

The Senate

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Community Affairs  
References Committee

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Complaints mechanism administered under  
the Health Practitioner Regulation National  
Law

May 2017

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## 45<sup>th</sup> Parliament

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# ABBREVIATIONS

ADA	Australian Dental Association
AFCC	Association of Family and Conciliation Courts
AHMAC	Australian Health Ministers' Advisory Council
AHPRA	Australian Health Practitioner Regulation Agency
CAA	Chiropractors' Association of Australia
COAG	Council of Australian Governments
MBA	Medical Board of Australia
MIGA	Medical Insurance Group Australia
National Law	Health Practitioner Regulation National Law
NHPOPC	National Health Practitioner Ombudsman and Privacy Commissioner
OHO	Office of the Health Ombudsman
RACGP	Royal Australian College of General Practitioners
TBMBA	Tasmanian Board of the Medical Board of Australia





# **LIST OF RECOMMENDATIONS**

## **Recommendation 1**

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

## **Recommendation 2**

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

## **Recommendation 3**

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

## **Recommendation 4**

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

## **Recommendation 5**

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

## **Recommendation 6**

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

## **Recommendation 7**

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

## **Recommendation 8**

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

## **Recommendation 9**

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

## **Recommendation 10**

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

## **Recommendation 11**

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

## **Recommendation 12**

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

## **Recommendation 13**

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

## **Recommendation 14**

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

# Chapter 1

## Introduction

### Genesis and focus of the inquiry

1.1 Between 2 February and 30 November 2016 the Senate Community Affairs References Committee (the committee) conducted an inquiry into the *Medical complaints process in Australia* (the previous inquiry).<sup>1</sup> That inquiry focussed on bullying in the health professions.

1.2 During the previous inquiry the committee received personal accounts from medical practitioners and complainants that raised systemic issues about the complaints process.

1.3 There was a perception among health practitioners that the complaints process permitted vexatious complaints and that there were deficiencies in the way investigations were handled.<sup>2</sup> Some patients and their family members were also dissatisfied with their experiences of the complaints process.<sup>3</sup> Those accounts prompted the committee to recommend that a new inquiry be established to examine the complaints mechanism as it applied under the Health Practitioner Regulation National Law with the following terms of reference:

- the implementation of the current complaints system under the National Law, including the role of the Australian Health Practitioner Regulation Agency (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

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1 The inquiry lapsed with the dissolution of the 44<sup>th</sup> Parliament and was readopted in the 45<sup>th</sup> Parliament. See Senate Standing References Committee on Community Affairs, *Medical complaints in Australia*, November 2016, p. 11, [http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/MedicalComplaints45](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MedicalComplaints45) (accessed 24 January 2017).

2 Senate Standing References Committee on Community Affairs, *Medical complaints in Australia*, November 2016, pp. 23, 30.

3 Senate Standing References Committee on Community Affairs, *Medical complaints in Australia*, November 2016, p. 22.

- other improvements that could assist in a fairer, quicker and more effective medical complaints process.<sup>4</sup>

## Overview of the scheme

1.4 In 2006 the Productivity Commission recommended that health professionals ought to be registered against uniform national standards to improve workforce mobility.<sup>5</sup>

1.5 The Council of Australian Governments (COAG) announced in March 2008 that the Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions had been signed.<sup>6</sup> The new scheme commenced operation on 1 July 2010 in all states and territories except Western Australia.<sup>7</sup>

1.6 The Australian Parliament does not have constitutional competence to regulate health practitioners. Therefore, the scheme was implemented by a suite of uniform state legislation that was initially introduced in Queensland as the *Health Practitioner Regulation National Law Act 2009* (Qld). The Health Practitioner Regulation National Law (the National Law) is schedule 1 to the legislation.<sup>8</sup>

1.7 The National Law transferred responsibilities for registration, accreditation and matters that relate to the health, performance or conduct of a practitioner from 80 state and territory boards to ten national boards—one that regulated each of the registered professions.<sup>9</sup>

1.8 The scheme now regulates 14 professions:

- Aboriginal and Torres Strait Islander health practice;
- Chinese medicine;
- chiropractic;
- dental;
- medical;

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4 See recommendation 6, Senate Standing References Committee on Community Affairs, *Medical complaints in Australia*, November 2016, p. x.

5 Productivity Commission, *Australia's Health Workforce*, Research Report, January 2006, p. xl, <http://www.pc.gov.au/inquiries/completed/health-workforce/report/healthworkforce.pdf> (accessed 13 January 2017).

6 COAG, *Communique*, 26 March 2008, [http://webarchive.nla.gov.au/gov/20150301030435/http://archive.coag.gov.au/coag\\_meeting\\_outcomes/2008-03-26/index.cfm](http://webarchive.nla.gov.au/gov/20150301030435/http://archive.coag.gov.au/coag_meeting_outcomes/2008-03-26/index.cfm) (accessed 25 January 2017).

7 The scheme commenced in Western Australia on 18 October 2010. Senate Standing References Committee on Community Affairs, *Medical complaints in Australia*, November 2016, p. 6.

8 *Health Practitioner Regulation National Law Act 2009* (Qld), sch 1 (National Law), <https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/H/HealthPracRNA09.pdf> (accessed 25 January 2017).

9 Senate Standing References Committee on Community Affairs, *Medical complaints in Australia*, November 2016, p. 8.

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- medical radiation practice;
  - nursing and midwifery;
  - occupational therapy;
  - optometry;
  - osteopathy;
  - pharmacy;
  - physiotherapy;
  - podiatry; and
  - psychology.<sup>10</sup>

1.9 The national boards are responsible for regulating the registered professions and setting the standards practitioners must meet.<sup>11</sup>

1.10 The national boards are supported by the Australian Health Practitioner Regulation Agency (AHPRA). AHPRA provides secretariat services, publishes registers of health practitioners, manages registrations, manages investigations, liaises with the health complaints entities and provides advice to the Australian Health Workforce Ministerial Council about the scheme.<sup>12</sup>

1.11 The national boards and AHPRA's mandate is to protect the public from practitioners whose conduct falls below the standards set by the national boards.<sup>13</sup>

#### ***2017 amendments to the National Law***

1.12 During the committee's inquiry the Australian Health Ministers' Advisory Council (AHMAC) commenced consultation on the first of two tranches of legislation to amend the National Law.<sup>14</sup> A representative of AHMAC, Ms Amity Durham, informed the committee at its public hearing on 17 March that the first tranche of legislation is scheduled to be introduced into the Queensland Parliament in May 2017 with passage expected by August 2017.<sup>15</sup>

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10 National Law, s. 5 (definition of 'health profession').

11 AHPRA, *2015/16 Annual Report*, November 2016, p. 1, <http://www.ahpra.gov.au/annualreport/2016/downloads.html> (accessed 11 January 2017).

12 AHPRA, *2015/16 Annual Report*, November 2016, p. 1. For an explanation of health complaints entities see [1.18].

13 AHPRA, *2015/16 Annual Report*, November 2016, p. 1.

14 AHMAC, *Submission 75*, [p. 1].

15 Ms Amity Durham, Acting Deputy Secretary, Department of Health and Human Services, Victoria, representing the Australian Health Ministers' Advisory Council, *Committee Hansard*, 17 March 2017, p. 22.

1.13 A comprehensive summary of the proposed amendments is included in AHMAC's submission to the inquiry.<sup>16</sup> For this inquiry, it will suffice to say that the draft Bill will:

- add paramedicine as a registered profession;<sup>17</sup>
- allow community members to be appointed as Chairpersons of national boards;<sup>18</sup>
- permit notifiers to be given greater information about the work of the board;<sup>19</sup>
- require national boards to set a period to review conditions imposed by the board;<sup>20</sup>
- provide stronger practice prohibition powers for tribunals;<sup>21</sup>
- allow the national boards to request practice information from practitioners;<sup>22</sup> and
- add additional grounds on which the national board may decide to take no further action.<sup>23</sup>

### *Co-regulatory jurisdictions*

1.14 New South Wales and Queensland do not participate in the part of the National Law that relates to complaints.<sup>24</sup> The Office of the Health Ombudsman (OHO) in Queensland and the relevant professional council in New South Wales manage health care complaints in their respective states.<sup>25</sup>

1.15 These states are known as co-regulatory jurisdictions under the National Law.<sup>26</sup>

1.16 Complaints received by AHPRA about practitioners in co-regulatory jurisdictions are referred to the relevant body (either the OHO or the relevant

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16 *Submission 75—Attachment 1*, pp. 3–9.

17 *Submission 75—Attachment 1*, p. 13.

18 *Submission 75—Attachment 1*, p. 14.

19 *Submission 75—Attachment 1*, p. 25.

20 *Submission 75—Attachment 1*, p. 18.

21 *Submission 75—Attachment 1*, p. 30.

22 *Submission 75—Attachment 1*, p. 21.

23 *Submission 75—Attachment 1*, p. 23.

24 *National Health Practitioner Regulation National Law Act 2009* (Qld), s. 7A; *National Practitioner Regulation (Adoption of National Law) Act 2009* (NSW), s. 6.

25 See *National Health Practitioner Regulation National Law Act 2009* (Qld), s. 7B; *National Practitioner Regulation (Adoption of National Law) Act 2009* (NSW), ss. 6B, sch. 1, s. 41B.

26 National Law, s. 5 (definition of 'co-regulatory jurisdiction').

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professional council).<sup>27</sup> Under Queensland legislation, the Health Ombudsman can then refer matters back to AHPRA and the relevant national board unless the matter is 'serious'.<sup>28</sup>

## Overview of the complaints process

1.17 Any one may make a complaint about a registered health practitioner.<sup>29</sup>

1.18 Complaints about registered health practitioners—known as notifications under the National Law—can be made to AHPRA or to the health ombudsman in the relevant state or territory. These health ombudsmen are referred to in the National Law as health complaints entities.<sup>30</sup>

1.19 Complaints received by AHPRA are assessed to ensure that they relate to a registered practitioner.<sup>31</sup> Notifications are then referred to the national board.

1.20 The relevant national board and health complaints entity must work together to determine how any notification/complaint about a registered health practitioner will be managed.<sup>32</sup> If there is a disagreement between them, the most serious action proposed must be taken.<sup>33</sup>

1.21 The complaints process is not linear. As can be seen in Diagram 1.1, the options available to the national board should be conceived of as actions that the board may decide to use at any stage in the process.

1.22 The possible actions are:

- take no further action;<sup>34</sup>
- take 'immediate action';<sup>35</sup>
- investigate;<sup>36</sup>
- request a health or performance assessment;<sup>37</sup>
- take action by:
  - issuing a caution;

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27 National Law, s. 148(2).

28 Mr Leon Atkinson-MacEwen, Health Ombudsman, Office of the Health Ombudsman, Queensland, *Committee Hansard*, 31 March 2017, p. 2.

29 National Law, s. 145.

30 National Law, s. 5 (definition of 'health complaints entity').

31 National Law, s. 148(1).

32 National Law, s. 150.

33 National Law, s. 150(4).

34 National Law, s. 151.

35 National Law, pt 8 div 7.

36 National Law, pt 8 div 8.

37 National Law, pt 8 div 9.

- accepting an undertaking;
- imposing conditions;<sup>38</sup>
- appoint a panel;<sup>39</sup>
- refer to a tribunal;<sup>40</sup> or
- refer to another entity.

**Diagram 1.1—The complaints process administered by AHPRA**

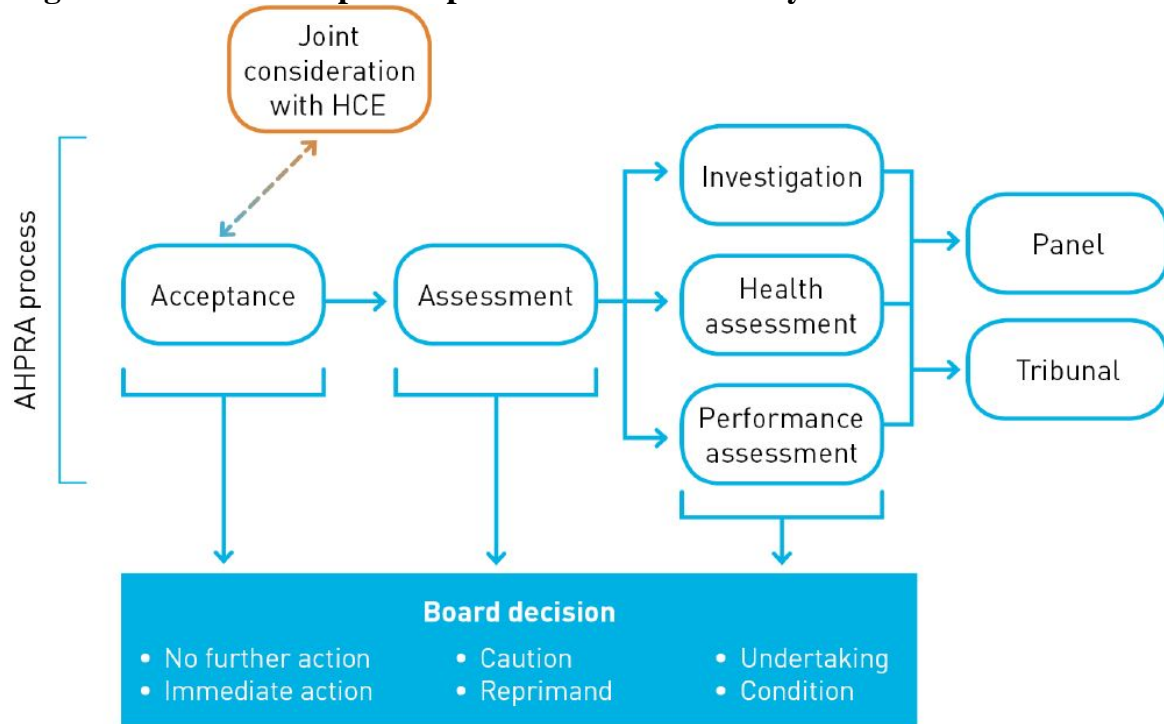


Diagram taken from AHPRA and MBA, *Submission 119*, p. 5.

1.23 Most final decisions are capable of being appealed to the responsible tribunal in the relevant state or territory.<sup>41</sup>

### Previous reviews

1.24 Since AHPRA's establishment in 2009, a variety of entities have conducted reviews into aspects of AHPRA's administration. The reviews have been met with varying degrees of responsiveness.

38 National Law, pt 8 div 10.

39 National Law, pt 8 div 11.

40 National Law, pt 8 div 12.

41 A list of appellable decisions can be found in National Law, s. 199.



### *Senate committees*

1.25 The Senate Standing Legislation Committee on Community Affairs has considered legislation relating to the National Law on two occasions and the Senate Standing References Committee on Finance and Public Administration examined AHPRA's administration of the National Law in 2011.<sup>42</sup>

1.26 Most relevantly, in each inquiry submitters raised concerns about the mandatory notification process and the chilling effect it may have on practitioners seeking assistance to manage their own health. In response, the Senate Finance and Public Administration Committee recommended that the effect of mandatory notifications be reviewed.<sup>43</sup>

### *Independent review*

1.27 AHMAC also commissioned an independent review of the scheme by Mr Kim Snowball, an experienced former public servant.<sup>44</sup> The Snowball Review made 33 recommendations to improve the National Registration and Accreditation Scheme for the Health Professions.<sup>45</sup> Four recommendations are relevant to this inquiry: recommendations 9, 10, 28 and 29.

1.28 Recommendation 9 outlined measures that AHPRA should implement to improve the complaints handling system, such as:

- interviewing complainants to ascertain their expectations;
- establishing benchmark timeframes for the completion of key aspects of the process;
- conveying the rationale for deliberations and progress reports to notifiers;

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42 Senate Standing Legislation Committee on Community Affairs, *National registration and accreditation scheme for doctors and other health workers*, August 2009, [http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/Completed\\_inquiries/2008-10/registration\\_accreditation\\_scheme/report/index](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2008-10/registration_accreditation_scheme/report/index) (accessed 22 December 2016).; Senate Standing Legislation Committee on Community Affairs, *Health Practitioner Regulation (Consequential Amendments) Bill 2010 [Provisions]*, 12 May 2010, [http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/Completed\\_inquiries/2008-10/health\\_practitioner\\_reg/index](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2008-10/health_practitioner_reg/index) (accessed 13 January 2017); Senate Standing References Committee on Finance and Public Administration, *The administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA)*, 3 June 2011, [http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Finance\\_and\\_Public\\_Administration/Completed\\_inquiries/2010-13/healthpractitionerregistration/report/index](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Finance_and_Public_Administration/Completed_inquiries/2010-13/healthpractitionerregistration/report/index) (accessed 13 January 2017).

43 Senate Standing References Committee on Finance and Public Administration, *The administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA)*, 3 June 2011, p. 115.

44 Kim Snowball, *Independent review of the national registration and accreditation scheme for health professions*, December 2014, p. 1.

45 Kim Snowball, *Independent review of the national registration and accreditation scheme for health professions*, December 2014, pp. 5–9.

- reviewing correspondence standards to ensure improved sensitivity and clarity in communication.<sup>46</sup>

1.29 Recommendation 10 recommended the national adoption of the Western Australian approach to mandatory notifications.<sup>47</sup> The Western Australian approach provides an exception from mandatory reporting if the practitioner is providing treatment to the practitioner they would otherwise have to report.<sup>48</sup> Recommendations 28 and 29 recommended better training for AHPRA investigators and stronger practice prohibition powers for tribunals, respectively.<sup>49</sup>

## Responses

1.30 The previous inquiries recommended that decisive actions be taken to improve the existing complaints system. To date, only the following actions have been taken in relation to the previous inquiries.

### *Senate inquiries*

1.31 The Australian Government noted the Finance and Public Administration Committee's recommendation to seek the support of the ministerial council to review the mandatory notification requirement.<sup>50</sup>

### *Independent review*

1.32 The Australian Health Workforce Ministerial Council released the Snowball Review and its response in August 2015.<sup>51</sup> The council accepted recommendations 9 and 28, accepted recommendation 29 in principle pending further advice and did not accept recommendation 10.<sup>52</sup>

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46 Kim Snowball, *Independent review of the national registration and accreditation scheme for health professions*, December 2014, p. 6.

47 Kim Snowball, *Independent review of the national registration and accreditation scheme for health professions*, December 2014, p. 6.

48 *Health Practitioner Regulation National Law (WA) Act 2010*, s. 4(7).

49 Kim Snowball, *Independent review of the national registration and accreditation scheme for health professions*, December 2014, p. 8.

50 Australian Government, *Response to the Senate Finance and Public Administration References Committee's Inquiry into the administration of health practitioner registration by the Australian Health Practitioner Regulation Agency*, 7 February 2012, p. 7, [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 7 April 2017).

51 COAG Health Council, *Communique – The independent review of the National Registration and Accreditation Scheme for health professionals*, 7 August 2015, <http://www.coaghealthcouncil.gov.au/Portals/0/The%20Independent%20Review%20of%20the%20National%20Registration%20and%20Accreditation%20Scheme%20for%20Health%20Professions.pdf> (accessed 17 January 2017).

52 COAG Health Council, *Communique – The independent review of the National Registration and Accreditation Scheme for health professionals*, 7 August 2015, pp. 4–14.

1.33 The 2017 amendments to the National Law will permit notifiers to be provided with information about the rationale behind board decisions in accordance with recommendation 9(d) and provide for stronger practice prohibition powers for tribunals.<sup>53</sup>

### **AHPRA**

1.34 In response to questions on notice to the previous inquiry, AHPRA informed the committee that it had made progress on the Snowball Review recommendations including:

- revising its three-day investigator training program;<sup>54</sup>
- convening a working group with the health complaints entities to identify areas of change, as recommended by the Snowball Review;<sup>55</sup> and
- commencing work to implement all parts of recommendation 9 that are controlled by AHPRA.<sup>56</sup>

### **Conduct of the inquiry**

1.35 The Senate referred the complaints mechanism under the Health Practitioner Regulation National Law to the Community Affairs References Committee on 1 December 2016, with a reporting date of 10 May 2017.<sup>57</sup>

### **Handling of submissions**

1.36 The inquiry was advertised on the committee's website and the committee wrote to stakeholders and participants in the previous inquiry.

1.37 On 1 February 2017, the committee clarified the phrase 'medical complaints' in the committee's terms of reference. A statement posted on the inquiry website advised:

The committee intends to adopt a broad interpretation of the phrase 'medical complaints' in terms of reference b., c. and f. to include all registered health practitioners. The committee welcomes all submissions

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53 AHMAC, *Submission 75—Attachment 1*, pp. 25, 30.

54 Mr Fletcher, Dr Flynn and Dr Mulcahy, AHPRA, answer to questions on notice, 1 November 2016, [pp. 4–5, 17–18] (received 16 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 24 April 2017).

55 Mr Fletcher, Dr Flynn and Dr Mulcahy, AHPRA, answer to questions on notice, 1 November 2016, [p. 6] (received 16 November 2016).

56 Mr Fletcher, Dr Flynn and Dr Mulcahy, AHPRA, answer to questions on notice, 1 November 2016, [pp. 6–11] (received 16 November 2016).

57 *Journals of the Senate*, No. 23, 1 December 2016, p. 755.

that specifically address the complaints mechanism under the National Law.<sup>58</sup>

1.38 The committee invited submissions to be lodged by Friday 24 February 2017.

1.39 The committee received 139 submissions from individuals and organisations. A list of submissions is available at Appendix 1.

1.40 To assist the committee to understand the existing process, representatives of AHPRA and Ms Karen Toohey, Australian Capital Territory Health Services Commissioner, provided the committee with a private briefing on 16 February 2017.

1.41 The committee held two public hearings in Canberra on 17 March 2017 and 31 March 2017. Transcripts of those hearings are available on the committee's website and a list of witnesses is available at Appendix 2.

#### ***Note on references***

1.42 In this report, references to *Committee Hansard* are to proof transcripts. Page numbers may vary between proof and official transcripts.

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

1.43 Following this introductory chapter, this report consists of four further chapters. The next chapter considers the lodgement and assessment of complaints. The third chapter examines the way AHPRA investigates complaints and the way decisions are made by the national boards. The fourth chapter considers AHPRA's administration of the complaints mechanism and the final chapter contains the committee's conclusions and recommendations.

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58 Available on the inquiry webpage, [http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/ComplaintsMechanism](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ComplaintsMechanism) (accessed 7 April 2017).

# Chapter 2

## Lodgement and assessment of complaints

### Introduction

2.1 This chapter focuses on the first part of the complaints process, up to and including assessment.

2.2 Submitters' main concerns about this part of the complaints process were:

- knowing where to lodge a complaint; and
- eliminating vexatious complaints.

2.3 In relation to the second issue, this chapter considers the concerns raised by submitters, the evidence regarding the prevalence of vexatious complaints and examines some of the proposed solutions.

### Knowing where to lodge a complaint

2.4 Before a complaint can be lodged, people seeking to make a complaint about a health practitioner need to find the appropriate forum to do so. In most jurisdictions there are multiple entities to which a complaint may be made.<sup>1</sup> Consumers are required to identify which entity is the most appropriate to deal with their concerns. Depending on the circumstances, it may not be clear where they should lodge a complaint.

2.5 The Health Practitioner Regulation National Law (the National Law) refers to a complaint about a registered health practitioner as a notification.<sup>2</sup> The person that makes the notification is referred to as the notifier.<sup>3</sup>

2.6 A concerned potential notifier may choose to approach the practice or entity where the patient received treatment, the health complaints entity (often a health complaints commissioner) in their state or territory or the Australian Health Practitioner Regulation Agency (AHPRA).<sup>4</sup>

2.7 As noted in Chapter 1, matters about a registered health practitioner or student are referred to the relevant national board that regulates the profession.<sup>5</sup>

2.8 To assist notifiers, the National Law requires that if a health complaints entity receives a complaint about a registered health practitioner, it is required to notify the relevant board and provide a copy of the complaint.<sup>6</sup> The complaints entity and the

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1 Carers Victoria, *Submission 113*, [p. 3].

2 *Health Practitioner Regulation National Law 2009* (Qld) (National Law), sch. 1, s. 140.

3 National Law, s. 5 (notifier).

4 *Submission 113*, [p. 3].

5 National Law, s. 148(2).

6 National Law, s. 150(2).

national board must then seek to reach agreement on how the complaint ought to be managed.<sup>7</sup>

2.9 The committee received evidence from the heads of the health complaints entities in the Australian Capital Territory, South Australia and Queensland about the process through which complaints were referred to the relevant national board, through AHPRA, in those jurisdictions. Each of these jurisdictions reported a positive relationship with AHPRA that included regular meetings to monitor progress.<sup>8</sup>

2.10 The commissioners reported that they were kept informed at each stage of the process at those regular meetings.<sup>9</sup> Mr Steve Tully, Commissioner, Health and Community Services Complaints Commissioner (SA) noted that:

...there has been a significant improvement around consultation and keeping up to date with where things are at, and we can certainly raise issues at any time.<sup>10</sup>

2.11 Despite these efforts, other submitters noted that confusion remains about responsibilities for handling complaints about health practitioners.<sup>11</sup>

2.12 It appears that notifiers who initially lodge their complaints with the health complaints entity are then transferred to AHPRA if their notification requires it. Mr Tully explained to the committee that, currently, a lot of notifiers come back to the health complaints entity if they are dissatisfied with the outcome of the AHPRA process rather than directly approaching the National Health Practitioner Ombudsman and Privacy Commissioner.<sup>12</sup>

2.13 To improve the experience of notifiers, AHPRA has established an online complaints portal.<sup>13</sup>

2.14 AHPRA started surveying notifiers about their experiences in November 2016 in an attempt to improve their experience of the process.<sup>14</sup> Survey data provided with AHPRA's submission revealed that:

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7 National Law, s. 150(3).

8 Mr Steve Tully, Commissioner, Health and Community Services Complaints Commissioner (SA), *Committee Hansard*, 31 March 2017, pp. 1, 5; Ms Karen Toohey, ACT Health Services Commissioner, ACT Human Rights Commission, *Committee Hansard*, 31 March 2017, p. 5; Mr Leon Atkinson-MacEwen, Health Ombudsman, Office of the Health Ombudsman (Qld), *Committee Hansard*, 31 March 2017, p. 5.

9 Ms Toohey, *Committee Hansard*, 31 March 2017, p. 5; Mr Atkinson-MacEwen, *Committee Hansard*, 31 March 2017, p. 5; Mr Tully, *Committee Hansard*, 31 March 2017, p. 5.

10 Mr Tully, *Committee Hansard*, 31 March 2017, p. 5.

11 Tasmanian Government, *Submission 131*, p. 3; Name withheld, *Submission 122*, p. 1; Women's Legal Services Australia, *Submission 80*, pp.4–5.

12 Mr Tully, *Committee Hansard*, 31 March 2017, p. 3.

13 Mr Martin Fletcher, Chief Executive Officer, AHPRA, *Committee Hansard*, 31 March 2017, p. 22.

14 AHPRA and MBA, *Submission 119*, p. 25.

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- 53 per cent of respondents agreed or strongly agreed that it was easy to find information about how to make a complaint with AHPRA;<sup>15</sup>
  - 78 per cent of respondents said locating the online portal was 'very easy' or 'easy';<sup>16</sup> and
  - 75 per cent of respondents said that using the online portal was very easy or easy.<sup>17</sup>

2.15 However, as Dr Judith Healy commented to the committee:

...it is very complicated to find out where you go. So it certainly helps to have one portal... you can go to lodge a complaint. But I do not know how well it is advertised to the public. I do not think it is...I think people are just not very clear on where that information lies.<sup>18</sup>

### ***Committee view***

2.16 The committee notes that navigating where to lodge a complaint has been confusing for consumers. The committee supports the work AHPRA is undertaking to attempt to make the process of lodging a complaint easier for consumers.

2.17 This is a complex area of regulation with many possible points of entry. The committee acknowledges that knowing where to lodge a complaint continues to be an ongoing issue for some people.

### **Vexatious complaints**

2.18 During the committee's previous inquiry, it found that the complaints process can sometimes be used by health practitioners for bullying or harassment.<sup>19</sup>

2.19 Similarly, most of the submissions to this inquiry from health practitioners, or groups aligned with health practitioners, considered vexatious, or baseless, notifications to be a significant issue for the complaints process.<sup>20</sup>

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15 *Submission 119*, p. 25.

16 *Submission 119*, p. 26.

17 *Submission 119*, p. 27.

18 *Committee Hansard*, 17 March 2017, p. 14.

19 Senate Community Affairs References Committee, *Medical complaints in Australia*, November 2016, p. 40.

2.20 It has been proposed by several witnesses that when vexatious notifications are not identified early in the complaints process, health practitioners can be subjected to unmerited adverse consequences including reputational damage;<sup>21</sup> misrepresentation in media reporting;<sup>22</sup> significant levels of stress;<sup>23</sup> and risks the loss of the practitioner's employment.<sup>24</sup>

2.21 The problem for the committee was that it received only limited independent evidence about the prevalence of these types of complaints.

### *Evidence of prevalence*

2.22 Most of the evidence the committee received about vexatious complaints was from practitioners who expressed concern that complaints made against them, their colleagues or members of their association were vexatious.

2.23 For example, the Australian Dental Association (ADA) reported to the committee that of the 421 notifications made against New South Wales dental practitioners in the 2015–16 financial year, 208 were dismissed by the Dental Council of New South Wales.<sup>25</sup> The inference seemed to be that the 208 notifications were vexatious, although that is not necessarily the case.<sup>26</sup>

2.24 The Association of Family and Conciliation Courts (AFCC) explained that single expert witnesses in family law proceedings have been subjected to notifications initiated by family law litigants seeking to 'find fault or discredit opinions given in the course of family law proceedings'.<sup>27</sup>

20 Mr Joel Levin, *Submission 27*, [p. 2]; MIGA, *Submission 30*, p. 9; Ms Kate Greenaway, *Submission 33*, p. 4; Royal Australian College of General Practitioners, *Submission 41*, [p. 2]; Ms Jennifer Ellis, *Submission 42*, [p. 2]; Avant, *Submission 50*, p. 2; Dr Gary Fettke, *Submission 54*, p. 4; Ms Jennifer Smith, *Submission 57*, p. 2; Dr Jeremy Rourke, *Submission 61*, [p. 2]; Ms Caroline Raphael, *Submission 69*, p. 2; Ms Elizabeth Dolan, *Submission 71*, p. 3; Dr Rachel Mascord, *Submission 73*, [p. 3]; Ms Marianna Masiorski, *Submission 74*, [p. 2]; Mr Harrison White, *Submission 79*, [p. 3]; Name withheld, *Submission 85*, [p. 2]; Ms Zoe Sherrin, *Submission 98*, [p. 2]; Ms Cristina Vitellone, *Submission 99*, [p. 2]; Australian Dental Association, *Submission 108*, [p. 1]; Dr Maxine Szramka, *Submission 109*, [p. 2]; Dr Vincent Papaleo, *Submission 116*, [pp. 2-3]; Australian Medical Association, *Submission 117*, p. 5; Ms Marg Fitzpatrick, *Submission 126*, [pp. 4-5]; Australian Psychological Association, *Submission 130*, p. 6–7.

21 Mr Joel Levin, *Submission 27*, p. 2.

22 Ms Johanne Brown, *Submission 7*, p. 1.

23 Dr Edwin Kruys, Vice-President, Royal Australian College of General Practitioners, *Committee Hansard*, 17 March 2017, p. 25.

24 Australian Medical Association, *Submission 117*, p. 5.

25 ADA, *Submission 108*, p. 2.

26 For other reasons no further action may be taken see [2.33].

27 AFCC, *Submission 38*, p. 4.



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2.25 The considerable anecdotal evidence provided by practitioners stood in contrast to independent evidence provided to the committee by the National Health Practitioner Ombudsman and Privacy Commissioner (NHPOPC).

2.26 The NHPOPC provided the committee with analysis of complaints lodged with her office. The NHPOPC's analysis suggests that there are not a significant number of cases in which the respective health practitioner believed the notification against them was made vexatiously.<sup>28</sup>

2.27 In response to a question on notice to the committee's previous inquiry, NHPOPC submitted that she received two vexatious notifications each year in 2014–15 and 2015–16. As a proportion of NHPOPC's total notifications for these periods, vexatious notifications comprised three per cent and one per cent respectively.<sup>29</sup>

2.28 NHPOPC's submission to the committee also indicates vexatious notifications for the 2016–17 year were trending higher than in the previous two years, with an estimated twelve complaints received at the time of submission, or 6.5 per cent of the total notifications received during the period.<sup>30</sup>

2.29 The conflict between the perspectives of the practitioners and the findings of the NHPOPC may be explained by differing interpretations of the use of the word vexatious.

2.30 During the hearing on 31 March 2017, AHPRA's Community Reference Group were asked about what constituted a vexatious complaint. In their answer to the question on notice, AHPRA's Community Reference Group provided 13 possible definitions of the word 'vexatious'.<sup>31</sup> The definitions provided are consistent with how practitioners may view the complaints.

2.31 However, Ms Georgie Haysom, Head of Advocacy at Avant noted that there is a difference between a lay definition of vexatious and the legal definition of vexatious. Ms Haysom explained:

The legal meaning of 'vexatious' is different from the ordinary meaning, and at law the definition of 'vexatious' is very narrow and the threshold for a complaint or other legal action to be considered to be vexatious is high. So the number of complaints that fall within this legal definition is likely to be very small. I think that the ordinary meaning of that is broader, though, and probably the word is used in that broader meaning by many who talk about vexatious complaints.<sup>32</sup>

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28 NHPOPC, *Submission 105*, p. 11.

29 NHPOPC, answers to questions on notice, 1 November 2016 (received 10 November 2016).

30 NHPOPC, *Submission 105*, p. 11.

31 AHPRA Community Reference Group, answers to questions on notice, 31 March 2017 (received 24 April 2017), [pp. 2–3].

32 *Committee Hansard*, 17 March 2017, p. 32.

***Power to take no further action***

2.32 If vexatious notifications are identified, it is within the power of the national boards to 'take no further action' in relation to a notification made under the National Law.<sup>33</sup>

2.33 However, it would be incorrect to assume that all matters that result in no further action being taken were vexatious. Mr Martin Fletcher, Chief Executive Officer of AHPRA informed the committee that this may be the case if the practitioner 'has already taken steps to address the concern' or there is no ongoing risk that needs to be managed.<sup>34</sup>

2.34 Following the preliminary assessment of a notification, AHPRA is required to refer a notification to the relevant national board that regulates the registered health practitioner to which the notification pertains.<sup>35</sup> Following the receipt of a referred notification, the national board is required to decide what action, if any, should be taken.<sup>36</sup> Under section 151 of the National Law, a national board may decide to take no further action on the basis that the national board has reasonable grounds to believe that the notification was made vexatiously.<sup>37</sup>

2.35 The power of a national board to take no further action can be employed at a relatively early stage in the complaints process. Despite this, some health practitioners perceive that the power is being exercised too late.<sup>38</sup>

2.36 All decisions, including those to take no further action, are required to be assessed by the national board or a committee of the national board.<sup>39</sup> In its submission to the inquiry, AHPRA reported that in an analysis of 2718 complaints closed about doctors during the 2015–16 financial year, 64 per cent of complaints were closed following assessment.<sup>40</sup> Complaints were closed in a median timeframe of around two months when regulatory action was not taken.<sup>41</sup> In instances when regulatory action was taken, the median timeframe to close the complaint was three and a half months.<sup>42</sup>

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33 National Law, s. 151.

34 *Committee Hansard*, 31 March 2017, p. 22.

35 National Law, s. 148(1).

36 See paragraph [1.22] for the list possible actions available to a national board.

37 National Law, s. 151(1)(a).

38 Australian Medical Association, *Submission 117*, p. 3.

39 Mr Fletcher, *Committee Hansard*, 31 March 2017, p. 22.

40 AHPRA and MBA, *Submission 119*, p. 9.

41 *Submission 119*, p. 9.

42 *Submission 119*, p. 19.

2.37 NHPOPC's submission to the inquiry noted it did not identify any issues with AHPRA's application of the power to dismiss vexatious notifications.<sup>43</sup>

### *Suggestions*

2.38 Submitters proposed a number of reforms that may assist to minimise the prevalence of vexatious complaints.

### *History of complainants*

2.39 Submissions from several health practitioner organisations suggested that a complaints entity, in its early assessment of notifications, should consider the notification history of complainants.<sup>44</sup>

2.40 The rationale underpinning the proposed consideration of a complainant's history is to address what has been described as AHPRA's 'guilty until proven innocent' approach.<sup>45</sup> In reviewing the history of notifications made by a complainant, vexatious complainants may be identified earlier in the complaints process and this information can be used to inform the subsequent deliberations of the national boards.

### *Triaging complaints*

2.41 Another recurring suggestion from witnesses and submitters to potentially eliminate vexatious complaints and increase timeliness was that AHPRA should recruit health practitioners to assist in triaging complaints.<sup>46</sup>

2.42 In November 2016, AHPRA advised the committee that 42 of 180 staff employed in its notifications division had a clinical background and that another 15 clinically trained staff advise the notifications, registration, compliance and legal teams.<sup>47</sup>

2.43 Under the existing process, the members of the board—both practitioners and community members—consider each notification to assess its seriousness and whether the board ought to open an investigation.<sup>48</sup>

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43 NHPOPC, *Submission 105*, p. 12.

44 Australian Medical Association, *Submission 117*, p. 5; Australian Psychological Society, *Submission 130*, pp. 7–8.

45 Dr Jennifer Neoh, Secretary, Australian Chapter, Association of Family and Conciliation Courts, *Committee Hansard*, 17 March 2017, p. 25.

46 Dr Marie Bismark, Associate Professor, University of Melbourne, *Committee Hansard*, 17 March 2017, p. 10; Mr Rhett Clayton, National Liability Claims Manager, Guild Insurance, *Committee Hansard*, 17 March 2017, p. 31; Health Consumers' Council, *Submission 96*, p. 4; Guild Insurance, *Submission 48*, p. 3.

47 Mr Fletcher, Dr Flynn and Dr Mulcahy, answer to questions on notice, 1 November 2016 [p. 3] (received 16 November 2017) [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 24 April 2017).

48 Dr Joanna Flynn, Chair, Medical Board of Australia, *Committee Hansard*, 31 March 2017, p. 29.

2.44 However, Dr Joanna Flynn, Chair of the Medical Board of Australia (MBA) explained to the committee that the MBA was currently refining its processes, saying:

...we have been trialling another process that I think is very productive, which is that the original letter of notification goes straight to a committee within a week of it being received.<sup>49</sup>

2.45 Dr Flynn informed the committee that the trial process was also under consideration by a number of other states and territories.<sup>50</sup>

2.46 The committee was surprised to learn that the original notification is not routinely provided to the board.

2.47 Submitters and witnesses raised the prospect that the boards and participants may benefit from more specialised clinical input at the initial stages of the process. For example, the AFCC suggested that complaints be screened by someone with family law experience where notifications were made about single expert witnesses in family law proceedings.<sup>51</sup>

2.48 In its submission, AHPRA confirmed that it had:

increased clinical input into the complaints assessment process earlier in the process, for example, through earlier and quicker clinical triage and assessment mechanisms.<sup>52</sup>

2.49 At the committee's public hearing on 31 March, Mr Fletcher reiterated that AHPRA was focussed on improving its assessment and triage processes.<sup>53</sup>

2.50 Avant Mutual Group Limited also submitted that triaging was an area that AHPRA had worked to improve.<sup>54</sup>

### ***Committee view***

2.51 The committee notes the perspective of some health practitioners—including the perspective of professional bodies representing health practitioners—that notifications made under the National Law are, at times, misused for the purpose of making a vexatious complaint against a registered health practitioner.<sup>55</sup>

2.52 Whilst the committee acknowledges the concerns raised by health practitioners, the independent evidence received by the committee does not suggest that vexatious notifications are a widespread issue; rather, they appear to be relatively infrequent.

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49 Dr Flynn, *Committee Hansard*, 31 March 2017, p. 27.

50 Dr Flynn, *Committee Hansard*, 31 March 2017, p. 27.

51 AFCC, *Submission 38*, p. 9.

52 AHPRA and MBA, *Submission 119*, p. 4.

53 Mr Fletcher, *Committee Hansard*, 31 March 2017, p. 27.

54 Avant, *Submission 50*, p. 3.

55 Mr Joel Levin, *Submission 27*, p. 2; AFCC, *Submission 38*, p. 4.

2.53 In instances where vexatious notifications are made, the committee recognises that there can be unwarranted and disproportionate adverse consequences for the health practitioner concerned. Accordingly, the committee considers it is essential for vexatious complaints to be identified and dismissed at the earliest possible stage in the complaints process through the 'take no further action' mechanism.

2.54 The committee maintains the view that it is central to the integrity of the complaints mechanism that prospective complainants are not discouraged from raising a notification. Excessive regulation of the 'front door' of the complaints mechanism may increase the risk that genuine complaints are not addressed. Such an outcome would diminish the efficacy of the regulatory protections offered by the complaints mechanism.

2.55 To that extent, the committee commends AHPRA's efforts to triage complaints to streamline the complaints process. The new trial process appears to enhance the existing triaging system and supports its expansion to the remaining jurisdictions. However, the committee considers that more can be done.



# Chapter 3

## Investigations and national board decisions

3.1 This chapter will consider the investigation and decision making parts of the complaints process and their administration.

3.2 The committee has found that these parts of the process have the most impact on practitioners and notifiers. This chapter contains two key themes that have been brought to the committee's attention:

- the lack of confidence in the complaints mechanism; and
- questions about the decisions of the national boards.

### Confidence in the decision making process

3.3 The complaints process under the National Law is a mechanism by which poor performing health practitioners and errors in their practice can be identified. It is important for patient safety that practitioners, patients and their family have confidence in the ability of the complaints mechanism to address practice issues.

3.4 It is clear that the current system does not enjoy the full confidence of many of the notifiers and practitioners who have engaged with it.

### *Notifiers and the relatives of patients*

3.5 Notifiers and the relatives of patients have expressed a lack of confidence in the Australian Health Practitioner Regulation Agency's (AHPRA) investigative processes, its competence, staff and management.<sup>1</sup>

3.6 One factor that appears to have undermined confidence in the system is a perception that investigations often do not uncover all of the information necessary to make an informed decision about the notification.

3.7 For example, Mr Maxwell Brown lodged a number of notifications in connection with medical treatment his wife received.<sup>2</sup> The Browns believe that, in their case, the board made decisions without the patient's complete medical records.<sup>3</sup> As Mr Brown said to the committee:

I always felt that the medical records of my wife that AHPRA had received were incomplete, and I felt that they should have had the experience to identify that they were incomplete. They would not accept that. They did not want to discuss it—no further action. So I got our solicitor to write letters to people I knew that would have them. I approached those people myself, and eventually that information came to light. I then took that

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1 Ms Marg Fitzpatrick, *Submission 126*, [p. 5]; Mrs Rhonda McNees, *Committee Hansard*, 31 March 2017, p. 10; Mr Ian McNees, *Committee Hansard*, 31 March 2017, pp. 11–12.

2 Mr Maxwell Brown, *Committee Hansard*, 31 March 2017, p. 12.

3 Mr Maxwell Brown, *Committee Hansard*, 31 March 2017, p. 12.

information to Melbourne, and they reopened their investigation again because it was new evidence. From a member of the public's point of view, AHPRA are the people we go to to identify proper records. I am a farmer and I could see that this information was missing. These were important documents relating to what happened on the night of the operation on my wife. Right or wrong, they should have been in the medical records. They were not.<sup>4</sup>

3.8 In the case of Mr Ian and Mrs Rhonda McNeese, an independent report by the Victorian Government Solicitor's Office found, among other things, that:

- not all aspects of the notifications were properly considered by AHPRA;
- the board was not provided with the relevant information necessary for them to make an informed decision; and
- in some cases the practitioner's account of events was accepted despite there being conflicting evidence from the notifiers.<sup>5</sup>

3.9 Confidence is undermined if notifiers do not believe that the investigators and the national board will conduct a rigorous assessment of their notification. A factor that may compound their initial misgivings is that, after making the initial notification or notifications, there is little opportunity for notifiers to be involved in the process unless the matter is referred to a health complaints entity.

3.10 Health complaints entities have the capacity to facilitate meetings between notifiers and practitioners to discuss issues and attempt to resolve matters.<sup>6</sup> However, the practitioner is often reluctant to engage with the notifier until the matter has been resolved through the complaints process.<sup>7</sup>

3.11 Unlike the health complaints entities, Mr Steve Tully, Commissioner, Health and Community Services Complaints Commissioner (SA) explained to the committee that the National Law was not designed to facilitate notifier engagement.<sup>8</sup> Instead, the National Law assumes that once the notification has been made the agency and the board will 'go about their business'.<sup>9</sup>

3.12 Where notifications are made by consumers concerned about their health or the health of someone close to them, Mr Tully told the committee:

What they say they want in a complaints process is the ability to sit [in] on hearings, to eyeball the practitioner, to ask questions of the practitioner and

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4 Mr Brown, *Committee Hansard*, 31 March 2017, p. 12.

5 Mrs Rhonda McNeese, *Committee Hansard*, 31 March 2017, p. 11.

6 Ms Karen Toohey, Australian Capital Territory Health Services Commissioner, Australian Capital Territory Human Rights Commission, *Committee Hansard*, 31 March 2017, p. 2.

7 Mr Leon Atkinson-MacEwen, Health Ombudsman, Office of the Health Ombudsman, Queensland, *Committee Hansard*, 31 March 2017, p. 4.

8 *Committee Hansard*, 31 March 2017, p. 2.

9 Mr Tully, *Committee Hansard*, 31 March 2017, p. 2.



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to face off with the practitioner about their situation and the impact it has had on their life.<sup>10</sup>

3.13 The desire for more active engagement was also highlighted by the Snowball Review:

...notifiers commonly see themselves as party to their case and expect to have an active and ongoing role in the resolution of it, whereas the system views them as a witness to an allegation of misconduct.<sup>11</sup>

3.14 This highlights a fundamental tension in the current complaints system: notifiers are often looking for a resolution, but the board's primary concern is whether the practitioner's conduct fell below the relevant standard.

3.15 Only if a matter progresses to a panel hearing may a notifier make a submission; and only then if they have the leave of the panel.<sup>12</sup> Otherwise, notifiers are only entitled to limited information and limited involvement.<sup>13</sup>

3.16 As Ms Karen Toohey, Australian Capital Territory Health Services Commissioner relayed to the committee:

I think there is certainly a sense that the process is focused on the disciplinary process for the practitioner rather than focused on the individual's or the consumer's experience.<sup>14</sup>

3.17 While the proposed 2017 amendments to the National Law will allow for greater information to be provided to notifiers, there are no plans for additional notifier involvement in the process.<sup>15</sup>

3.18 Ms Jen Morris, a member of AHPRA's Community Reference Group suggested that:

...different policies and different procedures should be applied depending upon whether one is dealing with a lay person's complaint or that of an employer or another practitioner...<sup>16</sup>

3.19 This approach was also supported by some practitioners.

3.20 Dr Simon Rosenbaum argued:

I press my argument for a genuine inquisitorial process and am convinced that most concerns about a medical practitioner... would be laid to rest after a meeting in a non-confrontational environment... This could be conducted

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10 *Committee Hansard*, 31 March 2017, p. 2.

11 Kim Snowball, *Independent review of the national registration and accreditation scheme for health professions*, December 2014, p. 28.

12 National Law, s. 187.

13 See for example National Law, ss. 151(3), 161(3), 180, 192(2), (4).

14 Ms Toohey, *Committee Hansard*, 31 March 2017, p. 4.

15 AHMAC, *Submission 75—Attachment 1*, p. 25.

16 *Committee Hansard*, 31 March 2017, p. 8.

by a medical practitioner with or without a legal person. I am aware that this is the typical process in countries like France.<sup>17</sup>

3.21 Similarly Ms Kate Greenaway, an allied health practitioner, supported the proposition that the complainant and the notifier should be treated equally through the complaints process.<sup>18</sup>

3.22 Such a model may also be more consistent with the Australian Commission on Safety and Quality in Health Care's *National Safety and Quality Health Service Standards* which already apply in most places consumers receive medical care.<sup>19</sup>

3.23 The system is intended to protect the public, but the evidence the committee received is that some members of the public do not feel like they are being protected.

### ***Health practitioners***

3.24 The health practitioners regulated by the scheme have a significant stake in how it operates. While the committee only received evidence from a small proportion of practitioners, those that made submissions made their views strongly.

3.25 Making a mistake, or being accused of making a mistake, as a health practitioner is stressful, but the stress associated with it appears to be compounded by the complaints mechanism.

3.26 Dr Joanna Flynn, Chair, Medical Board of Australia (MBA), explained the stress doctors come under when a notification is made against them, saying:

...it is devastatingly stressful for any doctor to be the subject of a complaint to AHPRA and the board. That is for two reasons. Firstly, having to answer to the board about your conduct is just the worst thing you could ever imagine happening. Secondly, doctors have a catastrophic view of the outcome of those processes. They have a mental model that many more doctors end up having their registration cancelled or severe restrictions, so they immediately feel very distressed. And that distress remains until the matter is closed-and, often, beyond.<sup>20</sup>

3.27 The Chief Executive Officer of the Australian Commission on Safety and Quality in Health Care also noted that doctors are often deeply affected by the mistakes they make:

There is an expression in health called the second victim, which is that, when there is particularly a very serious mistake, obviously there is the patient who has suffered from that mistake, but then also there is the person or the group of people involved. They carry that with them really for the rest of their career. There is not a clinician that I know that cannot tell you

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17 *Committee Hansard*, 31 March 2017, p. 16.

18 *Committee Hansard*, 31 March 2017, p. 17.

19 Adjunct Professor Debora Picone AM, Chief Executive Officer, Australian Commission on Safety and Quality in Health Care, *Committee Hansard*, 17 March 2017, p. 1.

20 *Committee Hansard*, 31 March 2017, p. 26.

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nearly every mistake that they have made that they are aware of. So it is felt very deeply.<sup>21</sup>

3.28 Regardless of their profession, practitioners routinely reported a sense of intimidation—of receiving a notification, of being investigated, of the boards.<sup>22</sup>

3.29 Practitioners attributed that fear to the scrutiny, professional embarrassment and financial hardship that they would experience (or believe they would experience if they became the subject of a notification) to the AHPRA administered complaints process.<sup>23</sup>

3.30 Some practitioners attribute harm directly to the complaints mechanism itself. One practitioner submitted that:

A close friend killed himself last year, as a direct result, not of the complaint itself, but of the complaints process. Financially ruined, publicly humiliated, and personally devastated, when he could not take the strain any more, he took his own life, stating his innocence until the end.<sup>24</sup>

3.31 Ms Kate Greenaway observed that 'in many parts... it has become a punitive process'.<sup>25</sup> Dr Rosenbaum said AHPRA's actions were 'overly legalistic, punitive and deny natural justice'.<sup>26</sup> Dr Rachel Mascord, a dental practitioner, commented that the process 'is creating an adversarial environment in which patients and doctors are positioned on either side of a divide'.<sup>27</sup>

3.32 The question is whether any process would feel punitive or whether the existing system is perceived as punitive because of the way the process is structured or administered.

3.33 The Royal Australian College of General Practitioners (RACGP) submitted that there were problems with the administration of the process:

It is perceived that the current complaints mechanism is more concerned with the prosecution of practitioners than protecting patient safety through remediation of the issues that lead to the complaint.<sup>28</sup>

3.34 Dr Edwin Kruys, the Vice-President of RACGP elaborated:

...it appears that there is room for a lot of cultural change within AHPRA. I guess the big issue is that it is perceived as extremely punitive. You could say that 'if all you have is a hammer then all you see is nails'. It would be

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21 Adjunct Professor Debora Picone AM, *Committee Hansard*, 17 March 2017, p. 4.

22 Ms Kate Greenaway, *Submission 33*, p. 5; Ms Elizabeth Dolan, *Submission 71*, p. 2.

23 Ms Elizabeth Dolan, *Submission 71*, p. 2; Dr Rachel Mascord, *Submission 73*, [p. 2].

24 Dr Anne Malatt, *Submission 65*, p. 1.

25 *Committee Hansard*, 31 March 2017, p. 17.

26 *Committee Hansard*, 31 March 2017, p. 16.

27 *Committee Hansard*, 31 March 2017, p. 18.

28 RACGP, *Submission 41*, [pp. 1–2].

really good if AHPRA had other options, like counselling or remediation, to solve problems, instead of just going down the punitive road.<sup>29</sup>

3.35 When Mr Martin Fletcher, Chief Executive Officer of AHPRA, appeared before the committee, he appeared cognisant that:

...although our jurisdiction is a protective jurisdiction, we recognise that...for the practitioner involved it can feel like a punitive process.<sup>30</sup>

3.36 Some people consider it to be punitive because, unless the matter results in no further action, the only outcomes are formal in nature. As Medical Insurance Group Australia (MIGA) representative Mr Timothy Bowen expressed:

What we have seen in the national system is a more punitive, disciplinary approach to dealing with [errors], using cautions to say 'you need to improve next time'.<sup>31</sup>

3.37 But Mr Bowen went on to explain that New South Wales operates quite differently:

The New South Wales approach is somewhat different: it is a matter of getting practitioners with a senior peer at an earlier stage, talking through those issues and educating them to make sure it does not happen again. We think that is a better approach...<sup>32</sup>

3.38 Other witnesses concurred with that opinion.<sup>33</sup>

3.39 In principle, providing the national boards with powers that may permit a different approach is an option currently being considered by the Australian Health Ministers' Advisory Council (AHMAC). Ms Durham advised the committee:

[AHMAC] are looking at amendments that might strengthen the role for the notifier in the disciplinary process, and powers for national boards to settle matters, so enabling greatest use of alternative dispute resolution between practitioners, notifiers and the national board.<sup>34</sup>

### *Advocates*

3.40 A small number of submitters proposed that advocates be provided by AHPRA—to one or both parties—or that advocates be permitted to make submissions

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29 *Committee Hansard*, 17 March 2017, p. 27.

30 *Committee Hansard*, 31 March 2017, p. 26.

31 *Committee Hansard*, 17 March 2017, p. 35.

32 *Committee Hansard*, 17 March 2017, p. 35.

33 Ms Georgie Haysom, Head of Advocacy, Avant Mutual Limited, *Committee Hansard*, 17 March 2017, p. 35.

34 Ms Amity Durham, Acting Deputy Secretary, Department of Health and Human Services, Victoria representing the Australian Health Ministers' Advisory Council, *Committee Hansard*, 17 March 2017, p. 17.

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to the board in an attempt to support notifiers and practitioners through the process.<sup>35</sup> The proponents of this recommendation focused on the support and guidance a support person could offer through the process.<sup>36</sup>

3.41 Mr Gary Clarke, a notifier, stressed that supporting complainants in preparing notifications is important because:

Obviously if you do not get your points...in order and you do not specifically identify what the issues are, then you cannot get an investigation that delivers the right outcome.<sup>37</sup>

3.42 The Health Consumers' Council also suggested that consumer groups could also assist with 'orchestrating reviews and appeals'.<sup>38</sup>

3.43 Whilst it was not explicitly stated, these suggestions appear to be motivated by a perception that the complaints process requires assistance to navigate.

#### ***Committee view***

3.44 The committee was concerned by the evidence it received from both notifiers and practitioners.

3.45 The committee acknowledges and understands the angst, dismay and frustration of notifiers who perceive that they have not been taken seriously by AHPRA or consider that their notifications have been mismanaged.

3.46 As consumers of health care, patients and their families are invited and encouraged to take an active interest in their own care. The committee notes that consumers have a right to comment on or complain about treatment they have received. Notifications are one of the few ways the board has to identify clinical practice issues that may need to be addressed.

3.47 Consumers have a substantial interest in resolving complaints and it seems inappropriate that they are marginalised to the degree that they are.

3.48 Equally, as the party being regulated, the outcome of the board's decision often has a significant impact on the life of the practitioner.

3.49 The committee is concerned about the effect that the complaints process is having on practitioners. Whilst having a professional mistake identified is always likely to be stressful, the committee is concerned by evidence that suggests the complaints process appears to be administered in a punitive way.

3.50 The committee understands that AHPRA's mandate is to protect the public, but that mandate does not require sanction for each mistake. Witnesses identified the

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35 Ms Cynthia Hickman, *Submission 29*, [pp. 3–4]; Ms Elizabeth Dolan, *Submission 71*, p. 4; Dr Jane Barker, *Submission 112*, [p. 1].

36 Ms Cynthia Hickman, *Submission 29*, [pp. 3–4]; Ms Elizabeth Dolan, *Submission 71*, p. 4; Dr Jane Barker, *Submission 112*, [p. 1].

37 *Committee Hansard*, 31 March 2017, p. 13.

38 Health Consumers' Council, *Submission 96*, p. 4.

New South Wales model as placing a greater emphasis on mentoring, education and conciliation options.

3.51 The committee acknowledges that there are circumstances in which the national boards need to take strong regulatory action, but the committee considers that, with a broader range of tools, AHPRA may be able to change the way it administers the process to make it both more rigorous and fair.

3.52 However, the committee recognises that these goals are hard to achieve if the information is not reaching the national boards that make the decisions.

### **Decisions of the national boards**

3.53 The national boards can only work with the information they have available to them. Therefore, the quality of the information that is provided to them has an impact on the decisions they make.

3.54 As noted above, some information can be missing in investigations. This part will consider the information the boards are provided with and the concerns of witnesses that have engaged with them.

3.55 In particular, the primary concerns raised with the committee have been:

- conflicts of interest;
- the adequacy of documentation provided to the boards; and
- whether board members have sufficient specialist knowledge.

### ***Conflicts of interest***

3.56 Currently both notifiers and practitioners fear that the process is being affected by conflicts of interest.

3.57 Effective complaints mechanisms provide participants with procedural fairness. It is crucial that participants within the complaints mechanism are free from conflicts of interest.

3.58 The committee has received evidence which suggests that apparent conflicts of interest have occurred, or are systemic, in the complaints process.

3.59 An individual submitter provided evidence that, in one instance, an expert witness contributing to a notification assessment had an apparent conflict of interest resulting from competing professional interests.<sup>39</sup> Similar concerns were also raised in confidential submissions.

3.60 The employment of 'independent external witnesses' has raised concerns that such witnesses may have:

a financial conflict of interest to write a report that aligns with the views of the agency paying for the report, particularly when they are a contractor who derives income from multiple reports for that agency.<sup>40</sup>

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39 Associate Professor Colin Moore, *Submission 55*, p. 1.

40 Name withheld, *Submission 68*, [p. 4].

3.61 If that is the case, there is a risk that the information being provided to the board has a particular bias. It is unclear whether the boards have the expertise to recognise and correct such bias if the advice has been sought to provide clinical peer expertise that is not otherwise available to the board.

3.62 A solution to financial conflicts of interest may be that independent experts are sourced from, and remunerated by, a central independent entity.<sup>41</sup> To ensure that the entity is able to retain the most suitable clinical peer available, the entity would need to be able to provide competitive remuneration to clinical peers to make it economically viable for practitioners. This would allow clinical peers with current clinical practice to be retained.

3.63 A potentially more insidious problem would be if the decision makers themselves were compromised. Notifiers provided examples to the committee of instances where they considered that conflicts of interest arose between members of the board and an aspect of the notification.

3.64 Mr Maxwell Brown notified AHPRA of a potential conflict of interest when he identified that a member of the board had also provided advice to his solicitor.<sup>42</sup> In another instance, it was suggested that a conflict arose between a member of the board and their senior position within another organisation whose employees were being investigated by the board.<sup>43</sup>

3.65 AHPRA and the MBA have submitted that appropriate processes are in place to avoid conflicts of interest.<sup>44</sup> The suggestion that there were conflicts of interest was adamantly denied by Dr Flynn, who insisted:

...we have very clear conflict of interest policies and processes, and if there is a situation where too many doctors in a particular jurisdiction who are on the board know the practitioner who is the subject of a notification then the matter is referred to another state to be dealt with.<sup>45</sup>

3.66 When pressed, Dr Flynn suggested that not prospectively declaring a material conflict of interest would go against the code of required behaviour for board members and potentially be grounds for resignation from the board. However, the consequence of an undeclared conflict of interest of an MBA board member remains untested.<sup>46</sup>

### ***Documentation provided to the boards***

3.67 As has been noted above, submitters have raised concerns about the adequacy of documentation received by the boards.

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41 Name withheld, *Submission 68*, [p. 4].

42 Mr Maxwell Brown, *Committee Hansard*, 31 March 2017, p. 12.

43 Mrs Rhonda McNees, *Committee Hansard*, 31 March 2017, p. 11.

44 AHPRA and the MBA, *Submission 119*, p. 19.

45 *Committee Hansard*, 31 March 2017, p. 28.

46 *Committee Hansard*, 31 March 2017, p. 28.

3.68 Dr Rachel Mascord observed that there could be considerable problems for practitioners in obtaining the documentation necessary to defend a notification after a practitioner has left that place of practice.<sup>47</sup> As will be noted in greater detail below, some investigations can take years to complete.

3.69 Another notifier, Mr Garry Clarke, concluded from his experience that:

What [health practitioners] are doing is they are not keeping medical records. My wife is an example of that. Close to 40 visits over eight years, and there were lucky to be medical notes for eight to nine visits over that period of time.<sup>48</sup>

3.70 These claims relate to ongoing concerns about whether AHPRA collects all of the necessary information and speaks to all relevant witnesses before providing the report and the evidence to the board. It also highlights the need for rigorous investigations and greater transparency.

### ***Transparency***

3.71 Some of the above concerns could be remedied with greater transparency.

3.72 Submitters to this inquiry endorsed introducing greater transparency to the complaints process to 'facilitate impartiality and address the issue of unnecessarily adversarial complaints'.<sup>49</sup>

3.73 Extensive evidence was received from individual practitioners who outlined the need for improvement to the transparency of AHPRA's assessments, investigations and decision making processes.<sup>50</sup>

3.74 The RACGP have also expressed concern that some of their members had been provided with limited information about complaints made against them and the reasons for commencing investigations were not explained to practitioners concerned.<sup>51</sup>

3.75 The goals in this area are clear. As AHPRA's Community Reference Group summarised:

...improvements in the timeliness and transparency of notification assessment, investigation and decision processes are desirable and necessary to improve the effectiveness of making a notification as a patient safety measure, while minimising the burden upon practitioners.<sup>52</sup>

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47 Dr Rachel Mascord, *Submission 73*, [p. 3].

48 Mr Gary Clarke, *Committee Hansard*, 31 March 2017, p. 13.

49 Tasmanian Government, *Submission 131*, p. 2.

50 Ms Donna McGrath, *Submission 6*, p. 6; Ms Jennifer Ellis, *Submission 42*, p. 4; Dr Anne Malatt, *Submission 65*, p. 4; Dr Rachel Mascord, *Submission 73*, [p. 3]; Dr Simon Rosenbaum, *Submission 104*, p. 3; Dr Maxine Szramka, *Submission 109*, p. 8.

51 RACGP, *Submission 41*, [p. 3].

52 AHPRA Community Reference Group, *Submission 127*, p. 4.



3.76 However, practitioners are adamant that transparency in this case should not be public transparency; at least not until all of the appeal processes have been exhausted.<sup>53</sup>

3.77 Notifiers, both publicly and in confidential submissions, requested greater transparency at every stage of the process.<sup>54</sup>

3.78 AHPRA and the MBA reported that they are working to improve the complaints process, and as part of the progress made over the past four years, the MBA has 'improved accountability and transparency, including through introducing quarterly reporting on our performance'.<sup>55</sup>

3.79 But as Dr Flynn observed 'we have a big job to do to help people understand how the process works and to build confidence in it'.<sup>56</sup>

### ***Knowledge of board members***

3.80 The National Law requires national boards to make decisions about the management of notifications.<sup>57</sup> Members of the national boards are appointed by state and territory health ministers.<sup>58</sup> The degree of specialty that exists in the health professions means that the members of the board, even though some are practitioners, may not be practitioners with the same professional speciality as the practitioner whose conduct is under consideration.

3.81 Many practitioner submitters—some of whom had been the subject of a notification—questioned whether board members had the requisite specialty knowledge to make a proper assessment about specialist practitioners.<sup>59</sup> As RACGP submitted:

The Medical Board of Australia is arguably the most diverse of all 14 National Boards, covering a large range of medical specialties. The RACGP recognises that this wide scope makes it inherently difficult for the Medical Board to represent all facets of the medical profession. However, in order for medical practitioners to receive a fair investigation, all cases should be assessed by a medical practitioner with in-depth knowledge and relevant experience in the specialty concerned.<sup>60</sup>

3.82 The committee notes that there is already scope to address these concerns within the existing legislative framework. Dr Flynn explained to the committee that

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53 RACGP, *Submission 41*, [p. 3].

54 Mrs Rhonda McNees, *Committee Hansard*, 31 March 2017, p. 12.

55 AHPRA and the MBA, *Submission 119*, p. 4.

56 Dr Flynn, *Committee Hansard*, 31 March 2017, p. 26.

57 See for example National Law, ss. 151, 156, 160, 169.

58 National Law, ss. 33, 36.

59 RACGP, *Submission 41*, [p. 2]; National Institute of Integrative Medicine, *Submission 94*, p. 2; Name withheld, *Submission 84*, p. 7.

60 RACGP, *Submission 41*, [p. 2].

the boards can already appoint additional members if clinical peer expertise is required.<sup>61</sup>

3.83 However, it was clear that appointing clinical peers to the board was not routine practice.<sup>62</sup> In answer to questions on notice, AHPRA dismissed the suggestion that additional specialist input was required because:

- some matters referred to the boards do not relate to a specialist field of medicine (such as communication, documentation or billing matters);
- approximately 40 per cent of registered medical practitioners do not hold specialist registration and in those cases specialist input would not necessarily result in more informed decision making;
- there are 23 fields of specialist practice and over 60 sub-specialties in the medical profession and ensuring that each decision making board or committee contained an independent specialist from the same discipline 'poses challenges to the complaints process in both protracted timeframes... and increased costs in the complaints process'.<sup>63</sup>

3.84 AHPRA also reiterated that it believes that specialist input can already be obtained where it is necessary.<sup>64</sup>

#### ***Committee view***

3.85 The committee is deeply concerned about actual or perceived conflicts of interest. The committee recognises that this is a system that has significant ramifications for the practitioners concerned and, to a lesser extent, the families of the patients involved. As such it is important that all parties can have confidence in the system.

3.86 The committee is also concerned about the completeness of the information being provided to the national boards. The national boards rely on the information that is provided to them to make a properly informed decision. If information is incomplete, the board runs the risk of error. They must work with the investigators and the secretariat to ensure that all the relevant information is obtained and provided to the board.

3.87 Where outside opinions are obtained, the board must be able to justify why that practitioner was approached and know with confidence that there is no conflict of interest between the clinical peer providing the advice and the practitioner whose conduct is in question. The board should be able to demonstrate, by some independent means that the advising clinical peer was the most appropriate person.

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61 *Committee Hansard*, 31 March 2017, p. 27.

62 Dr Flynn, *Committee Hansard*, 31 March 2017, p. 27.

63 Mr Fletcher and Dr Flynn, answers to questions on notice, 31 March 2017, p. 3 (received 24 April 2017).

64 Mr Fletcher and Dr Flynn, answers to questions on notice, 31 March 2017, p. 3 (received 24 April 2017).

3.88 The evidence to the committee suggests there is an ongoing need to correct the transparency of the system.

3.89 The committee understands practitioners' desire for greater clinical peer input into the complaints process. The committee was surprised that, despite the well-known calls from practitioners for greater clinical peer input into the complaints process, procedures to obtain clinical peer input are not yet routine.

3.90 The committee is disappointed that AHPRA did not recognise the benefits that may accrue from having clinical peer advice provided at the earliest stages in the process. At the very least, the committee considers that the idea is worthy of trial.



## Chapter 4

### AHPRA's administration of the complaints mechanism

4.1 This chapter examines the Australian Health Practitioner Regulation Agency's (AHPRA) role in administering the complaints mechanism. The main concerns that have been raised with the committee are:

- the knowledge and administration of national board guidelines and policies;
- timeliness of the process;
- issues around information sharing; and
- appeals.

#### National board guidelines and policies

4.2 Submitters have raised concerns that AHPRA's staff is not aware of key guidelines and policies that relate to notifications and the assessment process, including guidelines issued by specific national boards.

#### *Single Expert Witnesses*

4.3 One important example that was brought to the committee's attention relates to expert psychologists and psychiatrists that practice in family law proceedings.

4.4 In family law proceedings, it is often necessary to have an independent expert psychologist or psychiatrist, who is employed by the court, to assess individuals or families and report back to the court.<sup>1</sup> However, the committee received evidence that some family law litigants have attempted to use the National Law process to discredit practitioners if their report is unfavourable.<sup>2</sup>

4.5 The Association of Family and Conciliation Courts (AFCC) has emphasised that the court requirements of psychiatrists and psychologists contributing to family law proceedings are incompatible with the complaints process under the National Law.<sup>3</sup>

4.6 Dr Jennifer Neoh, Secretary of the Australian chapter of the AFCC, provided evidence to the committee on 17 March 2017 that family law practitioners are subject to the 'strict legal parameters and guidelines' in which they practice. Dr Neoh explained:

- AHPRA has requested that family law practitioners present confidential court documents for use in the complaints process; and

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1 Dr Jennifer Neoh, Secretary, Australian Chapter, Association of Family and Conciliation Courts (AFCC), *Committee Hansard*, 17 March 2017, p. 24.

2 AFCC, *Submission 38*, p. 8; Institute of Clinical Psychologists, *Submission 23*, pp. 4–5.

3 AFCC, *Submission 38*, pp. 3–4.

- AHPRA has initiated investigations against family law practitioners during, or prior to, a practitioners' engagement with a pertinent legal proceeding.<sup>4</sup>

4.7 As providing court documents that identify witnesses is contrary to the *Family Law Act 1975* (Cth), asking practitioners to provide documents in relation to a complaint presents 'professional, legal and ethical' dilemmas to family law practitioners.<sup>5</sup>

4.8 The AFCC noted that AHPRA's requests for confidential court documents are inconsistent with findings of the High Court of Australia which affirm that court documents cannot be used outside of the legal proceedings for which the document was produced without leave of the court.<sup>6</sup>

4.9 Similarly, Mr Vincent Papaleo, Convenor of the Family Law Interest Group, suggests that the involvement of regulatory bodies, such as AHPRA, in investigating notifications related to family law proceedings can compromise the involvement of psychologists in the proceedings.<sup>7</sup>

4.10 To resolve this issue, in 2012 the Psychology Board of Australia published a policy that provided 'AHPRA investigations would not be carried out prior to the conclusion of the proceedings without leave of the court'.<sup>8</sup>

4.11 However, the AFCC submitted that the policy is of 'little practical utility' and that practitioners are still 'routinely' asked to supply court documents.<sup>9</sup> In some cases, the practitioners have handed over documents to AHPRA because they felt pressured to do so.<sup>10</sup>

4.12 This is contested by AHPRA. Mr Matthew Hardy, National Director, Notifications, told the committee that both AHPRA and the Psychology Board of Australia understand that a complaint cannot be pursued against a practitioner without leave of the court and that he was not aware of any case where AHPRA, or the board, had done anything other than follow the policy.<sup>11</sup>

4.13 Mr Hardy said that in cases where practitioners have handed over the documents, the documents have been locked down to ensure there was no detriment to the Family Court process.<sup>12</sup>

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4 *Committee Hansard*, 17 March 2017, pp. 24–25.

5 Dr Neoh, *Committee Hansard*, 17 March 2017, p. 24.

6 Dr Neoh, *Committee Hansard*, 17 March 2017, pp. 24–25.

7 *Submission 116*, p. 3.

8 Dr Neoh, *Committee Hansard*, 17 March 2017, p. 25.

9 AFCC, *Submission 38*, pp. 3–4.

10 Dr Neoh, *Committee Hansard*, 17 March 2017, p. 27.

11 Mr Hardy, *Committee Hansard*, 31 March 2017, p. 24.

12 Mr Hardy, *Committee Hansard*, 31 March 2017, p. 25.

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4.14 On notice, AHPRA informed the committee that of the 15 single expert witness complaints that the national board have decided to investigate:

- in eight cases AHPRA was provided a copy of the report prepared for the court;
- in six cases the report was provided by the notifier;
  - two were returned to the notifier without a copy being retained by AHPRA;
  - four reports are retained on AHPRA's database with restrictions on use; and
- in two cases the Family Court granted leave for the board to use the report.<sup>13</sup>

### ***Chiropractor advertising guidelines***

4.15 Chiropractors that submitted to the inquiry were very critical of AHPRA's guidelines on advertising and its staff's knowledge of them.

4.16 The Chiropractors' Association of Australia (CAA) submission notes that a high proportion of notifications made about chiropractors to the Chiropractic Board of Australia are related to advertising concerns.<sup>14</sup>

4.17 Confidential submitters to the inquiry expressed apprehension that:

- actions of AHPRA were at times inconsistent with the National Law;
- the guidelines issues by the national boards were unclear; and
- AHPRA employees were not cognisant of critical aspects of the national board's guidelines.

4.18 The CAA suggests that AHPRA and the national boards have a more active role to play in educating practitioners on advertising regulations under the National Law, prior to an assessment being initiated.<sup>15</sup>

### ***Committee view***

4.19 The committee is concerned by reports that psychologists and psychiatrists that practice as single expert witnesses in courts are being asked to provide court documents for the purposes of the complaints process.

4.20 However, the committee acknowledges that the National Law imposes obligations on AHPRA and the committee supports all efforts to ensure that Family Court proceedings are not jeopardised by the complaints mechanism. Having said that,

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13 AHPRA and MBA, answers to questions on notice, 31 March 2017 (received 24 April 2017) pp. 1–2.

14 CAA, *Submission 125*, pp. 7–8.

15 CAA, *Submission 125*, pp. 7–8.

there may be a need to review relevant aspects of the National Law to clarify this matter.

4.21 While the committee recognises that AHPRA employees cannot be expected to be expert in all aspects of the National Law and AHPRA's guidelines, evidence provided to the committee suggests that deficiencies in corporate knowledge or training may exist.

### **Timeliness**

4.22 Since AHPRA commenced operation in 2009, the timeliness of the complaints process has regularly been commented on in reviews of AHPRA's work.<sup>16</sup>

4.23 The case of Dr Gary Fettke demonstrates the significant timelines that can occur within the complaints process. Dr Fettke provided evidence at the committee's 1 November 2016 hearing. Details about AHPRA's handling of Dr Fettke's case came to light during the committee's investigation into whether AHPRA had breached parliamentary privilege following Dr Fettke's appearance before the committee.<sup>17</sup> Dialogue Box 4.1 explains AHPRA's handling of Dr Fettke's case.

4.24 In Dr Fettke's case, the process—from notification to finalisation—took two years and five months to complete. In confidential submissions, others have also detailed processes taking up to four years.

4.25 Dr Fettke was investigated for almost two years before the investigation report was submitted to the board. Once the board proposed cautioning Dr Fettke, the notice of proposed decision was not provided to Dr Fettke for another four weeks.

4.26 The practitioner was afforded eight weeks to prepare to provide oral submissions to the board. The board then decided to caution the practitioner.

4.27 Under section 180 of the National Law the practitioner must be provided with notice of a decision 'as soon as practicable' after the decision has been made. Dr Fettke was provided with the notice more than three weeks later.

4.28 The committee received evidence of similar administrative practices, which suggests that Dr Fettke's experience was not an isolated occurrence.

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16 Senate Standing References Committee on Finance and Public Administration, *The administration of health practitioner registration by the Australian Health Practitioner Regulation Agency (AHPRA)*, 3 June 2011, p. 92, [http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Finance\\_and\\_Public\\_Administration/Completed\\_inquiries/2010-13/healthpractitionerregistration/report/index](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Finance_and_Public_Administration/Completed_inquiries/2010-13/healthpractitionerregistration/report/index) (accessed 19 April 2017); Senate Community Affairs References Committee, *Medical complaints in Australia*, pp. 24–26; Legislative Council Legal and Social Issues Legislation Committee, Parliament of Victoria, *Inquiry into the performance of the Australian Health Practitioner Regulation Agency*, Report No 2, March 2014, p. 90, [http://www.parliament.vic.gov.au/images/stories/committees/SCLSI/Leg\\_ctee/AHPRA/Final\\_version\\_AHPRA\\_report\\_30314.pdf](http://www.parliament.vic.gov.au/images/stories/committees/SCLSI/Leg_ctee/AHPRA/Final_version_AHPRA_report_30314.pdf) (accessed 19 April 2017).

17 For details about the parliamentary privilege matter see Chapter 6.



4.29 Mr Ian and Mrs Rhonda McNees read to the committee a list of findings by the Victorian Government Solicitor's Office. Those findings included that in their cases:

AHPRA failed to investigate and assess Notifications, or to forward the Board decisions in a timely manner, and in some instances closed matters without providing any communication.<sup>18</sup>

4.30 In cases where a national board has decided to refer a matter to the relevant tribunal, Avant submitted that 12–15 months have elapsed in some cases between the board making the decision and the initiating documents being filed with the tribunal.<sup>19</sup>

4.31 Associations representing medical practitioners also noted that the timeframes in which AHPRA completed investigations were often protracted.<sup>20</sup>

4.32 These reports stand in contrast to the timeframes reported by AHPRA.

4.33 As noted in chapter 2, AHPRA reported that in the 2015–2016 financial year: 64% of notifications about doctors were closed following assessment. When no regulatory action was taken, the median time to complete a matter was around two months. If regulatory action was taken, the median time was around three and half months...<sup>21</sup>

4.34 Where a matter required investigation or a health or performance assessment during the 2015–2016 financial year, AHPRA submitted:

If no regulatory action was taken the median time to complete a matter was just over nine months. If regulatory action was taken, the median time was just over ten months...<sup>22</sup>

4.35 In evidence to the committee on 31 March 2017, Mr Martin Fletcher, Chief Executive Officer, AHPRA, reiterated:

We are doing a lot of work to shorten our time frames. This includes: work with the health complaints entities...to make sure a complaint goes to the right place quickly; boosting resources in pressure points in our system; establishing an online complaints portal to give us better information up-front and take action more quickly; trialling innovative ways of working...and inviting practitioners and complainants to provide feedback on their experience of the complaints process via survey.<sup>23</sup>

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18 Mrs Rhonda McNees, *Committee Hansard*, 31 March 2017, pp. 10–11.

19 Avant, *Submission 50*, p. 11.

20 RACGP, *Submission 41*, [p. 4]; Australian Medical Association, *Submission 117*, p. 3.

21 AHPRA and MBA, *Submission 119*, p. 9.

22 AHPRA and MBA, *Submission 119*, p. 9.

23 Mr Fletcher, *Committee Hansard*, 31 March 2017, pp. 22–23.

### Dialogue Box 4.1 — Case study: Dr Gary Fettke

Dr Gary Fettke is an orthopaedic surgeon in Tasmania. A notification was made to the Tasmanian Board of the Medical Board of Australia (TBMBA) concerning Dr Fettke's provision of particular dietary advice. The notifiers suggested that providing dietary advice was not within Dr Fettke's scope of practice.

The notification was made to the TBMBA in 2014.

Section 149 of the National Law requires that the national board must, within 60 days of receipt of the notification, conduct a preliminary assessment of the notification.

In Dr Fettke's case:

- The initial assessment determined that the notification required investigation. The decision to investigate was taken 49 days after the board received the notification.
- The investigation report was considered by the TBMBA after 1 year, 11 months and 14 days. The TBMBA proposed to caution the practitioner.
- The notice of proposed decision was provided to Dr Fettke 27 days after the board had made its decision.
- Dr Fettke made submissions to the board in accordance with section 179 8 weeks later. Having heard Dr Fettke's submission, the board made the decision to caution Dr Fettke in accordance with section 179(2).

Under section 180 of the National Law the practitioner must be provided with notice of a decision made under section 179(2) 'as soon as practicable' after the decision has been made. In Dr Fettke's case:

- The notice was provided 25 days later; and
- AHPRA issued a media release 15 days after the notice was provided.

### *Parity of timeframes*

4.36 Another aspect of timeliness that was raised by practitioners was the inequitable parity between the lengths of time a matter was being managed by AHPRA or the national board and the amount of time practitioners were given to respond to requests made of them by the national board.<sup>24</sup>

4.37 Medical Insurance Group Australia (MIGA) observed in their submission that at each stage of the process AHPRA or the national board has significantly longer to consider the matter than the practitioner does to respond.<sup>25</sup> For example:

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24 MIGA, *Submission 30*, p. 4; Ms Jennifer Smith, *Submission 57*, p. 3; Dr Simon Rosenbaum, *Submission 104*, p. 3.

25 *Submission 30*, p. 4.

- for an initial complaint, the responsible body has at least 60 days to assess it, the practitioner is usually only afforded 7–21 days to respond;
- at investigation stage, the investigation can take one or two years, the practitioner is usually only afforded 14–28 days to respond; and
- if the matter progresses to the tribunal, the prosecutorial body has often had a year or more to prepare for the hearing, while the practitioner is usually only afforded 4–6 weeks to prepare for the hearing.<sup>26</sup>

4.38 Some practitioners consider this inequity to be unfair to the practitioners involved and places them at a disadvantage.<sup>27</sup>

### ***Committee view***

4.39 The committee considers that efforts to improve the timeliness of the complaints mechanism must continue.

4.40 The committee acknowledges that AHPRA has tried to improve its timeframes and it commends AHPRA for the steps it has already taken. The committee also acknowledges that the cases shared with the committee may not be indicative of average current timeframes. However, the evidence the committee received indicates that significant work is required to expedite the timeframe for practitioners and notifiers, particularly in circulating and administering decisions once they have been taken by the board.

4.41 The committee acknowledges that a substantial lack of parity in timeframes has the potential to put practitioners at a disadvantage in preparing their responses to the board. The committee encourages the national boards to set reasonable timeframes that balance the practitioner's right to be heard against the need for expediency.

4.42 The committee emphasises that timeliness continues to be an issue, despite AHPRA's ongoing efforts.

### **Information sharing**

4.43 Some submitters expressed concerns about whether important information collected by AHPRA in the course of investigations was communicated to other authorities.

4.44 A confidential submitter expressed serious concerns that allegations regarding sexual boundary violations were not being shared with police. Other submitters confidentially reported that, in their cases, they believe that AHPRA failed to share relevant information with either a college or the police in circumstances that they considered warranted further action.

4.45 These suggestions recognise that AHPRA often collects a considerable quantity of data about the practitioners they investigate. Some submitters have

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26 *Submission 30*, p. 4.

27 Ms Jennifer Smith, *Submission 57*, p. 3; Ms Marianna Masiorski, *Submission 74*, [p. 3]; Dr Simon Rosenbaum, *Submission 104*, p. 3.

considered that the information AHPRA collects could be harnessed to improve practitioner standards.

4.46 AHPRA is one of the only health agencies with a national remit. As Dr Marie Bismark told the committee, this provides potential advantages to Australia to assess the safety and quality of health care:

...one of the greatest advantages of the establishment of AHPRA is that Australia now has a national system for collecting data both about practitioners who are registered in Australia and also about concerns about the health and conduct and performance of those practitioners. That really opens up unprecedented opportunities to understand the types of concerns that are being brought forward to regulators and to assess the way in which agencies respond to those concerns.<sup>28</sup>

4.47 The Australian Medical Association also suggested that practitioners have the capacity to learn from data that led to no further action.<sup>29</sup> For example, even if no further regulatory action was required, a pattern of notifications may reveal that a certain category of patients may require a different communication strategy.<sup>30</sup>

### ***Committee view***

4.48 The committee recognises that data is a valuable resource. The committee encourages AHPRA to explore ways that the data can be used to improve health practice and share knowledge among practitioners, provided it respects the privacy of the patient and the practitioner involved.

### **Appeals**

4.49 In its previous inquiry the committee suggested that further consideration ought to be given to allowing an administrative review of cautions.<sup>31</sup>

4.50 Some submitters to this inquiry again suggested that further amendments ought to be made to the appeals process.<sup>32</sup>

4.51 Avant suggested that practitioners should be able to review immediate action decisions without the need to lodge an appeal in a relevant tribunal and that cautions should be appealable.<sup>33</sup>

4.52 Notifiers also pressed for a more equal appeals mechanism. Under the current arrangements, a practitioner can appeal most decisions to the relevant tribunal, but notifiers can only apply to the Health Practitioner Ombudsman and Privacy

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28 Dr Marie Bismark, Associate Professor, University of Melbourne, *Committee Hansard*, 17 March 2017, p. 7.

29 Australian Medical Association, *Submission 117*, p. 3.

30 *Submission 117*, p. 3.

31 Avant, *Submission 50*, p. 2; Dr Gary Fettke, *Submission 54*, p. 2; Name withheld, *Submission 84*, p. 8.

32 Avant, *Submission 50*, p. 2; Dr Gary Fettke, *Submission 54*, p. 2.

33 Avant, *Submission 50*, p. 5.

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Commissioner.<sup>34</sup> Providing both parties with access to the tribunal would create greater equality between the parties.

4.53 However, the tribunal, whilst it is a lower cost jurisdiction than the Supreme Court, remains a costly exercise for many people.<sup>35</sup>

***Committee view***

4.54 The committee notes that appeals processes are an important mechanism for review to ensure that the correct decision has been made. Whilst the committee recognises that certainty and timeliness are important factors for all parties, the committee sees considerable benefit in ensuring that parties have the ability to seek review of decisions of the boards.

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34 Mr Ian McNeese, *Committee Hansard*, 31 March 2017, p. 12.

35 Name withheld, *Submission 84*, p. 8.



# Chapter 5

## Conclusions and recommendations

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

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

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

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

### Notifier engagement

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

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

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

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

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

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

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

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

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

### **Recommendation 1**

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

### **Vexatious notifications**

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

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

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

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

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



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

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

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

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

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

## **Recommendation 2**

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

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

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

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

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

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

### **Recommendation 3**

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

#### **Clinical peer advice**

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

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

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

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

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

### **Recommendation 4**

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

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

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

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

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

### **Recommendation 5**

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

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

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

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

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

### **Recommendation 6**

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

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

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

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

### **Recommendation 7**

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

### **Using the process to support practitioners to manage their own risks**

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

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

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

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

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

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

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

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## **Recommendation 8**

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

### **Guidelines and policies**

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

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

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

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

## **Recommendation 9**

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

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

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

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

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

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

### **Recommendation 10**

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

### **Appeals**

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

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

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

### **Recommendation 11**

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

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

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

### **Recommendation 12**

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

### **Timeliness**

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

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

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

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

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

### **Recommendation 13**

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

### **Recommendation 14**

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

## **Conclusion**

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

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

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





## Chapter 6

### Matter of parliamentary privilege: Dr Gary Fettke

6.1 Concurrently with this inquiry, the committee has undertaken investigation of a matter of parliamentary privilege arising out of the committee's previous inquiry, *Medical complaints in Australia*, as required by Senate Privilege Resolution 1(18).

6.2 Dr Gary Fettke provided evidence to the previous inquiry, at the committee's public hearing in Sydney on 1 November 2016.

6.3 Shortly after Dr Fettke concluded his evidence to the committee, he was notified of a decision by the Tasmanian Board of the Medical Board of Australia (board) to caution him.

6.4 On 16 November 2016, the Australian Health Practitioner Regulation Agency (AHPRA) issued a media release about Dr Fettke's case.

6.5 Dr Fettke wrote to the committee in November 2016 and requested that the committee investigate whether AHPRA had breached parliamentary privilege because either:

- the timing of the caution was designed to intimidate or punish him for providing evidence to the committee; or
- the timing of the media release constituted bullying and harassment that resulted from him providing evidence to the committee.

6.6 Senate Privilege Resolution 1(18) provides:

Where a committee has any reason to believe that any person has been improperly influenced in respect of evidence which may be given before the committee, or has been subjected to or threatened with any penalty or injury in respect of any evidence given, the committee shall take all reasonable steps to ascertain the facts of the matter. Where the committee considers that the facts disclose that a person may have been improperly influenced or subjected to or threatened with penalty or injury in respect of evidence which may be or has been given before the committee, the committee shall report the facts and its conclusions to the Senate.<sup>1</sup>

6.7 It is also an offence to inflict any penalty or injury on a person on account of evidence given to the committee.<sup>2</sup>

6.8 The committee commenced its investigation of the matter during the previous inquiry by asking questions of Mr Fletcher at its public hearing on 22 November 2016 and in separate correspondence.

6.9 AHPRA advised the committee that there was no relationship between Dr Fettke's appearance before the committee and the timing of the notification.<sup>3</sup>

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1 Senate Privilege Resolution 1(18).

2 *Parliamentary Privileges Act 1987* (Cth), s. 12(2).

6.10 AHPRA also advised the committee that it issued the media release to combat a 'level of misinformation' in the media about Dr Fettke's case.<sup>4</sup>

***The committee's findings***

6.11 To establish that a matter is a contempt of the Senate, the committee must be satisfied:

- a witness suffered a penalty;
- the penalty was incurred 'as a result of' the witness' participation in parliamentary proceedings;<sup>5</sup>
- there was a culpable intention on behalf of the perpetrator;<sup>6</sup> and
- the committee has taken all reasonable steps to ascertain the facts of the matter.

6.12 The committee therefore sought to establish that Dr Fettke incurred a penalty and that the penalty was incurred 'as a result of' Dr Fettke's participation in parliamentary proceedings.

*The notice—1 November 2016*

6.13 The committee found the timing of issuing the notice of the board's decision to caution Dr Fettke to be of concern. AHPRA advised the committee that the issuing of the notice within hours of Dr Fettke giving evidence to the committee was coincidental. The committee's investigation revealed that the process of issuing the notice had been in train for some time. As noted in Chapter 4, Dr Fettke had become aware that the board was proposing to caution him approximately 12 weeks before he gave evidence to the committee and the board had made its decision to caution Dr Fettke 25 days before he gave evidence to the committee.

6.14 Consequently, the committee was not satisfied that it could establish a clear link between Dr Fettke's giving of evidence to the committee and the issuing of the notice.

6.15 However, from an administrative perspective, issuing the notice on the same day that a witness provided evidence to the committee seems either a remarkable coincidence or a remarkable oversight. AHPRA was aware of the committee's inquiry and the public hearing; a senior officer, Ms Kim Ayscough, Acting Chief Executive Officer and Executive Director, Regulatory Operations, appeared before the committee at the same hearing. A program for the committee's hearing, including

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3 Mr Martin Fletcher, Chief Executive Officer, AHPRA, *Committee Hansard*, 22 November 2016, p. 4.

4 Mr Fletcher, *Committee Hansard*, 22 November 2016, p. 6.

5 Committee of Privileges, *Parliamentary privilege: Precedents, procedure and practice in Australian Senate 1966–2005*, 125<sup>th</sup> report, December 2005, p. 47.

6 Harry Evans and Rosemary Laing, eds, *Odgers' Australian Senate Practice*, 14<sup>th</sup> edition, Department of the Senate, 2016, p. 88.

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Dr Fettke's name, was provided to AHPRA on the day before the hearing. It is regrettable that no one in the organisation considered that sending the notice on the day of the hearing might risk giving the appearance that the notice was a penalty for providing evidence to the committee.

*The media release—16 November 2016*

6.16 In investigating AHPRA's decision to release a media statement on 16 November 2016 in relation to Dr Fettke's case, the committee examined AHPRA's policy on releasing information.

6.17 As noted above, AHPRA informed the committee that it issued the press release to combat what it considered to be a 'level of misinformation' in the media about Dr Fettke's case. Dr Fettke was contacted 52 minutes before the media release was issued.

6.18 The committee considers that, notwithstanding AHPRA's concerns around misinformation, providing a busy surgeon with under an hour to read the proposed media statement, obtain advice from lawyers and indemnity insurers and provide AHPRA with an informed response is unreasonable.

6.19 The committee considered whether the issuing of the press release was in response to Dr Fettke's evidence to the committee or to other public statements made by Dr Fettke. Ultimately, the committee was not satisfied that a sufficient causal link could be drawn between Dr Fettke's evidence to the committee and the media release to warrant referral of the the matter to the Senate Committee of Privileges. Instead, the committee resolved to inform the Senate of the potential breach of privilege through this report.

6.20 The committee has commented in this report on the length of time taken to consider and finalise the notification concerning Dr Fettke. The committee remains concerned that AHPRA's management of the notification concerning Dr Fettke falls short of the committee's expectations of the treatment of witnesses participating in a committee inquiry. The committee considers that at the commencement of the committee's inquiry into the medical complaints process, AHPRA should have considered the possibility that individuals involved in notifications under consideration may seek to contribute to the committee's inquiry. In particular, the committee considers that AHPRA should have taken steps to ensure care in its dealings with actual or potential witnesses to the inquiry.

6.21 The committee resolved to write to the President of the Senate to seek his assistance in reminding AHPRA and other Commonwealth agencies of the need for care when dealing with witnesses who have provided evidence to a Senate committee. The committee requests that the President write to the heads of all Commonwealth agencies and provide a copy of the letter to all Senate committees for publication on committee web pages.

**Senator Rachel Siewert**

**Chair**

# **APPENDIX 1**

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

### **Submissions**

- 1** Confidential
- 2** Confidential
- 3** Professor Paddy Dewan
- 4** Confidential
- 5** Name Withheld
- 6** Ms Donna McGrath
- 7** Name Withheld
- 8** Confidential
- 9** Confidential
- 10** Confidential
- 11** Name Withheld
- 12** Confidential
- 13** Confidential
- 14** Confidential
- 15** Confidential
- 16** Confidential
- 17** Confidential
- 18** Confidential

- 19** Confidential
- 20** Confidential
- 21** Confidential
- 22** Confidential
- 23** Institute of Clinical Psychologists
- 24** Confidential
- 25** Confidential
- 26** Ms Julie Ferguson
- 27** Mr Joel Levin
- 28** Confidential
- 29** Ms Cynthia Hickman
- 30** MIGA
- 31** Confidential
- 32** Confidential
- 33** Ms Kate Greenaway
- 34** Dr Nick Melhuish
- 35** Dr Leong Ng
- 36** Name Withheld
- 37** Mrs Katie Walls
- 38** Association of Family and Conciliation Courts (Australian Chapter) (plus an attachment)
- 39** Dr David Mcnicol

- 40 Confidential
- 41 Royal Australian College of General Practitioners
- 42 Ms Jennifer Ellis
- 43 Confidential
- 44 Confidential
- 45 Confidential
- 46 Confidential
- 47 Mr Marek Jantos and Ms Sherie Johns
- 48 Guild Insurance
- 49 Confidential
- 50 Avant Mutual Group
- 51 Confidential
- 52 Confidential
- 53 Confidential
- 54 Dr Gary Fettke (plus two supplementary submissions)
- 55 Associate Professor Colin Moore
- 56 Confidential
- 57 Ms Jennifer Smith
- 58 Ms Simone Sleep
- 59 Confidential
- 60 Confidential
- 61 Dr Jeremy Rourke

- 62 Name Withheld
- 63 Confidential
- 64 Confidential
- 65 Dr Anne Malatt (plus a supplementary submission)
- 66 Confidential
- 67 Name Withheld
- 68 Name Withheld
- 69 Ms Caroline Raphael
- 70 Confidential
- 71 Ms Elizabeth Dolan
- 72 Confidential
- 73 Dr Rachel Mascord
- 74 Miss Marianna Masiorski
- 75 Australian Health Ministers' Advisory Council (plus an attachment)
- 76 Ms Johanne Brown
- 77 Confidential
- 78 Confidential
- 79 Mr Harrison White
- 80 Women's Legal Services Australia
- 81 Confidential
- 82 Confidential
- 83 Confidential



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- 84** Name Withheld
- 85** Name Withheld
- 86** Confidential
- 87** Dr Yolande Lucire
- 88** Confidential
- 89** Confidential
- 90** Confidential
- 91** HPARA (plus a supplementary submission)
- 92** Confidential
- 93** Chiropractors' Association of Australia (South Australia)
- 94** National Institute of Integrative Medicine
- 95** Confidential
- 96** Health Consumers' Council
- 97** Dr Kevin Doyle
- 98** Ms Zoe Sherrin
- 99** Ms Cristina Vitellone
- 100** Medicolegal Group
- 101** Confidential
- 102** Confidential
- 103** Mr David Lindsay
- 104** Dr Simon Rosenbaum
- 105** National Health Practitioner Ombudsman and Privacy Commissioner (plus

- three attachments)
- 106** Confidential
- 107** Mr Garry Clarke
- 108** Australian Dental Association
- 109** Dr Maxine Szramka
- 110** Confidential
- 111** Confidential
- 112** Dr Jane Barker
- 113** Carers Victoria
- 114** Confidential
- 115** Confidential
- 116** Mr Vincent Papaleo
- 117** Australian Medical Association
- 118** Australian Competition and Consumer Commission
- 119** Australian Health Practitioner Regulation Agency and the Medical Board of Australia
- 120** Confidential
- 121** Confidential
- 122** Name Withheld (plus a supplementary submission)
- 123** Confidential
- 124** Confidential
- 125** Chiropractors' Association of Australia

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- 126 Ms Marg Fitzpatrick (plus two attachments)
- 127 AHPRA Community Reference Group
- 128 Name Withheld
- 129 Confidential
- 130 Australian Psychological Society
- 131 Tasmanian Government
- 132 Dr Chandrika Barman
- 133 Confidential
- 134 Confidential
- 135 Name Withheld
- 136 Confidential
- 137 Confidential
- 138 Confidential
- 139 Confidential

### **Additional Information**

- 1 Health Ombudsmen in Polycentric Regulatory Fields: England, New Zealand, and Australia, journal article, from Dr Judith Healy, received 22 March 2017
- 2 How hospital leaders implemented a safe surgery protocol in Australian hospitals, journal article, from Dr Judith Healy, received 22 March 2017
- 3 Information relating to questions raised at the public hearing on 17 March 2017, from Australian Health Practitioner Regulation Agency, received 23 March 2017
- 4 NSW Health Complaint Management Policy, from Australian Commission on Safety and Quality in Health Care, received 31 March 2017

- 5 NSW Health Complaint Management Guidelines, from Australian Commission on Safety and Quality in Health Care, received 31 March 2017
- 6 Australian Open Disclosure Framework, from Australian Commission on Safety and Quality in Health Care, received 31 March 2017
- 7 Open disclosure of things that don't go to plan in health care, A guide for patients, from Australian Commission on Safety and Quality in Health Care, received 31 March 2017
- 8 Information regarding evidence given by AHPRA at 31 March public hearing, from Association of Family and Conciliation Courts (Australian Chapter), received 4 May 2017

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

- 1 Answers to Questions taken on Notice during 17 March public hearing, received from Association of Family and Conciliation Courts, 17 March 2017
- 2 Answers to Questions taken on Notice during 17 March public hearing, received from Australian Commission on Safety and Quality in Health Care, 31 March 2017
- 3 Answers to Questions taken on Notice during 17 March public hearing, received from Royal Australasian College of Surgeons, 31 March 2017
- 4 Answers to Questions taken on Notice during 17 March public hearing, received from Guild Insurance, 31 March 2017
- 5 Answers to Questions taken on Notice during 17 March public hearing, received from Avant Mutual Group, 6 April 2017
- 6 Answers to Questions taken on Notice during 31 March public hearing, received from Patient No. 122, 9 April 2017
- 7 Answers to Questions taken on Notice during 31 March public hearing, received from Australian Health Practitioner Regulation Agency and Medical Board of Australia, 24 April 2017
- 8 Answers to Questions taken on Notice during 31 March public hearing, received from Australian Health Practitioner Regulation Agency Community Reference Group, 24 April 2017

### **Tabled Documents**

- 1 Opening statement, tabled by Mr Ian and Mrs Rhonda McNeese, at Canberra public hearing 31 March 2017
- 2 Opening statement, tabled by Australian Health Practitioner Regulation Agency, at Canberra public hearing 31 March 2017

# **APPENDIX 2**

## **Public hearings**

*Friday, 17 March 2017*

*Parliament House, Canberra*

### **Witnesses**

#### **Australian Commission on Safety and Quality in Health Care**

PICONE, Adjunct Professor Debora, Chief Executive Officer

WALLACE, Mr Mike, Chief Operating Officer

DUGGAN, Conjoint Professor Anne, Senior Medical Advisor

**BISMARCK, Dr Marie**, Associate Professor, Centre for Health Policy, The University of Melbourne

**SPITTAL, Dr Matthew John**, Associate Professor, Melbourne School of Population and Global Health, The University of Melbourne

**HEALY, Dr Judith**, Private capacity

#### **Australian Health Ministers' Advisory Council**

DURHAM, Ms Amity, Acting Deputy Secretary, Department of Health and Human Services, Victoria

RAVEN, Mr Dean, Director, Health and Human Services Branch, Department of Health and Human Services, Victoria

#### **Department of Health**

GILLAM, Ms Lynne, Assistant Secretary

HALLINAN, Mr David, First Assistant Secretary

#### **Royal Australian College of General Practitioners**

KRUYS, Dr Edwin, Vice-President; and Chair, Royal Australian College of General Practitioners Queensland

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

BIVIANO, Mr John, Acting Chief Executive Officer

QUINN, Dr John, Executive Director for Surgical Affairs

#### **Association of Family and Conciliation Courts**

NEOH, Dr Jennifer, Secretary, Australian Chapter

LIST, Dr David, Board Member, Australian Chapter

SPONG, Ms Belinda, Committee Member, Australian Chapter  
ENTWISLE, Dr Timothy John, Medicolegal Psychiatrist

**Medical Insurance Group Australia**

BOWEN, Mr Timothy, Senior Solicitor, Advocacy, Claims and Education

**Guild Insurance**

CLAYTON, Mr Rhett, National Liability Claims Manager

BROWN, Ms Nevena, Principal, Meridian Lawyers

**Avant Mutual Group Limited**

HAYSOM, Ms Georgie, Head of Advocacy

*Friday, 31 March 2017*

*Parliament House, Canberra*

**Witnesses**

**Office of the Health Ombudsman, Queensland**

ATKINSON-MacEWEN, Mr Leon, Health Ombudsman

**Health and Community Services Complaints Commissioner, South Australia**

TULLY, Mr Steven, Commissioner

**Australian Capital Territory Human Rights Commission**

TOOHEY, Ms Karen, Australian Capital Territory Health Services Commissioner

**Australian Health Practitioner Regulation Agency Community Reference Group**

MORRIS, Miss Jennifer, Member

**McNEES, Mr Ian**, Private capacity

**McNEES, Mrs Rhonda**, Private capacity

**BROWN, Mr Maxwell**, Private capacity

**CLARKE, Mr Garry**, Private capacity

**PATIENT No. 122**, Private capacity

**DEWAN, Prof. Paddy**, Private Capacity

**GREENAWAY, Ms Kate**, Private Capacity

**MALATT, Dr Anne**, Private Capacity

**MASCORD, Dr Rachel**, Private Capacity

**MASIORSKI, Miss Marianna**, Private Capacity

**Honest Peer Review Group, Health Professionals Australia Reform Association**  
NG, Dr Leong-Fook, Chair

**ROSENBAUM, Dr Simon**, Private Capacity

**Australian Health Practitioner Regulation Agency**

FLETCHER, Mr Martin, Chief Executive Officer

FLYNN, Dr Joanna, Chair, Medical Board of Australia

HARDY, Mr Matthew, National Director, Notifications