.

90 Australasian College of Emergency Medicine, *Submission 4*, p. 4.

91 Australian Medical Association, *Submission 9*, p. 5.

92 Australian and New Zealand College of Anaesthetists, *Submission 5*, pp [4–5].

93 Australian Dental Association, *Submission 6*, p. [4].

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### *Professional and personal consequences of investigations*

2.118 Submitters note significant professional consequences from being investigated, where even minor findings against them have left a permanent mark on their record, affecting their employability. Submitters discussed the difficulty in applying for positions when it is standard practice to ask if the applicant has received a notification from AHPRA and noted that their employability has been negatively impacted by having an official record for 'trivial matters'.

2.119 Almost all confidential submitters who have been investigated by AHPRA discussed the personal toll of the stress incurred as a result of the investigations.

2.120 Professor John Stokes expanded on this and discussed the toll that being the subject of a vexatious complaint and subsequent AHPRA investigation can have on practitioners:

Many practitioners are dissatisfied with the mechanism. That is because of the significant unintended consequences of vexatious reporting, which causes practitioner illness. It also causes severe financial hardship and, in a number of cases that we know about, has caused the suicide of very good doctors.<sup>94</sup>

2.121 Dr Gary Fettke also emphasised the wide-ranging effects of having a complaint made against him and an investigation launched:

It has changed me as a person. I think we all go into medicine for all the right reasons: to try and make a difference. When you try and make that difference and you are hammered not only by your institution but then in the wider community, it changes you. I am more defensive about what I say to my patients. When you are under investigation, particularly for a vexatious claim, you think, 'Actually, I've done nothing wrong here; I'm helping people.' It becomes all-consuming. You lose sleep. My wife and I spend hours beyond normal work hours trying to sort this out. It has affected our children with a combination of anxiety, depression and becoming more introverted. What should be a pleasant experience of helping people is now something you question every day: 'Why do I keep doing this?'<sup>95</sup>

### *Committee view*

2.122 The committee notes the large number of personal accounts it received from, or on behalf of, medical practitioners whose lives and careers had suffered as a consequence of a complaint made against them. Patient safety and an open medical complaints process cannot be compromised, and the committee is deeply concerned by the evidence it has received which suggests that these may have been misused for the sake of bullying and harassing medical practitioners.

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94 Professor John Stokes, *Committee Hansard*, 1 November 2016, p. 13.

95 Dr Gary Fettke, *Committee Hansard*, 1 November 2016, p. 21.

**Conclusion and committee view**

2.123 Patient safety is of paramount importance in the medical profession, and for that reason it is vital that all Australians can trust that concerns about individual practitioners are taken seriously. As such, supporting a robust medical complaints system that takes appropriate action to ensure public safety is a central responsibility of the body created to administer the National Registration and Accreditation Scheme.

2.124 Equally, however, it is important that the process is trusted by medical practitioners themselves and is used only for its purpose of protecting public safety. It is clear that in this regard, Australia's medical complaints process does not have the complete confidence of sections of Australia's medical profession. As this committee has heard, AHPRA's notification and investigation process is vulnerable to misuse by individuals. Medical professionals have identified that lodging a notification against a colleague or competitor can serve as a tool of bullying and harassment.

2.125 While it is difficult to establish the prevalence of this practice, and noting the statistics on notifications which suggest it is relatively rare, the committee is nonetheless deeply concerned about this form of bullying and harassment. As many of the medical practitioners who made submissions to this inquiry noted, the toll on any individual can be very high. Furthermore, concerns which undermine any aspect of Australia's medical complaints process will have a negative effect on the integrity of the entire system and can serve to decrease public safety.

2.126 The committee has also received evidence that, in addition to the possibility of using the medical complaints process as a tool of bullying and harassment, other concerns with the complaints process exist. These concerns are explored in chapter 4.

## Chapter 3

### **Bullying and harassment in the medical profession**

3.1 While the focus of this inquiry was on the use of the medical complaints process as a tool of bullying and harassment within the medical profession, the committee also received a large number of submissions outlining broader concerns with the prevalence of bullying and harassment in Australia's medical profession. As discussed in the first chapter, this level of bullying and harassment presents a considerable risk to members of the health care sector, but also to the Australian public as a whole, and for that reason the committee is concerned by the evidence it has received.

3.2 This chapter discusses not just the prevalence and forms of bullying and harassment evident in the medical profession, but the real and perceived barriers to reporting these behaviours. It also examines responses to address bullying and harassment from the medical sector, including medical boards, government, colleges and hospitals. These responses emphasise the need for a cross-sector, coordinated approach to addressing these issues.

#### **Prevalence of bullying and harassment**

3.3 In their submissions to this inquiry, medical administrators and colleges emphasised that they take a 'zero-tolerance' approach to all forms of bullying and harassment.<sup>1</sup> However, as recent research has demonstrated, and as was further illustrated by evidence submitted to this inquiry, bullying and harassment remains prevalent within the medical profession.

3.4 Within the profession itself, there is general recognition that bullying and harassment is a significant problem. For example, the AMA acknowledges that recent reports indicate:

... the hierarchical nature of medicine, gender and cultural stereotypes, power imbalance inherent in medical training, and the competitive nature of practice and training has engendered a culture of bullying and harassment that has, over time, become pervasive and institutionalised in some areas of medicine.<sup>2</sup>

3.5 Mr John Biviano of the Royal Australasian College of Surgeons (RACS) made a similar point:

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1 See, for example: Australasian College for Emergency Medicine, *Submission 4*, p. 1; Australian and New Zealand College of Anaesthetists, *Submission 5*, p. 2; Royal Australasian College of Medical Administrators, *Submission 18*, pp 1–2; Royal Australian and New Zealand College of Psychiatrists, *Submission 19*, p. 1; Royal Australian and New Zealand College of Radiologists, *Submission 20*, p. 1.

2 Australian Medical Association (AMA), *Submission 9*, p. 1.

The college, or RACS as it is typically known, acknowledges that there is no doubt that bullying and harassment occurs in the surgical workplace and takes very seriously the subject of this inquiry.<sup>3</sup>

3.6 Dr Catherine Yelland of the Royal Australasian College of Physicians (RACP) concurred, noting that:

We regard bullying and harassment as unacceptable, and the college has no tolerance of these behaviours.

[...]

There is significant evidence in Australia and overseas that bullying and harassment are a problem across all healthcare professions. We can provide more detail if required. We regularly survey trainees, seeking feedback on the quality of their training, supervision and support. We may include questions on bullying and harassment in the future.<sup>4</sup>

3.7 The Royal Australasian College of Medical Administrators' Professor Gavin Frost likewise expressed concern about the prevalence of bullying and harassment and reiterated the College's policies against such behaviours:

As with my colleagues, our college has zero tolerance for harassment and bullying of any kind and our policies and procedures clearly set that out.<sup>5</sup>

3.8 The peak representative group for doctors, the Australian Medical Association, argued that:

... all doctors have the right to train and practice in a safe workplace free from bullying and harassment and [the AMA] holds a zero tolerance approach to all forms of bullying.<sup>6</sup>

3.9 Despite the consensus that bullying and harassment is unacceptable, there is concern that the actual prevalence of such behaviour is unknown or underreported. The Australian Nursing and Midwifery Federation (ANMF), for instance, noted that it is difficult to quantify the prevalence of bullying and harassment in the nursing and midwifery profession due to a lack of national data. However, the ANMF referred to recent research and submissions from organisations within the nursing and midwifery profession that all indicated 'significant levels' of bullying and harassment.<sup>7</sup>

3.10 The committee particularly notes the 2015 report by the Expert Advisory Group to the Royal Australasian College of Surgeons (RACS), which highlights the wide-reaching prevalence and negative impacts of bullying and harassment in the

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3 Mr John Biviano, Director, Fellowship and Standards, Royal Australasian College of Surgeons, *Committee Hansard*, 1 November 2016, p. 41.

4 Dr Catherine Yelland, President, Royal Australasian College of Physicians, *Committee Hansard*, 1 November 2016, p. 42, 43.

5 Professor Gavin Frost, Dean of Fellowship Education, Royal Australasian College of Medical Administrators, *Committee Hansard*, 1 November 2016, p. 43.

6 Australian Medical Association (AMA), *Submission 9*, p. 1.

7 Australian Nursing and Midwifery Federation, *Submission 99*, p. 2.

surgical profession. The key findings of this report are referenced throughout this chapter and summarised in **Box 3.1**.

**Box 3.1 – Royal Australasian College of Surgeons – Expert Advisory Group on discrimination, bullying and sexual harassment**

In March 2015, the Royal Australasian College of Surgeons (RACS) established an Expert Advisory Group to investigate the prevalence of discrimination, bullying and harassment within the surgical profession. The EAG consultations included over 3,500 participants including fellows, trainees and international medical graduates, as well as over 100 hospitals.

Key findings of the Expert Advisory Group's final report to RACS include:

- **49 per cent** of fellows, trainees and international medical graduates report being subjected to discrimination, bullying or sexual harassment;
- **54 per cent** of trainees and 45 per cent of fellows less than 10 years post-fellowship report being subjected to bullying;
- **71 per cent** of hospitals reported discrimination, bullying or sexual harassment in their hospital in the last five years, with bullying the most frequently reported issue;
- **39 per cent** of fellows, trainees and international medical graduates report bullying, **18 per cent** report discrimination, **19 per cent** report workplace harassment and **7 per cent** sexual harassment;
- the problems exist across all surgical specialties; and
- senior surgeons and surgical consultants are reported as the primary source of these problems.

Source: Royal Australasian College of Surgeons, *Submission 113*, p. 2.

### *Definitions*

3.11 For the purpose of this inquiry, the committee refers to bullying and harassment as defined by the RACS Expert Advisory Group.<sup>8</sup> **Box 3.2** outlines these key definitions.

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8 These definitions are also used by the AMA in its position statement on bullying and harassment. See: Australian Medical Association, *Position Statement – Workplace Bullying and Harassment*, 3 December 2015, <https://ama.com.au/position-statement/workplace-bullying-and-harassment> (accessed 9 November 2016).

**Box 3.2 – Definitions of bullying and harassment****Bullying**

Bullying is unreasonable and inappropriate behaviour that creates a risk to health and safety. It is behaviour that is repeated over time or occurs as part of a pattern of behaviour. Such behaviour intimidates, offends, degrades, insults or humiliates. It can include psychological, social, and physical bullying.

**Harassment**

Harassment is unwanted, unwelcome or uninvited behaviour that makes a person feel humiliated, intimidated or offended. Harassment can include racial hatred and vilification, be related to a disability, or the victimisation of a person who has made a complaint.

Source: Expert Advisory Group on discrimination, bullying and sexual harassment, *Report to the Royal Australasian College of Surgeons*, 28 September 2015, Appendix 1, p. 19, <http://www.surgeons.org/about-respect/what-we-have-done/building-respect.-improving-patient-safety/expert-advisory-group/> (accessed 9 November 2016).

3.12 Anecdotal evidence from submitters and witnesses to this inquiry supports the findings of the Expert Advisory Group report that bullying and harassment is a significant problem in the medical profession, across a range of specialities.

3.13 In many instances, this can be seen as a cultural problem within the profession; the committee notes considerable evidence suggesting that particular groups – including medical students and junior doctors, women and doctors of Indigenous or non-English speaking backgrounds – are more likely to be the subject of bullying and harassment.

3.14 Examples of the different types of bullying and harassment raised by submitters and witnesses are outlined below.

***Medical and nursing students and trainees***

3.15 The committee heard that many medical and nursing students and trainees experience a particular form of bullying and harassment during training. Submitters described either being a trainee or observing a trainee being bullied and harassed during clinical placements. In some instances, this resulted in the trainee either:

- being failed in assessments;
- transferring mid-placement to another hospital and thus delaying completion of their placement; or
- quitting their specialist training programs.

3.16 The Australian Medical Students' Association (AMSA) noted that bullying and harassment is widespread in medical education and includes 'teaching by humiliation' as well as 'derogatory remarks, inappropriate humour, ignoring students and setting impossible tasks or deadlines'.<sup>9</sup>

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9 Australian Medical Students' Association (AMSA), *Submission 10*, p. 2.

3.17 AMSA drew the committee's attention to a recent study of medical students in Sydney and Melbourne published in the *Medical Journal of Australia* that indicated that 74.0 per cent of medical students had experienced teaching by humiliation, and 83.6 per cent had witnessed it.<sup>10</sup>

3.18 Some confidential submitters to this inquiry particularly noted that, as trainees or junior doctors, they had particular concerns about making a complaint about this bullying since it would have a negative impact on their future career. This issue will be further discussed below as a barrier to reporting bullying and harassment.

### ***Sexual harassment and discrimination***

3.19 The committee is concerned by the reported prevalence of sexual harassment in the medical profession, perpetrated particularly against female doctors, students and trainees. **Box 3.3** outlines the definition of sexual harassment defined by RACS.

#### **Box 3.3 – Sexual harassment**

Sexual harassment is defined as unwelcome sexual advances, request for sexual favours and other unwelcome conduct of a sexual nature, by which a reasonable person would be offended, humiliated or intimidated. Sexual harassment may include, but is not limited to: leering; displays of sexually suggestive pictures, videos, audio tapes, emails & blogs, etc., books or objects; sexual innuendo; sexually explicit or offensive jokes; graphic verbal commentaries about an individual's body; sexually degrading words used to describe an individual; pressure for sexual activity; persistent requests for dates; intrusive remarks, questions or insinuations about a person's sexual or private life; unwelcome sexual flirtations, advances or propositions; and unwelcome touching of an individual, molestation or physical violence such as rape.

Source: Expert Advisory Group on discrimination, bullying and sexual harassment, *Report to the Royal Australasian College of Surgeons*, 28 September 2015, Appendix 1, p. 19, <http://www.surgeons.org/about-respect/what-we-have-done/building-respect.-improving-patient-safety/expert-advisory-group/> (accessed 9 November 2016).

3.20 Miss Elise Buisson, President of AMSA, described to the committee one example of sexual harassment experienced by female medical trainees:

...a student reported to me that they were sitting in surgical grand rounds, so that is when all the surgeons in the hospital come together and have an educational meeting. Someone presents some research to them. A trainee doctor stood up, gave an absolutely outstanding presentation—they had put a lot of work into it—and a quite established male surgeon was very loudly interrupting her as she went on, saying, 'My, my, my! Haven't they let you out of the kitchen a lot this month!' and various other statements about her being female ... He laughed, and everyone laughed, and the head of surgery at a medical school in that city was sitting in the room and did nothing, as did everybody else.<sup>11</sup>

10 Scott K, Caldwell P, Barnes E, Barrett J, "'Teaching by humiliation' and mistreatment of medical students in clinical rotations: a pilot study', *Medical Journal of Australia*, vol. 203, no. 4, 17 August 2016. See: AMSA, *Submission 10*, p. 3.

11 Miss Elise Buisson, President, Australian Medical Students' Association, *Committee Hansard*, 1 November 2016, pp 25–26.

3.21 AMSA drew the committee's attention to a recent survey by the Australian Medical Association Western Australia which found that sexual harassment is 'endemic' across WA Health and Medicine. The survey found that 31 per cent of the 950 respondents had experienced sexual harassment in the workplace, including whilst applying for a job or training program. Of those reporting sexual harassment, 81 per cent were women.<sup>12</sup>

### ***Racial discrimination***

3.22 Alongside sexual harassment and discrimination, recent reports have suggested that racial discrimination remains a problem in the medical profession.

3.23 The committee heard that Aboriginal and Torres Strait Islander doctors and students experience racial discrimination as part of their training and practice.

3.24 The Australian Indigenous Doctors' Association (AIDA) told the committee that results of a recent survey, *Bullying, Racism and Lateral Violence in the workplace*, indicated almost all members reported having witnessed bullying in their workplace, and over half reported having witnessed racism at least once a week.<sup>13</sup> Examples of racism included:

... doubting members' status as Aboriginal and Torres Strait Islander, experiences of 'unrelenting and systematic bullying', being belittled and shamed, and verbal racist abuse'.<sup>14</sup>

3.25 AIDA submitted that bullying and harassment 'often in the form of racist remarks or behaviour', together with inadequate reporting mechanisms:

... create a culturally unsafe work environment, lacking in respect and support, and create a barrier for Indigenous medical students and doctors to pursue and persist on their medical career.<sup>15</sup>

3.26 The Expert Advisory Group final report to RACS found that 27 per cent of international medical graduates reported either racial or sexual discrimination.<sup>16</sup>

3.27 In its 2012 inquiry into registration processes and support for overseas trained doctors, the House of Representatives Standing Committee on Health and Ageing heard that international medical graduates reported bullying and harassment as they

12 See: Australia Medical Association WA, 'Shattering the silence', *Medicus*, 18 April 2016, p. 22, <http://www.amawa.com.au/wp-content/uploads/2016/04/Cover-18-April-2016.pdf> (accessed 9 November 2016).

13 Dr Benjamin Armstrong, Board Director, Australian Indigenous Doctors' Association (AIDA), *Committee Hansard*, 1 November 2016, p. 31.

14 AIDA, *Submission 8*, p. 3.

15 AIDA, *Submission 8*, p. 1.

16 Expert Advisory Group on discrimination, bullying and sexual harassment, *Report to the Royal Australasian College of Surgeons*, 28 September 2015, p. 4, <https://www.surgeons.org/about-respect/what-we-have-done/building-respect,-improving-patient-safety/expert-advisory-group/> (accessed 7 November 2016).

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worked through accreditation and registration.<sup>17</sup> Its final report, *Lost in the Labyrinth*, recommended that:

... the Medical Board of Australia extend the obligations it applies to employers, supervisors and international medical graduates in its *Guidelines – Supervised practice for limited registration* to include a commitment to adhere to transparent processes and appropriate standards of professional behaviour that are in accordance with workplace bullying and harassment policies.<sup>18</sup>

3.28 As of November 2016, the government had not responded to this report.<sup>19</sup>

3.29 While it was not a major theme of this inquiry, several confidential submitters noted their own experiences of race-based bullying and harassment.

### ***Media and social media***

3.30 Following on from the use of the medical complaints process as a tool of bullying and harassment, as discussed in the previous chapter, some submitters noted that they had been subject to a further level of bullying and harassment when the details of complaints made against them were given to the media, or disseminated via social media.

3.31 Submitters state in these instances, the media often report false allegations, doing irreparable damage to their reputation. Others claim they have been cyberbullied through social media.

3.32 For example, Dr Gary Fettke explained to the committee that during his investigation by AHPRA, he became aware that the person who lodged the notification against him had also been posting what he characterised as 'defamatory material on a social media hate site'.<sup>20</sup>

### ***Patients and families***

3.33 The committee received a small number of submissions from patients or their families who reported that they had been bullied and harassed by medical professionals. Most of these submitters have made complaints to AHPRA and were unsatisfied with AHPRA's response.

3.34 Submitters expressed concern that bullying and harassment between medical practitioners may impact on patients. For example, the Health Care Consumers Association expressed concern that:

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17 House of Representatives Standing Committee on Health and Ageing, *Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors*, March 2012, p. 189.

18 House of Representatives Standing Committee on Health and Ageing, *Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors*, March 2012, p. 194.

19 *Notice Paper*, 21 November 2016, House of Representatives, p. 60.

20 Dr Gary Fettke, *Committee Hansard*, 1 November 2016, p. 19.

...a culture that accepts and condones bullying is not conducive to good patient care and must be addressed. Further, where a culture condones bullying in the staff, there is evidence that this can reduce empathy towards patients and can led [sic] to disrespect and bullying of patients.<sup>21</sup>

3.35 Several confidential submitters argued that the lack of focus on bullying's impact on patient safety means that there is not appropriate recognition of the problem or clear lines for patients and members of the public to report bullying and harassment by medical practitioners. These submitters expressed concern that their complaints were not taken seriously.

3.36 Some confidential submitters noted that questioning any aspect of their treatment resulted in bullying and harassment and in some cases this affected their ability to receive further treatment. Conversely, other patients discussed their problems receiving treatment because their doctor had their practice restricted because of a vexatious complaint.

### **Committee view**

3.37 The committee expresses deep concern about the reported prevalence of bullying and harassment in the medical profession and reiterates that bullying and harassment in any workplace is unacceptable and must not be tolerated.

3.38 The committee notes that evidence from submissions supports recent research that highlights the prevalence of bullying and harassment across different specialities.

3.39 The committee recognises that bullying and harassment in the medical profession pose threats to public safety and patient wellbeing, and for that additional reason is particularly concerned by the prevalence of bullying and harassment in the medical profession.

### **Barriers to reporting bullying and harassment**

3.40 Submitters and witnesses identified two key barriers to reporting bullying and harassment in the medical profession related to:

- lack of clarity and trust in the reporting process; and
- cultural issues within the medical profession.

### ***Process issues***

#### *Clarity of existing reporting mechanisms*

3.41 The committee heard that there is a lack of clarity and awareness in the medical profession of the appropriate mechanisms for reporting bullying and harassment. Submitters highlighted that processes for making complaints, or for subsequently addressing complaints, are not well understood. For example, the AMA noted in its submission that a 2014 survey of specialist trainees found that general

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21 Health Care Consumers Association, *Submission 16*, p. 12.

awareness of bullying and harassment policies across all colleges is low, with only 30 per cent reporting that they are aware of these.<sup>22</sup>

3.42 The committee notes that confusion about the complaints process was one of key findings of the Expert Advisory Group in its report to RACS, particularly:

... with a lack of coordination or clarity about where to lodge a complaint or how to raise an issue (between the College, employers and, for students, universities), if one were brave enough to do so.<sup>23</sup>

3.43 Mr John Biviano from RACS told the committee the existing complaints mechanisms lack coordination across the sector:

... the oversight of health professions is complex and difficult to navigate. It involves medical colleges, health departments, hospitals and regulators, including the Medical Board of Australia and AHPRA. There is a clear lack of coordination between these bodies and fragmentation of the system.<sup>24</sup>

#### *Trust in existing complaints processes*

3.44 Submitters expressed a lack of trust in the complaints system's ability to produce a fair outcome, suggesting that this may discourage victims from reporting bullying and harassment. For example, AIDA's survey of its membership found that the majority of members:

... reported that policies and procedures were in place at their workplace but stated that they did not believe that victims or perpetrators were adequately supported by the existing policies and procedures, suggesting a lack of confidence, particularly in complaints procedures and the actual application of existing policies.<sup>25</sup>

3.45 Similarly, the Australian College of Emergency Medicine argued that:

... medical practitioners are less likely to make a report if they are not confident that the issue will be dealt with in a way that will bring about meaningful and positive outcomes, and/or if they believe that their day-to-day lives in the workplace will be impacted upon negatively as a result of making a report.<sup>26</sup>

3.46 The Royal Australian and New Zealand College of Psychiatrists (RANZCP) also submitted that many workplaces that do not have appropriate processes for reporting bullying:

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22 AMA, *Submission 9*, p. 2.

23 See: Expert Advisory Group on discrimination, bullying and sexual harassment, *Report to the Royal Australasian College of Surgeons*, 28 September 2015, p. 11, <https://www.surgeons.org/about-respect/what-we-have-done/building-respect,-improving-patient-safety/expert-advisory-group/> (accessed 7 November 2016).

24 Mr John Biviano, Director, Fellowship and Standards, Royal Australasian College of Surgeons, *Committee Hansard*, 1 November 2016, p. 42.

25 Australian Indigenous Doctors' Association, *Submission 8*, p. 3.

26 Australasian College of Emergency Medicine, *Submission 4*, p. 1.

... a key question is how the relevant workplace deals with bullying and harassment claims and how it conducts and resolves investigations into these claims. If appropriate and supportive mechanisms are not in place, this represents a clear barrier to medical practitioners reporting bullying and harassment.<sup>27</sup>

3.47 The committee notes that the Expert Advisory Group to RACS also found:

... there is a lack of trust and confidence in the people handling complaints and the processes in place at the College and across the health sector. There is confusion about processes that are often legalistic and narrowly defined; and a demonstrable lack of consequences for perpetrators.<sup>28</sup>

3.48 Despite the recent media and public attention on bullying and harassment within the medical profession, the committee notes that awareness amongst practitioners of the existing policies and procedures is not high. While it is evident that some work has been done to improve this, it is clear that this remains a problem requiring the attention of medical colleges, workplaces and medical schools.

### ***Cultural issues***

3.49 The committee was particularly concerned by evidence that suggests that the culture of the medical profession does not support the reporting of bullying and harassment.

#### *Accepted culture of bullying*

3.50 Submitters and witnesses suggested that in some sections of the medical profession, bullying is accepted as part of the workplace culture. For example, beyondblue submitted that recent research indicates that there is some concern that:

... there may be a "culture" that allows bullying and harassment to occur within the medical profession, and that this may be a transgenerational phenomenon ingrained in the profession.<sup>29</sup>

3.51 The committee notes that submissions to this inquiry support the findings of the Expert Advisory Group's report to RACS which found that in relation to the surgical profession, 'bullying has become normalised as a culturally accepted behaviour' and issues of discrimination, bullying and sexual harassment are:

... enmeshed with questions about the culture of surgical practice, as well as the culture of medicine and the healthcare sector more widely.<sup>30</sup>

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27 RANCP, *Submission 19*, pp 1–2.

28 Expert Advisory Group on discrimination, bullying and sexual harassment, *Report to the Royal Australasian College of Surgeons*, 28 September 2015, p. 5, <http://www.surgeons.org/about-respect/what-we-have-done/building-respect,-improving-patient-safety/expert-advisory-group/> (accessed 9 November 2016).

29 Beyondblue, *Submission 11*, p. 17.

30 Expert Advisory Group on discrimination, bullying and sexual harassment, *Report to the Royal Australasian College of Surgeons*, 28 September 2015, p. 7.

3.52 The committee heard that the culture of bullying particularly affects medical students and trainees. AMSA highlighted that a recent study of mistreatment of medical students indicated that 50 per cent of students had come to believe that mistreatment is 'necessary and beneficial for learning'.<sup>31</sup> Similar findings were reported by the Victorian Auditor-General, which noted a high degree of acceptance of bullying and harassment among junior doctors:

Such behaviour was explained as a 'training technique' that helped motivate them to work harder, or as unfortunate but an inevitable rite of passage and part of the 'old-school way'.<sup>32</sup>

### *Fear of repercussions*

3.53 One of the key barriers to reporting instances of bullying and harassment reported by submitters and witnesses was fear of negative repercussions from making a complaint. Many submitters were concerned that making a complaint against a senior colleague would adversely affect their future career. Others expressed a fear of reprisals against them for making a complaint at their workplace against a colleague. As discussed in chapter 2, confidential submitters who have suffered bullying or harassment are also concerned that the retaliation would take the form of a vexatious notification being lodged against them.

3.54 For example, Dr Artiene Tatian from AIDA told the committee that a survey of its members found that over half did not report bullying and harassment due to a fear of negative repercussions.<sup>33</sup> Dr Ben Armstrong from AIDA also told the committee that for the 40 per cent of members who had initiated some sort of complaint reconciliation, the vast majority were ignored or not actioned and 'they often had negative repercussions, which discouraged them from making further complaints'.<sup>34</sup>

3.55 The committee heard that fear of negative repercussions are particularly acute among students and trainees who are concerned about the impact of making a complaint on their career progression. Miss Elise Buisson from AMSA told the committee, that often students are advised not to make reports, due to possible negative impacts on their careers:

Even very well-meaning clinicians or faculty members will advise you not to report certain things: 'Look, it's probably not that bad. If you are to do it, it's going to have a really negative effect on your career.' And if someone

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31 Scott K, Caldwell P, Barnes E, Barrett J, "'Teaching by humiliation" and mistreatment of medical students in clinical rotations: a pilot study', *Medical Journal of Australia*, vol. 203, no. 4, 17 August 2016. See: AMSA, *Submission 10*, p. 3.

32 Victorian Auditor-General, *Bullying and Harassment in the Health Sector*, March 2016, p. 19, [http://www.audit.vic.gov.au/reports\\_and\\_publications/latest\\_reports/2015-16/20160323-bullying.aspx](http://www.audit.vic.gov.au/reports_and_publications/latest_reports/2015-16/20160323-bullying.aspx) (accessed 9 November 2016).

33 Dr Artiene Tatian, Board Director, AIDA, *Committee Hansard*, 1 November 2016, p. 33.

34 Dr Benjamin Armstrong, Board Director, AIDA, *Committee Hansard*, 1 November 2016, p. 33.

was to come to me and say, 'Should I report X', I would find it very difficult to know what is the best course of action for them.<sup>35</sup>

3.56 Similarly, the Royal Australasian College of Medical Administrators argued that concern for career progression is the paramount reason why complaints about bullying and harassment are often not lodged:

The key barrier for medical practitioners taking action is the belief that it will adversely affect future career options. This is supported by the survey undertaken by RACMA in 2015 on bullying, harassment and discrimination and consultations with RACMA's membership. Additionally reasons cited are the perceived stress associated with filing a complaint and enduring an investigation, and the perception there is potential for victimisation as a result of raising the matter.<sup>36</sup>

#### *Silence of by-standers*

3.57 The committee heard that the combination of process and cultural issues contributes to an environment where those by-standers who witness bullying and harassment are not supported to report the behaviour. The AMA submitted that there may be two different reasons why by-standers do not speak up when witnessing 'unacceptable behaviour', they may:

- not recognise the behaviour as discrimination, bullying or sexual harassment; or
- harbour distrust in the complaint mechanism – that the complaint will not be taken seriously, that someone else's word will be taken over theirs, that victimisation will ensue, or that it would ultimately not be in the best interests of the victim to raise it.<sup>37</sup>

3.58 The 'silence of by-standers' was identified by the Expert Advisory Group to RACS as a 'critical issue', which:

... stems from fear of reprisal, fear of 'making it worse', concerns about their position or right to raise an issue given hierarchical structures and power differences; prominent people are perpetrators, bullies are seen as untouchable.<sup>38</sup>

#### *Gender inequality and cultural diversity*

3.59 The committee also heard that gender inequality presents barriers for reporting bullying and harassment, particularly for women. The AMA pointed out that:

Gender inequity has a proven causal relationship with the incidence of discrimination, bullying and sexual harassment of women. It is important

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35 Miss Elise Buisson, President, AMSA, *Committee Hansard*, 1 November 2016, p. 27.

36 Royal Australasian College of Medical Administrators, *Submission 18*, p. 2.

37 AMA, *Submission 9*, p. 3.

38 Expert Advisory Group on discrimination, bullying and sexual harassment, *Report to the Royal Australasian College of Surgeons*, 28 September 2015, p. 8.

that sexual harassment, discrimination and non-sexualised incivility is acknowledged as a manifestation of broader gender inequality.<sup>39</sup>

3.60 The Expert Advisory Group also highlighted that lack of cultural diversity, together with gender inequality, contribute to a workplace culture that does not support the reporting of bullying and harassment:

Gender inequity and limited cultural diversity also featured as both cause and effect in relation to culture. Both were seen to enable the continuation of the dominant surgical culture and were a consequence of it.<sup>40</sup>

### **Addressing bullying and harassment**

3.61 Submitters and witnesses highlighted that addressing bullying and harassment in the medical profession will require a cross-sector approach, including government, medical boards, AHPRA, hospitals and speciality colleges. Some of the approaches to addressing bullying and harassment undertaken so far are outlined below.

#### ***Medical boards and AHPRA***

3.62 Submitters highlighted that the formal medical complaints process administered by AHPRA and the Medical Board of Australia (MBA) and Nursing and Midwifery Board of Australia (NMBA) is just one mechanism for addressing bullying and harassment. As discussed in chapter 2, the key focus of the formal AHPRA complaints process is patient safety.

3.63 AHPRA, the MBA and the NMBA acknowledged that they have an important role to play in addressing bullying and harassment:

Bullying and harassment can be very damaging to the people who are subject to these behaviours and to the safety of patients. There is no place for these behaviours in the Australian medical, nursing, midwifery or registered health practitioner workforce. Through our role in the national regulation of health practitioners, we are committed to playing our part in supporting the health and well-being of medical practitioners, nurses and midwives and ending discrimination, bullying and harassment.<sup>41</sup>

3.64 However, the MBA, NMBA and AHPRA emphasised that:

Not all allegations of bullying and harassment that involve medical practitioners, nurses or midwives are appropriate for action by the MBA or NMBA as the threshold for regulatory action may not be met.<sup>42</sup>

3.65 Dr Joanna Flynn, Chair of the MBA, told the committee that in most cases, AHPRA and the boards are not the most appropriate place to address discrimination, bullying and harassment:

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39 AMA, *Submission 9*, p. 4.

40 Expert Advisory Group on discrimination, bullying and sexual harassment, *Report to the Royal Australasian College of Surgeons*, 28 September 2015, p. 8.

41 MBA, NMBA and AHPRA, *Submission 21*, p. 1.

42 MBA, NMBA and AHPRA, *Submission 21*, p. 4.

... the boards are not the appropriate first point of call for most matters in relation to bullying, which ought to be dealt with locally and investigated locally. Most problems should be solved close to the source of they can.<sup>43</sup>

3.66 Dr Flynn emphasised that:

While the Medical Board and Nursing and Midwifery Board and AHPRA have important roles to play, the medical complaints process and our regulation of health practitioners will not, on its own, address bullying and harassment and deliver the change in culture that we seek. That is why we work in partnership with the professions, employers, colleges, health departments and other health complaints bodies to help end bullying and harassment.<sup>44</sup>

3.67 Similarly, the ANMF commented that AHPRA:

... are unlikely to be able to deal with reporting of bullying in a useful manner, particularly in dealing with the underlying issues which are usually organisational, rather than individual. A report to AHPRA actually negates the occupational health and safety nature of bullying, and the need for a risk management approach to be implemented, as well as investigating the root cause of the issue.<sup>45</sup>

#### *Codes of conduct*

3.68 The MBA, NMBA and AHPRA noted that one of their key roles is to provide guidance on what is expected of registered practitioners through a code of conduct:

Such guidance sets out the principles that characterise good practice and makes explicit the standards of ethical and professional conduct expected by their professional peers and the community.<sup>46</sup>

3.69 The MBA pointed to its publication, *Good Medical Practice: A Code of Conduct for Doctors*, which was developed to guide doctors in their professional practice and roles, and set 'clear expectations on medical practitioners to act and communicate respectfully to both patients and colleagues'.<sup>47</sup>

3.70 The NMBA noted that the *Codes of Professional Conduct for midwives and nurses* is currently under review, and expects to conduct a public consultation on the revised codes in early 2017.<sup>48</sup>

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43 Dr Joanna Flynn, Chair, Medical Board of Australia, *Committee Hansard*, 1 November 2016, p. 61.

44 Dr Joanna Flynn, Chair, Medical Board of Australia, *Committee Hansard*, 1 November 2016, p. 53.

45 ANMF, *Submission 99*, p. 3.

46 MBA, NMBA and AHPRA, *Submission 21*, p. 3.

47 MBA, NMBA and AHPRA, *Submission 21*, p. 3.

48 The NMBA notes that its analysis of notifications made between 2010 and 2015 identified that 'aggression' and 'bullying' were two of the largest categories of notifications. A focus of the review process is 'ensuring that the revised codes address these issues and set clear requirements for expected behaviours'. See: MBA, NMBA and AHPRA, *Submission 21*, p. 3.

3.71 Some submitters suggested that one way that AHPRA and the boards could assist in addressing bullying and harassment is through the codes of conduct they administer. The Australian Dental Association (ADA) recommended that 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'.<sup>49</sup>

3.72 Beyondblue recommended that responses to bullying and harassment levels should be part of a broader focus on mental health, recognising the substantial impact on mental health that workplace bullying and harassment have. Beyondblue suggested that action on bullying and harassment should be based on a culture of 'respectful relationships' and recommended that reference to 'respectful relationships' be incorporated in the code of conduct administered by the MBA and those of the individual colleges.<sup>50</sup>

3.73 The Australian Indigenous Doctors' Association recommended that a key measure to reduce the levels of bullying and harassment in the medical profession would be to mandate cultural safety training for all employees in the health sector.<sup>51</sup>

### ***Speciality colleges***

3.74 Following the release of the Expert Advisory Group's report to RACS in 2015, the committee heard that all speciality colleges have undertaken reviews of their reporting and complaints mechanisms. The Committee of Presidents of Medical Colleges stated that:

All specialist Medical Colleges are fully committed to fulfilling their obligations to eliminate or minimise the risk of bullying. Each has undertaken a system review to ensure appropriate policies and procedures are in place to manage complaints relating to bullying, which also includes regular compliance checks to ensure policies and procedures are up-to-date and staff are provided with information and training.<sup>52</sup>

3.75 In particular, the committee heard that RACS has dedicated 'enormous resources' to responding to the Expert Advisory Group report through its November 2015 action plan, *Building respect, improving patient safety*.<sup>53</sup> Mr John Biviano from RACS told the committee that the key actions taken by RACS to date as part of the action plan include:

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49 Australian Dental Association, *Submission 6*, p. 2.

50 Beyondblue, *Submission 11*, p. 3.

51 Australian Indigenous Doctors' Association, *Submission 8*, p. 4.

52 Committee of Presidents of Medical Colleges, *Submission 14*, p. 1.

53 See: *Building Respect, Improving Patient Safety*, RACS Action Plan on Discrimination, Bullying and Sexual Harassment in the Practice of Surgery, tabled by Royal Australasian College of Surgeons, at Sydney public hearing 1 November 2016, [http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/MedicalComplaints45/Additional\\_Documents](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MedicalComplaints45/Additional_Documents) (accessed 14 November 2016).

- working with health departments and hospitals to develop strategies to address discrimination, bullying and sexual harassment, including developing memorandums of understanding between RACS and hospitals;<sup>54</sup>
- introducing mandated courses for surgeons involved in education on 'basic adult education principles', building awareness of discrimination, bullying and harassment, and skills for supervisors; and
- devoting more resources to complaints management, including a centralised database and process to resolve complaints.<sup>55</sup>

3.76 The committee heard that while RACS is leading the colleges in addressing these issues, other colleges are also seeking to address bullying and harassment. The Committee of Presidents of Medical Colleges (CPMC) noted that:

... all specialist Medical Colleges have subsequently undertaken assessment processes to recommend actions their individual College could take directly and in partnership with hospitals and employers to mitigate and prevent such behaviours from occurring.<sup>56</sup>

3.77 A number of colleges made submissions to the inquiry outlining the specific measures they have taken to address bullying and harassment. For example, Mr John Ilott noted that the Australian and New Zealand College of Anaesthetists (ANZCA) has:

... strengthened the internal professional conduct framework. We have also established a centralised complaints-handling process, which is for complaints to the college. While our education program has not been as extensive as that of RACS, we acknowledge the generosity of RACS in providing much of the material that they developed at their own cost, which has been made available to other colleges.<sup>57</sup>

3.78 Similarly, the Royal Australasian College of Physicians (RACP) set up working party in 2015 to 'further ensure our current systems, policies, procedures and practices were robust'.<sup>58</sup> Mrs Linda Smith, Chief Executive Officer of RACP told the committee that some of the changes introduced as a result include:

- improved compulsory supervisor training workshops;
- education leadership and supervisor support that allows identification of inappropriate supervisor behaviour and a process of working with supervisors to change behaviour;

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54 RACS provided the committee with a draft MOU as part of its submission. See: RACS, *Submission 113, Attachment 1*.

55 Mr John Biviano, Director, Fellowship and Standards, Royal Australasian College of Surgeons, *Committee Hansard*, 1 November 2016, p. 44.

56 Committee of Presidents of Medical Colleges, *Submission 14*, p. 2.

57 Mr John Ilott, *Committee Hansard*, 1 November 2016, p. 44.

58 Dr Catherine Yelland, *Committee Hansard*, 1 November 2016, p. 42.

- producing 'Creating a safe culture', a new e-learning resource for fellows, plus online curated learning collections on bullying and harassment;
- extensive assessment of the resources provided by other colleges; and
- implemented a 24/7 confidential online support service for fellows and trainees that is not just limited to problems they may be having in the workplace.<sup>59</sup>

3.79 However, the committee also heard concerns about the efficacy of these measures by colleges, and whether they are in fact having any real impact on reducing bullying and harassment. For example, Miss Elise Buisson from AMSA told the committee:

I do think there has been significant change, but I do not think it has been all surgeons. And I think that change has been focused within the College of Surgeons because the other colleges have not had that same pressure applied to them. We have developed this kind of media idea that it is the surgeons who are particularly at fault, whereas I think there are quite a lot of poorly behaving doctors who are not surgeons who are getting away with it just fine. There absolutely are some surgeons who are still behaving badly, but I do think it is substantially less than it was a year-and-a-half ago. Whether that change will be sustained for another 18 months or the 18 months after that I am a little less certain of.<sup>60</sup>

3.80 Similarly, Dr Michael Mansfield, discussing the increase in bullying he has seen throughout his career, described the professional colleges as 'impotent, with respect to any meaningful action, despite the window-dressing'.<sup>61</sup>

### **Need for greater coordination**

3.81 Evidence to the committee highlights the need for coordination across the medical sector to address bullying and harassment.<sup>62</sup> Beyondblue submitted that:

Action on bullying and harassment is everyone's responsibility. Governments have a role through enacting legislation and funding relevant programs. Statutory authorities have a role in overseeing adherence to legislation through education, investigation of complaints, and the enforcement of laws and penalties. Employers are required by law to create an environment that protects the health and safety of their staff. Employees are obliged to follow the law and the lawful directions of their employers.<sup>63</sup>

3.82 Evidence from the speciality colleges highlights that addressing bullying and harassment requires cooperation with hospitals and employers. The Australasian College of Emergency Medicine (ACEM) argued that:

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59 Mrs Linda Smith, *Committee Hansard*, 1 November 2016, pp 44–45.

60 Miss Elise Buisson, President, AMSA, *Committee Hansard*, 1 November 2016, pp 26–27.

61 Dr Michael Mansfield, *Committee Hansard*, 1 November 2016, p. 12.

62 Australian Dental Association, *Submission 6*, p. 2.

63 Beyondblue, *Submission 11*, p. 2.

In order to address the culture of bullying, ACEM considers that hospital management or executives, as well as hospital governing bodies, must be held accountable for the culture of the organisations that they lead. Through addressing bullying issues associated with those who are responsible for establishing the culture of a workplace, positive changes for those working at all levels within the hospital could be achieved.<sup>64</sup>

3.83 Similarly, the CPMC submitted that 'while all Colleges are making a considerable effort to improve processes they cannot do it alone and there needs to be agreed principles between all parties'.<sup>65</sup> Mr Biviano from RACS told the committee:

... the responsibility to end a culture of bullying and harassment does not reside with any one individual or entity. Employers, hospitals, governments, health professionals, industrial associations, regulators and other partners in the health sector must all commit to sustained action. While each of these groups can and should develop individual solutions, at the core of the issue is the need for cooperation and collaboration across the health sector.<sup>66</sup>

3.84 Mr John Ilott, CEO of ANZCA, told the committee that:

Lasting improvements can only be achieved with the cooperation of the health services in both private hospitals and public hospitals.<sup>67</sup>

3.85 A number of submitters suggested that better sector-wide coordination is an important step to address the lack of clarity and trust in existing reporting mechanisms. The AMA submitted that:

Greater cooperation between employers and colleges with respect to the development and implementation of bullying and harassment policies and in relation to complaints handling would be beneficial to all parties involved. The current environment discourages effective compliance both with respect to the development of well understood and effective policies, as well as in relation to having accessible and trusted complaints mechanisms.<sup>68</sup>

3.86 As part of this coordination, RANZCP suggests that:

... there should be further practitioner education in regards to bullying and harassment as practitioners are often confused about what should be reported to AHPRA and what should be reported to their workplace.<sup>69</sup>

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64 Australasian College of Emergency Medicine, *Submission 4*, p. 2.

65 Committee of Presidents of Medical Colleges, *Submission 14*, p. 1.

66 Mr John Biviano, Director, Fellowship and Standards, Royal Australasian College of Surgeons, *Committee Hansard*, 1 November 2016, p. 42.

67 Mr John Ilott, Chief Executive Officer, Australian and New Zealand College of Anaesthetists, *Committee Hansard*, 1 November 2016, p. 43.

68 AMA, *Submission 9*, p. 3.

69 RANZCP, *Submission 19*, p. 2.

3.87 Similarly, the ANMF noted that its policy statement on bullying and harassment asserts that 'the first level for raising a bullying complaint is within the workplace'. When this fails, nurses and midwives are advised to report the bullying to a range of state and territory based authorities, such as Occupational Health and Safety Regulators.<sup>70</sup>

3.88 In 2016, the Victorian Auditor-General conducted an audit of four public health services to assess their effectiveness in managing the risk of bullying and harassment in the workplace. The Auditor-General's report into *Bullying and Harassment in the Health Sector* found that the leadership of health sector agencies 'do not give sufficient priority and commitment to reducing bullying and harassment within their organisations' and that the health sector is 'unable to demonstrate that it has effective controls in place to prevent or reduce inappropriate behaviour, including bullying and harassment'.<sup>71</sup>

3.89 The Victorian Auditor-General made a number of recommendations for health sector agencies, WorkSafe, the Victorian Public Sector Commission and the Department of Health and Human Services to better address:

- early intervention mechanisms to address bullying and harassment;
- management of formal complaints; and
- collaboration between agencies that have a role in the safety culture of the health sector.<sup>72</sup>

### **Committee view**

3.90 The committee acknowledges the work undertaken across the medical sector, particularly by colleges, to address bullying and harassment. The professional colleges are uniquely placed to respond to the medical profession's concerning record of tolerating or ignoring bullying and harassment.

3.91 However, the committee notes that while work is being done, a genuine change in the way the profession responds to incidents of bullying and harassment remains to be seen. Substantial and lasting change is the only metric on which such efforts will be assessed.

3.92 The committee is pleased to see increased recognition that supports further work to encourage cooperation and coordination across the sector to eliminate bullying and harassment and remove any barriers to making complaints.

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70 ANMF, *Submission 99*, p. 3.

71 Victorian Auditor-General, *Bullying and Harassment in the Health Sector*, March 2016, p. x, [http://www.audit.vic.gov.au/reports\\_and\\_publications/latest\\_reports/2015-16/20160323-bullying.aspx](http://www.audit.vic.gov.au/reports_and_publications/latest_reports/2015-16/20160323-bullying.aspx) (accessed 9 November 2016).

72 Victorian Auditor-General, *Bullying and Harassment in the Health Sector*, March 2016, p. xiii–xv, [http://www.audit.vic.gov.au/reports\\_and\\_publications/latest\\_reports/2015-16/20160323-bullying.aspx](http://www.audit.vic.gov.au/reports_and_publications/latest_reports/2015-16/20160323-bullying.aspx) (accessed 9 November 2016).



# Chapter 4

## Responses and recommendations

4.1 As this report highlights, the committee has received evidence of considerable concern about the way in which medical complaints in Australia are handled, including the use of notifications as a tool of bullying and harassment.

4.2 While the focus of the terms of reference for this inquiry was on the medical complaints process, the committee is concerned by evidence that clearly shows that bullying and harassment remain prevalent across the medical profession, affecting patients and their families, medical practitioners, students and trainees.

4.3 The committee notes that, in principle, the medical profession has a 'zero tolerance' approach to bullying and harassment. The committee is encouraged by evidence it received from parts of the medical profession, particularly some of the speciality colleges, outlining recent steps they have taken to better address these issues.

4.4 However, as discussed in chapter 3, evidence to this committee highlights that bullying and harassment is a widespread and significant problem. The committee is concerned that despite assurances from witnesses representing medical professionals, including speciality colleges, a sector-wide change to the way bullying and harassment is addressed and managed remains to be seen. The committee was particularly concerned by evidence suggesting that medical students and junior doctors continue to be among the most frequent subjects of bullying and harassment.

4.5 The committee recognises that addressing bullying and harassment can only be addressed with the cooperation of all sections of the medical profession, including Commonwealth, state and territory governments, hospitals, speciality colleges and universities. Without a coordinated, sector-wide response to preventing such behaviour, it will continue to put patient safety at risk, and see capable and dedicated people leave the sector, to the detriment of the Australian health system.

4.6 The committee is particularly concerned by the number of individual submissions it has received from medical practitioners, nurses and patients sharing their experience with the complaints process. The committee recognises the substantial impact that a notification investigation can have on both the notifier and subject of the complaint. As outlined in chapter 2, the committee has heard from multiple practitioners and members of the public about the consequences of lodging a notification. Individuals have written to the committee detailing the significant and ongoing effects they have suffered. The calls for a Royal Commission from some submitters are just one illustration of the level of community concern about the prevalence and impacts of bullying and harassment in Australia's medical profession.

4.7 The committee agrees that these cases demonstrate possible systemic problems with the medical complaints process that go beyond the scope of this inquiry related to both the administration of the process, and the regulatory framework that governs it.

4.8 The committee agrees that the evidence it has received to date highlights the need for a new line of inquiry, including:

- the relationships between and roles of the different bodies involved in the complaints process;
- the administration and implementation of the complaints process; and
- the adequacy of the regulatory framework for managing complaints under the National Law.

4.9 This chapter recommends that the committee initiate a new inquiry to investigate these matters.

### **New areas for inquiry**

4.10 This inquiry focused on the intersection between bullying and harassment in the medical profession – a problem identified to be prevalent across the profession by a number of studies – and the medical complaints process in Australia. As such, its primary focus was on the ways in which the complaints process may be open to misuse as a tool of bullying and harassment within the profession. However, in the course of investigating this issue, the committee identified the following aspects of the medical complaints process that warrant further inquiry.

#### ***Relationships between different bodies***

4.11 One point made by many of the submitters and witnesses to this inquiry was that there are unclear boundaries and responsibilities amongst the many bodies involved in the regulation and administration of the medical profession. As illustrated in chapters 2 and 3, responsibility for different aspects belongs to the Australian Health Practitioner Regulation Agency (AHPRA), the National Boards for each profession, the health complaints entities in each state and territory, professional colleges and individual workplaces.

4.12 The management of a notification lodged against an individual practitioner may involve most or all of those bodies. Evidence to the committee in this inquiry suggests that there is some confusion among patients and medical practitioners as to the specific roles of each of these bodies in resolving complaints.

4.13 The committee agrees that these relationships – and the different responsibilities held by each of these bodies – require further investigation to determine whether any improvements can be made to better assist all parties to the complaints process achieve a satisfactory outcome.

4.14 The committee is particularly interested in examining the roles of and relationships between AHPRA, the National Boards, the State and Territory Boards, panels established by National Boards and the health complaints entities in relation to the complaints-handling process.

#### ***Administration and implementation of complaints process***

4.15 As discussed in chapter 2, one of the key concerns raised by many submitters was about the administration and implementation of the complaints process. Submitters identified a wide range of concerns, including:

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- the timeliness of the process;
  - the level and manner of communication from AHPRA;
  - the adversarial nature of the process;
  - perceived issues with conflict of interest;
  - the qualifications of AHPRA investigators; and
  - the failure to recognise that bullying and harassment within the medical profession is a patient safety issue.

4.16 Evidence received during this inquiry indicates that the process as it currently operates does not have the confidence of the entire medical profession. In particular, the process' vulnerability to misuse as a tool of bullying and harassment warrants further investigation.

4.17 In particular, the committee considers that the question of the effectiveness of the current notifications and investigation process merits further attention. AHPRA's legislated purpose is ensuring public safety, yet the concerns raised with the notifications process by submitters to this inquiry were focused, in the main, on the use of this process as a tool of bullying and harassment. The committee intends to investigate the process more broadly to gain an understanding of how well it is fulfilling its role in protecting public safety and responding to complaints from patients and others.

4.18 The committee notes that the administration of AHPRA has already been the subject of an inquiry by the Senate Finance and Public Administration References Committee in 2011. However, that inquiry focussed specifically on the AHPRA's role in health practitioner regulation following the introduction of the national scheme in 2010, and only addressed the complaints process as a related issue. The committee agrees with the conclusion of that inquiry that 'further development of the complaints process is urgently required'.<sup>1</sup>

### ***Adequacy of regulatory framework***

4.19 Following on from the previous area of further inquiry, the committee considers that there is scope for a broader investigation of the framework underpinning medical regulation in Australia. The committee notes that the National Registration and Accreditation Scheme (NRAS) has been the subject of several reviews since its implementation in 2010, most notably the 2015 Independent Review

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1 Senate Finance and Public Administration References Committee, *Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA)*, 3 June 2011, p. 93, [http://www.aph.gov.au/parliamentary\\_business/committees/senate/finance\\_and\\_public\\_administration/Completed%20inquiries/2010-13/healthpractitionerregistration/index](http://www.aph.gov.au/parliamentary_business/committees/senate/finance_and_public_administration/Completed%20inquiries/2010-13/healthpractitionerregistration/index) (accessed 24 November 2016).

for the Australian Health Ministers' Advisory Council.<sup>2</sup> However, these reviews have not focussed specifically on the regulatory principles and practices of the complaints process, which the committee regards as warranting detailed examination.

4.20 On the basis of evidence received as part of this inquiry, the committee does not have sufficient information to judge whether the concerns discussed throughout this report are problems with the administration of the National Law, or whether the underlying regulatory framework is itself in need of review. The committee therefore considers this an important area for more focused investigation.

### **Conclusion and recommendations**

4.21 The committee thanks all those who assisted in this inquiry by making submissions or appearing at the public hearings. Through the large volume of submissions and correspondence received for this inquiry, the committee was able to gain an understanding of the concerns expressed by many submitters at the forms bullying and harassment in Australia's medical profession takes.

4.22 The committee has established that there are significant concerns about the way in which medical complaints in Australia are handled, particularly the use of notifications as a tool of bullying and harassment. The cases highlighted by submitters have demonstrated to the committee that there are broader issues with the administration and regulation of the current medical complaints process that warrant investigation.

4.23 In particular, the committee was concerned by the evidence suggesting that Australia's medical complaints process – a system designed to ensure public safety and optimal patient outcomes – has been misused by some for their own purposes. A world-class health system requires an open, transparent and rigorous process for patients and others to raise concerns with the healthcare they receive, and the undermining of this process for vexatious purposes is unacceptable.

4.24 The committee recognises that the NRAS, now just over six years old, faced some implementation problems, particularly with regard to the management of individual complaints. The committee notes that AHPRA, along with the MBA and NMBA, has worked to improve this process. However, it is clear from the evidence received for this inquiry that the process does not have the confidence of the entire medical profession. Just as a complaints process is a necessary component of a health system, practitioner confidence in the fairness and transparency of that system is necessary.

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2 See: COAG Health Council, *Independent Review of the National Registration and Accreditation Scheme for health professionals*, 2015, <http://www.coaghealthcouncil.gov.au/Projects/Independent-Review-of-NRAS-finalised> (accessed 24 November 2016).

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## Recommendation 1

**4.25 The committee recommends that all parties with responsibility for addressing bullying and harassment in the medical profession, including governments, hospitals, speciality colleges and universities:**

- **acknowledge that bullying and harassment remains prevalent within the profession, to the detriment of individual practitioners and patients alike;**
- **recognise that working together and addressing these issues in a collaborative way is the only solution; and**
- **commit to ongoing and sustained action and resources to eliminate these behaviours.**

4.26 The committee agrees that bullying and harassment should be addressed at the very first opportunity – at university. The committee considers that it is imperative that students are prepared at university to feel comfortable about making a bullying and harassment complaint, to know who has responsibility for them during placement and subsequent employment, and to know their options in making a complaint and any appeal processes that may be available to them.

## Recommendation 2

**4.27 The committee recommends that all universities adopt a curriculum that incorporates compulsory education on bullying and harassment.**

4.28 The committee is particularly concerned by evidence that indicates a lack of clarity around reporting bullying and harassment for medical students while on placements in hospitals. The committee notes evidence from Ms Elise Buisson, President of the Australian Medical Students' Association, who told the committee:

In a hospital, if you are being taught by a doctor—which does not mean that they are employed at the university anyway, it just means that you are following them around for perhaps three months at a time—and you make a complaint against that doctor, that complaint needs to be made to the hospital ostensibly, but you are not covered by hospital policy. That generally covers employees and volunteers, and you are neither.<sup>3</sup>

4.29 The committee agrees that universities need to accept responsibility for students who are on placement in a hospital so these students do not fall through the cracks of the system.

## Recommendation 3

**4.30 The committee recommends that all universities accept responsibility for their students while they are on placement and further adopt a procedure for dealing with complaints of bullying and harassment made by their students while on placement. This procedure should be clearly defined and a written copy provided to students prior to their placement commencing.**

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3 Miss Elise Buisson, President, Australian Medical Students' Association, *Committee Hansard*, 1 November 2016, p. 27.

4.31 The committee considers that all hospitals should be required to have a provision in their code of conduct that specifically states that bullying and harassment in the workplace is not tolerated. The code of conduct should also state that this applies to students and volunteers.

#### **Recommendation 4**

**4.32 The committee recommends that all hospitals review their codes of conduct to ensure that they contain a provision that specifically states that bullying and harassment in the workplace is strictly not tolerated towards hospital staff, students and volunteers.**

4.33 The committee is concerned that despite the apparent prevalence of bullying and harassment identified by the speciality medical colleges, few practitioners have been formally sanctioned. The committee notes evidence from Mr John Biviano, Director of Fellowship and Standards, Royal Australasian College of Surgeons (RACS), who told the committee that RACS had 7 000 members; however, to date, none had been sanctioned for bullying and harassment.<sup>4</sup>

4.34 The committee considers that there should be a requirement on all speciality colleges to report each year on how many complaints their members have been subject to and how many sanctions they have imposed.

#### **Recommendation 5**

**4.35 The committee recommends that all specialist training colleges publicly release an annual report detailing how many complaints of bullying and harassment their members and trainees have been subject to and how many sanctions the college has imposed as a result of those complaints.**

4.36 While this inquiry's focus has been on bullying and harassment, it has also identified broader systemic issues with Australia's medical complaints process that go beyond the scope of this inquiry's terms of reference. For that reason, the committee intends to establish a new inquiry focused on the process itself, rather than this inquiry's examination of the ways in which the process can be used and misused.

#### **Recommendation 6**

**4.37 The committee recommends that a new inquiry be established with terms of reference to address the following matters:**

- **the implementation of the current complaints system under the National Law, including role of AHPRA and the National Boards;**
- **whether the existing regulatory framework, established by the National Law, contains adequate provision for addressing medical complaints;**
- **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;**

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4 Mr John Biviano, Director, Fellowship and Standards, Royal Australasian College of Surgeons, *Committee Hansard*, 1 November 2016, p. 45.

- **the adequacy of the relationships between those bodies responsible for handling complaints;**
- **whether amendments to the National Law in relation to the complaints handling process are required; and**
- **other improvements that could assist in a fairer, quicker and more effective medical complaints process.**

**Senator Rachel Siewert**

**Chair**



# **APPENDIX 1**

## **Submissions and additional information received by the Committee**

### **Submissions**

- 1** Confidential
- 2** Professor Paddy Dewan (plus a supplementary submission)
- 3** Name Withheld
- 4** Australasian College of Emergency Medicine
- 5** Australian and New Zealand College of Anaesthetists
- 6** Australian Dental Association
- 7** Australian Doctors' Fund
- 8** Australian Indigenous Doctors' Association
- 9** Australian Medical Association
- 10** Australian Medical Students' Association
- 11** BeyondBlue
- 12** National Health Practitioner Ombudsman and Privacy Commissioner
- 13** Department of Health
- 14** Committee of Presidents of Medical Colleges
- 15** Cultural Inspirations
- 16** Health Care Consumers' Association of the ACT
- 17** Multicultural Communities Council of NSW and Chinese Community Council of Australia

- 18 Royal Australasian College of Medical Administrators
- 19 Royal Australian and New Zealand College of Psychiatrists
- 20 The Royal Australian and New Zealand College of Radiologists
- 21 AHPRA, Medical Board of Australia and Nursing and Midwifery Board of Australia
- 22 Confidential
- 23 Confidential
- 24 Confidential
- 25 Confidential
- 26 Confidential
- 27 Confidential
- 28 Confidential
- 29 Confidential
- 30 Confidential
- 31 Confidential
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- 35 Mr Kevin Doyle
- 36 Confidential
- 37 Dr Leong Ng
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- 57** Australian Medical Council
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- 60** Dr Peter Ashton

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- 93** Confidential
- 94** Dr James Fratzia
- 95** Confidential
- 96** Confidential
- 97** Confidential
- 98** Confidential
- 99** Australian Nursing and Midwifery Federation
- 100** Confidential
- 101** Confidential
- 102** Mr Trevor Stuart
- 103** Dr Kerry Breen (plus twelve attachments and a supplementary submission)
- 104** Dr Margaret Fitzpatrick (plus three attachments)

- 105 Confidential
- 106 Confidential
- 107 Confidential
- 108 Confidential
- 109 MIGA
- 110 Aboriginal Health Council of WA and the Health Consumers' Council of WA
- 111 Australian Society of Anaesthetists
- 112 Confidential
- 113 Royal Australasian College of Surgeons (plus two attachments)
- 114 Health Professionals Australia Reform Association
- 115 Confidential
- 116 Confidential
- 117 Dr John Piesse
- 118 Confidential
- 119 Confidential
- 120 Confidential
- 121 Confidential
- 122 Confidential
- 123 Universities Australia
- 124 Confidential
- 125 Name Withheld

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- 126 Confidential
- 127 Confidential
- 128 Confidential
- 129 Confidential

### **Answers to Questions on Notice**

- 1 Answers to Questions taken on Notice during 1 November public hearing, received from Dr Gary Fettke, 6 November 2016
- 2 Answers to Questions taken on Notice during 1 November public hearing, received from Australian Medical Students' Association, 8 November 2016
- 3 Answers to Questions taken on Notice during 1 November public hearing, received from Associate Professor John Stokes, 8 November 2016
- 4 Answers to Questions taken on Notice during 1 November public hearing, received from Health Professionals Australia Reform Association, 8 November 2016
- 5 Answers to Questions taken on Notice during 1 November public hearing, received from National Health Practitioner Ombudsman and Privacy Commissioner, 10 November 2016
- 6 Answers to Questions taken on Notice during 1 November public hearing, received from Dr James Fratzia, 10 November 2016
- 7 Answers to Questions taken on Notice during 1 November public hearing, received from Department of Health, 11 November 2016
- 8 Answers to Questions taken on Notice during 1 November public hearing, received from Royal Australasian College of Surgeons, 11 November 2016
- 9 Answers to Questions taken on Notice during 1 November public hearing, received from Royal Australasian College of Physicians, 11 November 2016
- 10 Answers to Questions taken on Notice during 1 November public hearing, received from Australian and New Zealand College of Anaesthetists, 11 November 2016
- 11 Answers to Questions taken on Notice during 1 November public hearing, received from Australian Indigenous Doctors' Association, 16 November 2016

- 12** Answers to Questions taken on Notice during 1 November public hearing, received from Australian Health Practitioner Regulation Agency, Medical Board of Australia, and Tasmanian Board of the Medical Board of Australia, 16 November 2016
- 13** Answers to Questions taken on Notice during 22 November public hearing, received from Australian Health Practitioner Regulation Agency, 28 November 2016

### **Correspondence**

- 1** Response from Dietitians Association of Australia to adverse comments made during the public hearing on 1 November 2016

### **Tabled Documents**

- 1** Building Respect, Improving Patient Safety, RACS Action Plan on Discrimination, Bullying and Sexual Harassment in the Practice of Surgery, tabled by Royal Australasian College of Surgeons, at Sydney public hearing 1 November 2016
- 2** Let's Operate with Respect, campaign information, tabled by Royal Australasian College of Surgeons, at Sydney public hearing 1 November 2016

# **APPENDIX 2**

## **Public hearings**

*Tuesday, 1 November 2016*

*Portside Centre, Sydney*

### **Witnesses**

#### **National Health Practitioner Ombudsman and Privacy Commissioner**

GAVEL, Ms Samantha, Ombudsman and Privacy Commissioner

**STOKES, Prof. John, Private capacity**

**MANSFIELD, Dr Michael, Private capacity**

**FRATZIA, Dr James Demetrios, Private capacity**

**FETTKE, Dr Gary, Private capacity**

#### **Australian Medical Students' Association**

BUISSON, Miss Elise, President

#### **Australian Indigenous Doctors' Association**

ARMSTRONG, Dr Benjamin, Board Director

TATIAN, Dr Artiene, Board Director

RALLAH-BAKER, Dr Kristopher, Board Director

DUKES, Mr Craig, Chief Executive Officer

DINKLER, Mr Ludger, Policy Officer

#### **Health Professionals Australia Reform Association**

KANE, Dr Donald William, Chairman

#### **Royal Australasian College of Surgeons**

BIVIANO, Mr John, Director, Fellowship and Standards

#### **Royal Australasian College of Medical Administrators**

FROST, Professor Gavin, Dean of Fellowship Education

#### **Royal Australasian College of Physicians**

YELLAND, Dr Catherine, President

SMITH, Mrs Linda, Chief Executive Officer

**Australian and New Zealand College of Anaesthetists**

ILOTT, Mr John, Chief Executive Officer

**Australian Health Practitioner Regulation Agency**

AYSCOUGH, Ms Kym, Acting Chief Executive Officer; Executive Director,  
Regulatory Operations

**Medical Board of Australia**

FLYNN, Dr Joanna, Chair

**Nursing and Midwifery Board of Australia**

CASEY, Ms Veronica, Board Member

**Department of Health**

SOUTHERN, Dr Wendy, Deputy Secretary

HALLINAN, Mr David, First Assistant Secretary

*Tuesday, 22 November 2016*

*Parliament House, Canberra*

**Witnesses**

**Australian Health Practitioner Regulation Agency**

FLETCHER, Mr Martin, Chief Executive Officer

**Australian Nursing and Midwifery Federation**

THOMAS, Ms Lee, Federal Secretary