

**Australian Medical Association Joint Submission on the  
proposed arrangements for handling complaints, and dealing with  
performance, health and conduct matters for the  
National Registration and Accreditation Scheme for the Health Professions  
(the scheme)**

**Executive summary**

This joint submission is made by the Australian Medical Association (the AMA), the Australian Society of Otolaryngology Head & Neck Surgery, the Australian Medical Students' Association, the Royal Australian College of General Practitioners, the Australian Association of Surgeons, the Australian Society of Anaesthetists, the Australian Orthopaedic Association, the Council of Procedural Specialists, the Australian Society of Orthopaedic Surgeons, the Urological Society of Australia and New Zealand, the Australian Association of Pathology Practices, the Australian Society of Ophthalmologists and the Australian College of Rural and Remote Medicine (the co-signatories).

The AMA continues to engage in the government's consultation process on the proposed National Registration and Accreditation scheme. We continue to hold our opposition to this model which is costly, lacks transparency and provides Health Ministers with powers over registration and accreditation of the medical profession and other health providers which puts at risk the standards of health care delivery in Australia.

The AMA and the co-signatories support a system of national registration arrangements and consistent standards for the medical profession across Australia to facilitate workforce mobility. This can be effectively achieved without compromising the independence of accreditation and does not require the COAG model.

The AMA and the co-signatories are committed to offering the highest standards of care to patients. However, the complexity of the delivery of care and the sheer volume of services provided every day means that dissatisfaction with some incidents of care is inevitable.

The process of managing the concerns and complaints of patients is critical to the functioning of the health system. The appropriate, expeditious and fair management of complaints gives patients confidence and reduces the sense of harm or dissatisfaction from patients who experience real or perceived adverse outcomes.

The process of managing complaints has been subject to considerable scrutiny both within Australia and internationally. It is therefore of grave concern to be advised during a consultation with the National Registration Working Party (Sydney – 21 October 2008) that there has been no review of international evidence or best practice in the development of this complaints handling consultation paper.

The overarching concern of the AMA and the co-signatories is that the proposed complaints handling process, where the 'front end' is run through national administration in accordance with a national law and the 'back end' is dealt with

through state-based tribunals in accordance with varying state based laws, is contrary to the objective of having a national scheme. This, together with previous advice that the day to day registration decisions will be made at a state level by state-based committees of the medical board, ultimately leads us to question what is being gained through this process.

In this context, as individual cases are considered and handled by different entities within the scheme operating variously under commonwealth and state laws, there is a risk that decisions on their outcomes will be unduly delayed because of lack of clarity about the application of the appropriate laws.

Further, we note that the manner in which complaints are investigated and managed in each state has developed in response to specific local circumstances, decisions of local tribunals and courts or local developments in areas of practice. The familiarity of patients and registrants with the underlying basis for legislation or legislative change is an important element to ensuring confidence in the system. As such, while we would seek to ensure the most appropriate mechanism for the management of complaints, we note that this may well differ from state to state. The assessment of the “best” system must consider the confidence that patients and registrants will have in an externally imposed system.

It is against this framework that the AMA has considered the complaints handling discussion paper. Unfortunately, despite the seriousness of the issues the paper contemplates, there is a lack of detail provided on the manner in which complaints will be managed and a disregard for the extensive work of states, registration boards, medical colleges, professional associations and other contributors to the framework of complaints handling which currently exist across Australia. The AMA and the co-signatories are concerned that formatting the consultation paper as a large number of options gives a false impression that all of the important issues are being canvassed. Given the lack of detail contained in the consultation paper, and the fact that the implications of what is being proposed differ from state to state depending on what arrangements are currently in place in each jurisdiction, this submission will not seek to address each element of the complaints paper. We note that individual state AMAs, colleges and associations may be making specific submissions.

### **Complaint Management Pathways**

The medical profession has led the way in finding models to ensure the management of practice is addressed in a broader fashion than just the response to complaints. The development of health programs for doctors has helped retain valuable skills and workforce, and has helped to develop a culture of greater openness about impairment issues.

While the consultation paper broadly proposes that there should be differing pathways in the management of complaints, these pathways must be established and clearly defined in legislation. Further, the AMA and the co-signatories are of the view that any proposed national system must include conduct, performance and health based pathways. These pathways must be clearly defined to ensure registrants fully understand their rights and obligations under each pathway. However, there must be

arrangements to take into account circumstances where a particular complaint relates to more than one pathway.

We have heard the strong views of state boards and associations on the relative merits of their existing differing performance and health systems. It is not our intention to comment on this other than to emphasise that amendments to any program must not compromise the confidence of registrants in that state.

At page 10, it is stated “[I]n developing the requirements for the new arrangements it is important to distinguish between the functions and powers that must be provided for and forms and arrangements which may be used on an optional basis to give effect to these functions and powers. The mandatory features of the scheme must suit the circumstances of all professions and the distribution of registrants in these professions across the country.” This sentiment is subsequently repeated throughout the paper. With respect, this statement is wrong. The mandatory features of the scheme should be based on the protection and confidence of the **public and registrants**.

The AMA and the co-signatories believe that any attempt to undermine the strong legal framework surrounding the medical profession’s registration and complaint handling processes for the convenience of smaller professions defeats the purpose of moving to a national system and will be opposed by the medical profession.

Complaint, health and performance pathways must be established and clearly defined in the primary legislation.

Further, in respect of conduct management, the paper proposes the board will be able to immediately suspend the registration of a practitioner on the grounds of potential risk to public health and safety. While we acknowledge the need to have a rapid mechanism to prevent patients from being harmed, we maintain there should be specific criteria around the use of this power. Given that registration for a medical practitioner is her or his livelihood, “potential risk” is too broad a basis on which to suspend registration on an indefinite basis. Further, there should be an avenue for review of decisions to suspend registrants pending the outcome of the investigation being conducted.

## **Legal Frameworks**

It is critical that any complaints handling system affords natural justice and procedural fairness to both the complainant and the registrant. Failure to provide fair, just and transparent systems reduces the confidence of patients and registrants and results in longer complaints processes, more legal action and dissatisfaction.

While we acknowledge that further detail on the legal framework may be provided in later consultation papers, this issue is of such importance that specific details should have been provided in this consultation paper to allow proper consideration of the complaints handling proposals.

For example, the consultation paper is unclear on issues relating to the application of the rules of evidence, the rights of the registrant including the right to choose not to respond to avoid incrimination, the right of the registrant to access or be provided with evidence and the consideration under which decisions of appropriate or inappropriate practice will be made. All of these issues must be set out clearly in the primary legislation.

There is also a lack of clarity around rights of appeal, the grounds upon which appeals of decisions may be made and where such appeals should be directed. It appears that the intention is to maintain the existing tribunal or court system in each state but to impose upon that tribunal a broad set of principles or requirements. It will be imperative that such requirements include provision that a tribunal must include at least 2 members of the registrant's profession.

It does not appear that consideration has been given to the impact of differing conduct of proceedings (based on differing jurisdictional legislation) in each state tribunal or the fact that the decisions of the tribunals may not have direct standing as a precedent in other jurisdictions (which undermines the stated workforce objective of creating a mobile healthcare workforce). This is further exacerbated by the ongoing right to then appeal to individual state Supreme Courts, where the same complexity will arise.

There is also insufficient information about the processes to be followed by specific complaints panels. This is covered in detail in existing state legislation and would need to be clearly specified in any primary legislation underpinning a national system.

We also submit that the primary legislation must require the majority of members on any complaints, impairment or performance panel to be from the registrant's profession.

Finally, to ensure appropriate procedural fairness, there must be an appropriate separation of the investigation, prosecution and decision functions.

## **Legal Representation**

Legal representation is critical to ensuring procedural fairness for registrants. It is therefore not acceptable to expect a registrant who is facing the potential loss of, or restriction of, their registration to represent themselves in such an environment.

NSW is currently the only state that does not provide for legal representation before professional standards committees. The Medical Practice Act does provide for a right of non-legal representation as per option 4b (consultation paper section 9.3). This amendment was introduced in 2004 and has proven to be of little benefit to the process and may have posed increased risk to registrants. We understand that the NSW Health Department has offered in-principle support to amending state legislation to allow the right to legal representation.

This change in policy recognises the difficulties in obtaining appropriately experienced non-legal advocates and the potentially serious consequences of the complaints handling process. In practice, in NSW many registrants still chose to

attend hearings with both a legal advisor and a non-legal advocate, resulting in a debate about the existing legislative provisions and further costs and delays.

There is no evidence to suggest that hearings in other jurisdictions experience excessive legal delay or argument when compared with the NSW system. We therefore reject any proposal that does not allow legal representation and submit that registrants must be entitled to legal representation at all stages of the complaints management process. The AMA and the co-signatories strongly support this entitlement being enshrined in legislation and not left to the discretion of National Boards, as per Option 2 (section 9.3).

### **Investigation of notifications**

The AMA notes the considerable differences in assessment and investigation of complaints across jurisdictions. We submit that insufficient consideration has been given to the jurisdictional ramifications of changing existing arrangements. As we have stated, the best system is a system that has and maintains the confidence of patients and registrants in every jurisdiction.

In effect this means that a state-by-state case will need to be provided outlining the proposed benefits of moving to new complaints handling arrangements in each state before it could be expected that patients, registrants and the communities will accept a departure from their current state-based system. We do not accept that such a case has yet been made.

In terms of procedural fairness, the proposal that boards will not be required to notify a registrant that he or she is being investigated is unacceptable under any circumstances.

### **Timely Management of Complaints**

Any system of managing complaints must ensure complaints are addressed expeditiously and that “low level” complaints receive appropriate consideration and immediate resolution. All assessment and decision processes must be timely (at every point from notification until completion) – these processes and final decisions effect the livelihood of the registrant and are also significant for patients. However, it is also vital to ensure that there is an appropriate balance between a timely process and ensuring natural justice to registrants. The primary legislation must also ensure more regular feedback on progress to the affected registrant than the three-monthly intervals proposed in this consultation paper.

The AMA and the co-signatories are also concerned about the proposal at 5.6, option 2, proposing a right of review of preliminary assessment decision by the notifier. While not all parties will be satisfied with the outcome of a preliminary assessment, it is inappropriate to direct resources to allow for right of review for preliminary assessment. Such a broad right will also serve to extend the duration of the complaint process and frustrate participants with unnecessary costs and processes. It could be seen that such a provision assumes a lack of confidence in the process from the outset.

We therefore support Option 1 (section 5.6) combined with an appropriate focus on ensuring processes are conducted so that notifiers are confident in the initial assessment decisions.

### **Role of Colleges**

The AMA and the co-signatories remain concerned that the consultation paper again makes no mention of the critical role of the medical colleges in the complaints and performance system. While we understand the “lowest common denominator” nature of the consultation paper process, this does not justify failing to recognise the bodies which set and maintain standards in many professional groups. In most states, colleges are involved in the complaint system through appointment of nominees to medical boards. In the absence of such nominees, colleges must be specifically enabled through primary legislation to participate, as required, in processes associated with the management of complaints. In the Federal jurisdiction and in every state and territory, the authority of medical colleges is currently acknowledged in many ways, including recognition of vocational competence, individual and institutional credentialing and accreditation processes, and roles of investigation, prosecution and decisions in relation to standards of practice.

### **Mandatory Reporting**

The introduction of mandatory reporting legislation in one jurisdiction followed negative publicity about one or two doctors. However, this state’s legislative response has been largely driven by political imperatives, rather than consideration of whether such a response improves the care and protection of patients.

Doctors understand their responsibilities to their patients and to the patients of their colleagues. Considerable work has gone into developing codes of ethics and programs that encourage doctors and other health professionals to be more open about health and impairment issues. Programs that recognise addiction and impairment as health issues have encouraged doctors to self-report, obtain treatment and return to productive careers.

Any consideration of supplementing these processes with new mandatory reporting requirements across the health professions as part of this scheme would require extensive consultation on much more detailed proposals with health providers and the community.

### **Practice Offences**

The AMA and the co-signatories reiterate our view, as set out in our response to the registration arrangements consultation paper, that it is inappropriate and indeed anti-competitive to include practice restrictions only in respect of optometry, spinal manipulation and dentistry in the legislation.

## **Monitoring of Registrants**

As per the AMA et al submission on the registration paper, we remain concerned by the proposed links between Medicare and the registration system. Registration of health professionals may have an incidental administrative relationship to Medicare. However, this should not be enabled through the primary legislation for national registration and accreditation.

In relation to the specific proposal in this consultation paper, we consider that the direct linking of Medicare billing and performance or conduct would undermine confidence in the registration system and create the potential for registrants to have economic sanctions which interact with registration processes. The AMA and the co-signatories therefore oppose a legislated link between Medicare and the imposition of registration conditions. The current legislative arrangements provide sufficient protection for the public.

## **Direct or Incite Offences**

The AMA and the co-signatories support the proposal relating to inappropriate direction of registered practitioners (section 11.5). Any legislation must protect the rights of a doctor against the actions of a third party, including employers or principal contractors, who try to inappropriately influence the medical care a doctor seeks to provide to his or her patients.

For instance, if a doctor was employed or contracted to a GP Super Clinic, the doctor **must** be entitled to refer to the most appropriate health professionals or specialists, including to those who practice outside the super clinic structure, without direct or implied penalty.

The penalties imposed on the third parties in such circumstances should be commensurate with the penalties that apply or may apply to registrants.

## **Regulation of Advertising**

Any provisions regarding advertising should complement or clarify existing codes, legislation and policy. It is our preference for this to be included in primary legislation and applied to all health professions. As noted above, restrictions must also apply to non-registrants.

## **Definitions of inappropriate practice – Attachment 1**

We note the proposed definitions relating to unsatisfactory professional conduct and professional misconduct, as set out in Attachment 1 of the consultation paper. Agreement on definitions of inappropriate practice is critical to the appropriate functioning of any complaints system. Any definitions should apply to all health professions, must be clear, must be well articulated, and must be easy to understand for a practising medical practitioner or other health professional.

We note the intention to include provisions regarding accepting a benefit and inappropriate endorsements in the legislation. As currently set out in Attachment 1 of the consultation paper, the definitions are excessively general in nature and will not aid in promoting high standards of clinical practice. For instance, under the definitions of unsatisfactory professional conduct, there is included a prohibition on “influencing or attempting to influence the conduct of another health practitioner in a way which may compromise patient care”. This is a very subjective measure which appears designed to cause conflict and confusion.

In summary, all definitions in Attachment 1 need to be more clearly articulated and should recognise existing policy and ethical statements. Further consultation with the medical profession is required to ensure that such definitions do not adversely affect currently accepted legal arrangements within the medical profession.

## **Conclusion**

We note the requirements of the IGA that the proposed national scheme will improve upon the current state frameworks. The discussion paper into complaints handling does not offer patients or registrants any evidence or explanation as to how this objective will be met. Instead, the proposal as articulated will result in a less responsive system with no clear avenues for accountability, more complexity in pathways and grave legal uncertainty across jurisdictions.

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