

NSW Health Care Complaints Commission  
Response to the consultation paper titled

**“Proposed arrangements for  
handling complaints, and  
dealing with performance  
health and conduct matters”**

issued by the Practitioner Regulation  
Subcommittee of the Health Workforce  
Principal Committee

17 November 2008

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## Executive Summary

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This paper responds to the consultation paper issued on 7 October 2008 by the Practitioner Regulation Subcommittee of the Health Workforce Principal Committee titled "Proposed arrangements for handling complaints, and dealing with performance health and conduct matters".

The paper notes that the scheme proposed is essentially one of self-regulation by practitioner registration boards, with the addition of an external tribunal before which serious matters must be prosecuted. The paper notes some public failures of self-regulation and alternate regulatory schemes that have resulted.

The paper considers the nature of the traditional method of self-regulation in health, peer review, and notes its lack of consistent procedure, lack of responsiveness to patient concerns and its inability to deal effectively with non-compliant practitioners. The paper notes that peer review is the foundation of complaint handling by registration boards.

The paper then examines the reports of the few public inquiries that have been conducted into the conduct of Medical Boards being the Shipman Inquiry, which covered the Greater Medical Council in England and the South Australian Parliament's inquiries into the South Australian Medical Board. Both reports are critical of self-regulation and some of the criticisms are set out in the report. They include a lack of responsiveness to patient interests and the preference of practitioner interests, the lack of clear procedural rules and consistent outcomes.

The paper then examines the complaint handling of the Victorian Medical Board, which appears to be the model on which the proposed scheme appears to be largely based, including a report on the consumer experience with complaint handling by boards in Victoria and two recent examples of public incidents which reflect on the effectiveness of peer review and complaint handling.

The paper then looks in more detail at alternatives to self-regulation and reports some detail, and notes the advantages, of how the New South Wales system of co-regulation works in practice. The paper also contains a comparison of serious disciplinary outcomes for medical practitioners in NSW and Victoria over the past five years, which shows that there have been more complaints per practitioner in Victoria and a higher proportion of serious disciplinary outcomes, relative to complaints made, in New South Wales.

The paper then comments on some of the detail of the proposed model concluding that it proposes a largely self-regulatory model, with insufficient independence from the relevant professions to be either in the public interest or in the best interests of practitioners.

## 1. Introduction

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1.1: The consultation paper proposes an essentially self-regulatory model, with a very limited role for non-practitioners. There is little discussion in the paper of the merits of alternative models, such as co-regulation. In proposing a national scheme for the regulation of health professions, it is relevant to consider whether or not self-regulation is the best model and is in the public interest. Given the minimal consideration of this issue in the consultation paper – it requires discussion in this response.

## 2. Failures of self-regulation resulting in alternative models

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2.1: Unfortunately, the increase in the degree of independence brought to the regulation of health professions has not arisen from, or been driven by, the professions. It has come about the hard way, usually under public and political pressure following catastrophic failures of self-regulation.

### 2.2 Queensland

2.2.1: The case of Dr Patel represents one of the more spectacular and public failures in Australia of self-regulation. His application for registration was taken on trust although there were significant failures to disclose which would probably have prevented his registration. In practice his medical colleagues and hospital administrators failed to take any effective action at least partly because he was not amenable to peer review and made it clear that he would cause a good deal of trouble for anyone who reported him. Nurses who tried to report his conduct were victimised and disbelieved.

2.2.2: Following a Commission of Inquiry, the regulatory system in Queensland was substantially amended to allow, among other things the independent Health Quality and Complaints Commission to investigate complaints about individual registered health service providers in the public interest – section 86 Health Quality and Complaints Commission Act 2006 (Qld).

### 2.3 New Zealand

2.3.1: Following a Commission of Inquiry into a public scandal about the conduct of medical trials on cervical cancer patients, including the withholding of treatment, without appropriate consent, New Zealand passed the Health and Disability Commissioner Act 1994 (NZ). The Act established an independent Commission with the responsibility to mediate, investigate and prosecute complaints against health service providers.

### 2.4 New South Wales

2.4.1: The introduction of the Health Care Complaints Act 1993 (NSW) in NSW followed a royal commission into the use of deep sleep therapy by doctors at Chelmsford private hospital. The Act established an independent Commission with the

responsibility of investigating and prosecuting health related complaints before disciplinary bodies in a co-regulatory model with the various health registration Boards.

2.4.2: The advantages of alternatives to self-regulation will be returned to later in this response following some examination of how self-regulation in health traditionally works.

### 3. The nature of self-regulation in health

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3.1: It would be a mistake to count the failures of self-regulation in Queensland, New Zealand and NSW as isolated aberrations. The inherent nature of self-regulation in health means that it has the tendency to act in the interests of the health profession and individual practitioners rather than the public interest.

3.2: The predominant mode of regulation in the health professions is peer review. The practice of regulation by health registration Boards is based on and reflects peer review processes. What is peer review and how effective is it in protecting patients and the public?

#### **Peer review**

3.3: Despite its widespread use, there is little published material on how peer review actually works in practice. Peer review does not operate under any clear procedural rules. The extent to which the source and nature of alleged misconduct is disclosed to a miscreant practitioner is completely open and can be arbitrary and inconsistent. There are no rules requiring procedural fairness and the private nature of peer review results in the application of inconsistent standards, both procedurally and with respect to the outcomes.

3.4: Peer review as a regulatory mechanism lacks transparency and accountability. It essentially consists of an intervention by a practitioner's peers where concern, which may or may not include patient complaints, can no longer be ignored. It is conducted in private and excludes any participation by patients, regardless of whether they have complained, who may have suffered harm at the hands of the practitioner. Peer review is based fundamentally on trust - the practitioner concerned is expected to respect the views of their peers and amend their practice in accordance with the advice given. This approach may be appropriate for many practitioners in minor matters – it is deeply flawed, however, as a regulatory mechanism and completely inappropriate in cases of serious misconduct.

3.5: If the practitioner the subject of peer review displays sufficient deference to their peers and senior colleagues during the process; or feigns insight and contrition and promises to reform, then that is the end of the matter. If a practitioner is deceptive and lies, there is little effort to investigate all the circumstances. If the peer review group suggests the practitioner might limit or restrict their practice, their word that they will do so is taken on trust. The outcome is generally kept private and others, including those working with the practitioner, are unlikely to be informed. The public and patients of the practitioner are most unlikely to be given any notice of the outcomes.

3.6: If a practitioner challenges the process, disputes the standing, capacity or motivation of their peers; claims victimisation and/or threatens counter complaints and defamation against colleagues, then peer review can be paralysed and may not proceed at all.

## 4. Handling of complaints by registration boards

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4.1: Like peer review, it is difficult to find much published material on how registration Boards operate. Their proceedings are largely private and public examination is rare. There are, however, a few cases where public inquiries have examined the operation of medical boards.

### 4.2 The General Medical Council - England

4.2.1: Harold Shipman was a general practitioner in Manchester who was ultimately convicted of widespread murder of elderly patients. Following disclosure of his crimes, a public inquiry was eventually constituted - chaired by Dame Janet Smith DBE ("the Shipman Inquiry"). The Inquiry issued a series of reports between 2002 and 2005. The terms of reference for the Inquiry included:

By reference of the case of Harold Shipman, to inquire into the performance of the functions of those statutory bodies ... responsible for monitoring the primary care provision.<sup>1</sup>

4.2.2: The body responsible for regulation of medical practitioners is the General Medical Council ("GMC"), the English equivalent of the Australian medical boards. In the fifth report of the Shipman Inquiry, the culture of the GMC was closely examined. The Chair said:

I have been driven to the conclusion that the GMC has not, in the past, succeeded in its primary purpose of protecting patients. Instead, it has, to a very significant degree, acted in the interests of doctors.<sup>2</sup>

4.2.3: The Inquiry made it clear that the GMC had, in response to a number of scandals (Bristol, Ledward, Green as well as Shipman), made some attempt to reform its procedures but concluded:

However, the disappointing feature is that all these changes appear to me to have been made as a reaction to some form of external pressure. Those changes do not demonstrate that there has been a change of culture within the GMC. During the same period, the GMC failed to make a number of changes which, in my view, it would have made if it had had patient protection at the forefront of its collective mind.<sup>3</sup>

4.2.4: Although the GMC had issued a set of unified procedures in 2001, apparently for the first time, the Shipman Inquiry had no confidence that the procedures would be

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<sup>1</sup> Shipman Inquiry - Terms of Reference. Available at [www.the-shipman-inquiry.org.uk](http://www.the-shipman-inquiry.org.uk)

<sup>2</sup> Ibid, Fifth Report, The Culture within the GMC -paragraph 148.

<sup>3</sup> Ibid, paragraphs 150-151.

practised with the primary purpose of protecting patients. This lack of confidence was based on a careful examination of the GMC's actual complaint handling processes.

4.2.5: The Shipman Inquiry noted that in 1975, the Merrison Committee, said that the then GMC procedures required complainants to assemble evidence themselves and present their case before a Disciplinary Committee, recommended that the GMC set up its own investigative procedures. These recommendations were not implemented. Investigations would rarely be contracted out to private lawyers in high profile public interest matters but were still mainly reliant on individual complainants to present the full case. Representatives of the GMC claimed that its lack of formal investigatory powers resulted in its failure to actively investigate but the Chair of the Shipman Inquiry thought that this was an inadequate excuse, and continued:

... I was told that there had never been any attempt to seek such a power. It seems to me that the lack of investigation was attributable mainly to a feeling that it was for the complainant (not the GMC) to substantiate his/her complaint.<sup>4</sup>

4.2.6: Public bodies, such as hospitals, that made complaints against doctors could afford to investigate the circumstances and provide the GMC with substantial evidence. Individuals, however, could rarely do so. In 1996, a GMC report noted that the large majority of matters referred on by its investigation process to committees for possible disciplinary action came from public bodies. In 2000, a similar review noted that the proportion of complaints from private individuals referred to committees was 5% in 1997; 6% in 1998 and 13% in 1999.<sup>5</sup> The Chair of the Shipman Inquiry said:

I fear that many valid complaints will have been closed because of the failure to investigate. I recognise that to undertake such investigations would have been a costly exercise for the GMC. However, I have the clear impression that cost was not the only reason why investigations were not undertaken. The impression I received was that complaints from individuals were suspected of being, in some way, unreliable, at least unless and until the complainant could produce sufficient evidence to amount to a prima facie case ... backed - until November 2002 – by a statutory declaration. Also, there was resistance to any action which might be seen as “assisting complainants” and therefore as “unfair to doctors.”<sup>6</sup>

4.2.7: The Inquiry went on to expose a complaint handling system that actively discouraged investigation unless that matter was referred to a Preliminary Proceedings Committee (“PPC”), which acted as gatekeeper for the Professional Conduct Committee (“PCC”), which could, in turn, deregister or impose conditions on registration. It also detailed the practice of cases being closed without reference to previous complaints and extraordinary examples of inaction and delay in apparently serious matters.<sup>7</sup>

4.2.8: The resistance to effective complaint handling contaminated even the initial receipt of complaints. Minimal or no effort was made to identify doctors the subject of complaints. The Inquiry understood the difficulty for complainants in clearly identifying doctors and examined the GMC on this point. It cited a GMC paper from 2003 reporting that, in 1997, 15% of doctors the subject of complaint were not identified, resulting in no further action, and that this number rose to 25% in 2001. The Inquiry expressed surprise that 22% of the complaints against unidentified doctors made allegations of

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<sup>4</sup> Ibid, Fifth Report, Investigating the Circumstances of a Complaint, para 18.122

<sup>5</sup> Ibid, para 18.125

<sup>6</sup> Ibid, para 18.128

<sup>7</sup> Ibid, The Fifth Report, *Some Problems with Cases Closed by GMC staff*, paragraphs 18.179 – 18.203

“dishonesty/criminality” and that 10% of doctors who had not been identified had been reported by public health bodies. The Inquiry noted:

This was particularly surprising because it is hard to imagine that a public body would make a complaint about a doctor without being aware of the doctor’s identity.<sup>8</sup>

4.2.9: The conduct of the GMC’s disciplinary committees is also worth comment – the functions of the Committees are set out briefly above. The Shipman Inquiry noted that the PPC “sat in private and there was no means of monitoring or auditing outcomes.”<sup>9</sup> There were also minimal record of proceedings. In examining all the available evidence, including appeal decisions, the Inquiry found:

..the PPC often exceeded its powers and applied the wrong legal test ... I am driven to the conclusion that it was wrong in a significant number of cases and that those cases give rise to a real concern that the PPC has been far too much influenced by its desire to be “fair to doctors” and far little concerned about the protection of patients and the public.<sup>10</sup>

4.2.10: The Inquiry also expressed concern:

... about the way in which some cases were referred by the PPC into the voluntary health procedures despite the fact that there was plainly evidence of conduct capable of amounting to SPM [the equivalent of professional misconduct] and no real evidence of ill health.<sup>11</sup>

The Inquiry examined the case of one doctor being referred to the health procedures rather than being dealt with as a disciplinary matter and said:

The truth about the doctor’s allegedly dishonest and unethical conduct was never established and there was no real medical evidence that he was driven to obtain drugs by dishonest means as the result of an addiction. After a while under the voluntary health procedures, that doctor will doubtless be free to practise without restriction and yet, for all anyone knows, he might be thoroughly dishonest.<sup>12</sup>

4.2.11: In concluding, the Chair of the Inquiry noted that there was a lack of clarity about the powers and duties of the PPC in the legislation. She was also concerned about the serious underlying problem of the absence of any proper criteria for decision-making and the failure of the GMC to develop any clear procedures to define and classify the various forms of misconduct and applying such tests to the complaints before the PPC.

4.2.12: The Inquiry was also broadly critical of the Professional Conduct Committee (“PCC”) for what amounted to an application of criminal standards to the admissibility of evidence, resulting in the exclusion of evidence against doctors. It also thought a legally qualified Chair should be mandatory due to difficulties doctors had with the application of proper procedure and standards of proof.<sup>13</sup> The Inquiry was also critical of the lack of consistent standards and criteria in reaching decisions.

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<sup>8</sup> Ibid, Fifth Report, Ascertaining the Identity of a Doctor who is the subject of a Complaint, paragraph 18.602

<sup>9</sup> Ibid, Fifth Report, Chapter 20 The GMC Conduct Procedures: the Preliminary Proceedings Committee, para 20.236

<sup>10</sup> Ibid, at para 20.236

<sup>11</sup> Ibid, at para 20.238

<sup>12</sup> Ibid

<sup>13</sup> Ibid, Fifth Report, Ch 21, GMC Procedures: The Professional Conduct Committee.

4.2.13: The GMC had submitted to the Inquiry that such standards were neither appropriate nor necessary. The Inquiry rejected this approach:

The GMC suggested that established standards, criteria and thresholds were neither appropriate nor necessary. They have not been necessary, it says, because the decision-makers of the past were experienced and well- respected members of the medical profession and were all members of the GMC. In essence, it is said, their judgement could be trusted ... All that may be true but they are and will be all individuals and, however, conscientious they are, they will reach inconsistent decisions unless guided by established standards, criteria and thresholds.<sup>14</sup>

### 4.3 South Australia

4.3.1: The Statutory Authorities Review Committee of the Parliament of South Australia conducted an inquiry into the conduct of the Medical Board of that state. On 14 March 2006, the Parliamentary Committee delivered an interim report part way through its Inquiry because, as it noted, it was:

... deeply disturbed as to the manner in which the Medical Board processes complaints and investigations, from the perspective of both the general public and the medical practitioner. The Committee is also not convinced that the conduct of the Medical Board throughout the Inquiry was exemplary of a professional body.

The Committee believes the Medical Board of South Australia has failed in its legislative duty to protect the health and safety of the general public. The Committee finds it most lamentable to hear from a Board member that "The Board may well have made a mistake" with reference to the loss of a life when the life could potentially have been saved by the statutory body whose function is to protect the health and safety of the public.<sup>15</sup>

4.3.2: On the Board's handling of complaints, the Committee said that it:

... finds the manner in which the Board has handled its complaints is extremely poor, both from the viewpoint of the consumer and the medical practitioner. The Committee believes that the Board is not the appropriate authority to investigate complaints or undertake disciplinary hearings ... The Committee is severely disparaging of the manner in which the Board has dealt with complaints, and recommends strongly that the Board be stripped of its powers in relation to the conduct complaints and investigations.<sup>16</sup>

4.3.3: By the time of the Committee's final report, its extent of its disturbance appears to have been quelled, at least somewhat, by changes to Medical Board personnel and legislation, although significant concerns remained. The final report of the Committee, tabled on 24 July 2007, also contained a foreword by the Presiding Member which, while noting that complaint handling "failed to meet adequate standards of service" also said that the Committee considered recommending more lay representation but affirmed what the view that medical practitioners "are best qualified to assess the clinical judgement and practice of other practitioners" even though "this can lead to a perception that doctors protect their own."<sup>17</sup> He continued:

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<sup>14</sup> Ibid, at para 21.201

<sup>15</sup> Parliament of South Australia, Interim Report of the Statutory Authorities Review Committee, 43<sup>d</sup> Report, Inquiry into the Medical Board of South Australia, Chapter 4. Summary, page vii

<sup>16</sup> Ibid, page vii

<sup>17</sup> Parliament of South Australia, Inquiry into the Medical Board, 45<sup>th</sup> Report of the Statutory Authorities Review Committee, Presiding Members foreword, page iv. (all quotes)

I am not satisfied that non-practitioners, whatever their experience in the health system, can truly make an adequate assessment of whether doctors have acted appropriately in the medical sense. I am gravely concerned that such a model has the potential to imperil the lives of patients by substituting a less than optimal judgement in the interests of transparency.<sup>18</sup>

4.3.4: In a co-regulatory model, as occurs in New South Wales, the Boards work together with an independent complaints authority, each having carefully balanced powers and roles. The Presiding Member of the South Australian Parliamentary Committee appears to have been expressing an opinion on the proposition that complaints and discipline are left either totally to practitioners or entirely to non-practitioners.

4.3.5: The final report of the South Australian Parliamentary Committee remained scathing about the quality of complaint handling by the Medical Board. In the report's summary, the Committee found complaint handling was "extremely poor, both from the viewpoint of the consumer and medical practitioner" and procedures needed "to be strengthened"; that complaints "had not been dealt with in a timely fashion" and that "no definition of 'unprofessional conduct' (used by the Board in hearings) could be found." It also considered that the Board was "adequately resourced to investigate complaints, but it is not particularly efficient or effective in these operations."<sup>19</sup>

4.3.6: The Committee believed a review of complaint handling procedures was required as well as the "development of standard processes to form an appropriate judgement regarding what should be considered acceptable standards for doctors practising in specialised areas ..."<sup>20</sup>

4.3.7: With respect to the time taken to handle complaints, the Committee noted that Annual Reports of the Board prior to 2005-06 did not report any information on timeframes; that one complaint took over ten years to finalise; that complaints against medical practitioners by other practitioners were particularly problematic and long standing and that the lack of information available to the public on hearings conducted by the Board was "disturbing."<sup>21</sup> The Committee recommended an independent consulting firm be engaged to review all of the Board's processes.

4.3.8: The Committee reported that it "heard allegations that the Board was an "old boys club" and concluded that "this was indeed a possible perception." However, given "new legislation, a completely new Board" and a "relatively new Registrar" and aware of the "many challenges from a new generation of informed, aware and demanding health consumers" the Committee said it "hopes these changes will address the culture of the Medical Board."<sup>22</sup>

4.3.9: On 28 July 2008, the President and Registrar of the Board appeared again before the Committee to update it on progress in implementing the Committee's recommendations. Committee members became particularly interested in the publication of disciplinary decisions and restrictions on practice on the Board's website. Although the transcript is somewhat confusing, particularly in relation to the public availability of conditions on practice, the Board appears to defend the non-publication of information on its website variously on the basis of the site's technical capacity and

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<sup>18</sup> Ibid, page iv.

<sup>19</sup> Ibid, Summary, pages 8-9

<sup>20</sup> Ibid, page 10

<sup>21</sup> Ibid, page 10

<sup>22</sup> Ibid, page 11 (all quotes)

the privacy of doctors. The Board's testimony gave rise to some frustration from Committee members:

The Hon RI Lucas: I would like to clarify your evidence. Did I understand it correctly that you said all findings of the Board are against individual practitioners are easily publicly accessible through the website?

Mr Hooper (Board Registrar): What I said was that there are some findings that are publicly accessible through the website – certainly those of public interest ... The others are available through the annual report, where all findings are made available.

Q: If you are prepared to make findings available through the annual report – which is obviously too late in terms of accessibility – why wouldn't that be more immediately accessible through the website?

A: There is not an answer to that, In terms of the body of the report, basically there is a prescription in the legislation that provides us with a requirement to provide those findings. To lift those findings and put them on the website is something that the board has been discussing on a case by case basis in relation to the public interest

...

...

Q: But if a decision has been taken by the board in August 2006, it is still 15 months later before it is publicly available. I invite Dr Mudge [the President] to explain whether there is any reason why the board itself, if it is required to make it available 15 months later, would not authorise a decision to the registrar and staff to make it available on the website once the decision has been taken.

Dr Mudge: There is absolutely no reason why we cannot apart from the technical difficulty. It simply represents a decision as to where we put our resources.<sup>23</sup>

## 4.4 Victoria

4.4.1: The Victorian Medical Board has not been the subject of any public inquiry or examination and there is relatively little information, apart from its annual reports, on which to assess its complaint handling. Nevertheless, as the model proposed appears to substantially replicate the Victorian system, it requires some examination in this paper.

4.4.2: The Victorian Board's complaint handling processes are very briefly outlined in its annual reports. In the past three years, the Board has received the following number of complaints or, to use the Victorian term, "notifications" – 690 in 2005; 582 in 2006 and 633 in 2007. Over the same years, the number of complaints closed without any inquiry by a Vetting Committee was 276 (40%) in 2005, 217 (37%) in 2006 and 235 (37%) in 2007. The 2005 report notes that "the vast majority required additional information, which was not provided."<sup>24</sup> The 2006 report also says "the vast majority ... required more information from the notifiers ... If the information requested was not provided within six weeks the Board advised the notifier that the matter had been closed."<sup>25</sup> The 2007 report is silent on this initial procedure but presumably it followed previous years.

4.4.3: There is no indication in the annual reports of the nature of these complaints or of any process to determine whether the Board might investigate even though a complainant may not have provided sufficient information at the outset. Relevant considerations would be the seriousness of the matter and the capacity of the

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<sup>23</sup> Legislative Council, Statutory Authorities Review Committee, Inquiry into the Medical Board of South Australia, Official Hansard report, page 4.

<sup>24</sup> Medical Practitioners Board of Victoria, Annual Report 2005, page 20

<sup>25</sup> Medical Practitioners Board of Victoria, Annual Report 2006, page 16

complainant to provide further material. There also is no mention of any procedure of contacting complainants to assist them with providing sufficient information to satisfy the Board's requirements. The 2007 report notes that changes to legislation operative from 1 July 2007 provided notifiers with the right to request a review of such a decision. No review had been requested from the start of the legislation to the end of the reporting period at 30 September 2007.

4.4.4: The Board's account of its preliminary investigation process provides little information. The 2005 and 2006 reports note that complaints are provided to investigation officers with "a Board member to be responsible for each notification."<sup>26</sup> The nature and extent of this responsibility is unclear. There is nothing on the process of the investigation, its level or the nature of any inquiry, the capacity and skills of its investigators or the methods it employs.

4.4.5: The Board does assert "improved investigation processes"<sup>27</sup> in both its 2005 and 2006 reports. The annual reports also provide little information about the time taken for investigation processes, except for the 2007 report, which notes that the average time taken to complete an investigation was 6.8 months.<sup>28</sup>

4.4.6: The recommendations of a preliminary investigation are discussed with one of two Professional Conduct Committees, which then makes a determination as to whether further action is to be taken. This can include an informal or formal hearing, the latter having the power to cancel or suspend registration and impose conditions on practice.

#### *Reported consumer experience with registration boards in Victoria*

4.4.7: The Health Issues Centre published a report titled *Bringing in the Consumer Perspective* in October 2004.<sup>29</sup> The research was qualitative in nature and those surveyed selected were chosen to provide a reasonable number who had gone through each stage of the complaints process, including to formal hearings. The research covered five registration boards including the Medical Board. Half the interviewees had their complaints closed after preliminary investigation and the remainder proceeded to either informal or formal hearings. The sample is not proportionally representative of how most complaints are dealt with – 1905 complaints were made to the Medical Board from 2005 to 2007 and 340 (17%) were referred for hearing by panels in the same period.

4.4.8: The report notes that caution should be exercised in drawing conclusions from its survey:

However, within that context, the general quantum of dissatisfaction with the current processes of health practitioner registration boards and outcomes of complaints is an important finding. Virtually all complainants interviewed were dissatisfied with some elements of the current system.<sup>30</sup>

4.4.9: The report also provides some information about board investigation processes:

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<sup>26</sup> Medical Practitioners Board of Victoria, *Annual Report 2006*, page 16 and Medical Practitioners Board of Victoria, *Annual Report 2006*, page 20

<sup>27</sup> Medical Practitioners Board of Victoria, *Annual Report 2006*, page 17 and Medical Practitioners Board of Victoria, *Annual Report 2005*, page 21

<sup>28</sup> Medical Practitioners Board of Victoria, *Annual Report 2007*, page 18

<sup>29</sup> *Bringing in the Consumer Perspective*, Final Report, Consumer Experiences of Complaint Processes in Victorian Health Practitioner Registration Boards, October 2004, Health Issues Centre Inc [www.healthissuescentre.org.au](http://www.healthissuescentre.org.au)

<sup>30</sup> *Ibid*, Executive Summary, page 12

... many interviewees reported no opportunity to review the response of the health practitioner to their complaint allegations, to reply to this, and to be able to correct what they perceived to be factual errors, misconceptions and untruths, before the Board made a decision.<sup>31</sup>

The report also noted that about a quarter of interviewees did not understand the reasons for the Board's decision and the issue of bias was clearly a concern:

The perception of bias noted above was a recurring theme, however, and links directly to the issue of public confidence ... A board investigation and deciding about complaints made up of membership dominated by members of the same profession as that of the practitioner under scrutiny does not necessarily inspire community confidence.<sup>32</sup>

4.4.10: It should be noted that legislation has changed procedures in Victoria since the time of the report. Significantly, since July 2007, boards are required to prosecute serious complaints before an independent tribunal, rather than hear them in house. The transitional arrangements appear to allow the boards to continue to deal with existing matters under the old legislation until they are finalised. Consequently, the Medical Board of Victoria website's latest published decision of an internal formal hearing panel is dated 30 July 2008 and the independent Victorian tribunal has published no decisions of complaints that have been prosecuted before it by the Board as at 31 October 2008.

4.4.11: There are two further matters arising from Victoria that should be mentioned – the first reflects some light on the effectiveness of medical peer review; the second on the complaint handling processes of the Medical Board.

#### *Bayside Health and Professor Kossman*

4.4.12: The Victorian Ombudsman published a report to Parliament of an investigation into this matter in October 2008. The investigation concentrated mainly on Professor Kossman's fraudulent billing and financial practices and relied on an existing peer review report in relation to clinical issues - which included performing surgery with insufficient cause; performing surgery which was flawed and harmful in its effect and undertaking surgery which he was incapable of performing.<sup>33</sup>

4.4.13: The report notes that the evidence "portrays a dysfunctional hospital racked by back-biting and interpersonal conflicts over a number of years"<sup>34</sup> and found that Professor Kossman "failed to act with integrity and placed his private interests ahead of his public duty."<sup>35</sup> The report also said:

Accountability systems failed. Professor Kossman was able to exploit a situation in which he had little, if any, effective supervision and oversight. Those in positions of authority did not address underlying problems as they became evident ... matters that did come to their attention were explained away as personality conflicts, turf wars or professional jealousy. Complaints were discouraged.<sup>36</sup>

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<sup>31</sup> Ibid, at page 9

<sup>32</sup> Ibid, at page 11

<sup>33</sup> Ombudsman Victoria, Whistleblowers Regulation Act 2001, Report of an investigation into issues at Bayside Health, October 2008, pages 106-107, paragraph 439

<sup>34</sup> Ibid, Executive Summary, paragraph 32

<sup>35</sup> Ibid, paragraph 18.

<sup>36</sup> Ibid, paragraph 20.

4.4.14: When complaints were made, Professor Kossman lodged counter-complaints and made the careers of the clinician complainants untenable:

My investigators asked these complainants why they had not complained earlier. There was a common thread in their explanations – they had seen what happened to peers who challenged Professor Kossman. As discussed earlier, it was common knowledge at the Alfred that one clinician’s contract had not been renewed because he had clashed with Professor Kossman. Further, several complainants were concerned about their personal positions. Some were married with children and feared loss of their positions and income; others had limited tenure contracts or were from overseas and felt particularly vulnerable.<sup>37</sup>

4.4.15: The Ombudsman’s report assumes that the medical fraternity had:

... rigorous peer review processes and a robust culture that recognises the value of being subjected to critique and held accountable for one’s actions.<sup>38</sup>

It found, however, that:

Professor Kossman was able to expose the weakness of this system – over time he refused to participate in these activities – he was in a powerful and influential position and he exploited this to his personal advantage.<sup>39</sup>

4.4.16: Professor Kossman’s registration was limited to orthopaedic surgery. He nevertheless “performed surgery on patient’s lungs, bladders and kidneys – procedures that are normally performed by specialists surgeons.”<sup>40</sup> Peer concern does appear to have stopped Professor Kossman doing cranial surgery, although the neurosurgeon that raised concerns about this “claimed that he was censured for questioning Professor Kossman’s plan.”<sup>41</sup>

4.4.17: It emerges from the Ombudsman’s report that everyone expected Professor Kossman to act with integrity and did not appear willing to consider any other possibility. This resulted in the absence of accountability and the active discouragement of complaints when they were made.

*David Wee Kin Tong*

4.4.18: According to media reports, Dr Tong was imprisoned for more than eight years in March 2008 for sexually abusing more than 14 female patients. Two of the women who were victims in the criminal proceedings had complained to the Medical Practitioners Board of Victoria in 2004 and 2005. The Board apparently took no substantive action against Dr Tong. There is no information available from the Board as to the nature of the complaints or whether they were linked by the Board or handled completely separately.

4.4.19: The Board issued a statement saying that it was “extremely sorry about the distress suffered by these women as a result of the conduct that led to Dr Tong’s convictions”<sup>42</sup>. As for the handling of the two complaints made to it, the Board said:

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<sup>37</sup> Ibid, page 149, paragraph 665

<sup>38</sup> Ibid, paragraph 21

<sup>39</sup> Ibid, paragraph 21

<sup>40</sup> Ibid, page 97, paragraph 399

<sup>41</sup> Ibid, page 98, paragraph 401

<sup>42</sup> Medical Practitioners Board, Media statement – Dr David Wee Kin Tong – 14 March 2008.

The Board does not investigate allegations of rape – that is the job of the police. Any person who believes that a doctor's conduct has been criminal should go to the police.

In this case the Board had information from two women who were concerned about the way the doctor conducted a medical examination. The Board investigated their concerns in this context. It did not appear at the time that the issues they raised were sexual assault. Had the Board thought these were criminal matters, it would have encouraged the women to go to the police.<sup>43</sup>

## 5. Other health professionals

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5.1: The focus of this paper to this point has been on the medical profession. This reflects the fact that doctors are the most powerful of the health professions and their failures, generally, appear to have the most severe outcomes for patients. Consequently, they are subject to larger numbers of complaints, have been the subject of most external scrutiny and there is more publicly available evidence about the regulation of medical practitioners than other health professionals.

5.2: While there will be important differences, the same lack of experience and knowledge about the objective forensic investigation and prosecution of complaints, and about procedural fairness, are likely to be evident in self regulatory systems so far as other health service providers are concerned.

5.3: A Parliamentary Committee Inquiry into the Nurses Board of South Australia tabled an interim report in November 2005.<sup>44</sup> The Summary of the report notes that the Committee:

... has heard considerable evidence describing the current procedures. It believes the present situation has the potential to deny natural justice because of its lack of transparency. Delays and lack of information provided to nurses caused frustration and distress.

Initial notification letters give no details of the complaint. Language is adversarial, accusatory, couched in legal terms and non-explanatory. At a later date, upon a finding of unprofessional conduct not found, the details of the complaint are still not given and the letter is vague.

Timeframes take many months, sometimes even years. No written documentation is available to the nurse, their advocate or legal counsel giving details of the hearing process.<sup>45</sup>

The final report of the Parliamentary Committee confirmed and elaborated on the comments in its interim report.<sup>46</sup>

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<sup>43</sup> Ibid.

<sup>44</sup> Parliament of South Australia, Inquiry into the Nurses Board of South Australia, Interim report of the Statutory Authorities Review Committee, 41<sup>st</sup> Report.

<sup>45</sup> Ibid, Summary, page 7.

<sup>46</sup> Parliament of South Australia, Inquiry into the Nurses Board of South Australia, 42<sup>nd</sup> report of the Statutory Authorities Review Committee.

5.4: The reports of the South Australian Parliamentary Committee do not reflect so much on the lack of appreciation of the patient and public interest but on another problem with boards being responsible for complaint handling. Boards with relatively small numbers of complaints do not build up the investigative expertise gained by organisations handling large numbers of complaints. They tend to have little practical idea of the application of procedural fairness, can become paralysed by privacy issues or when faced with counter-complaints alleging bullying and victimisation.

5.5: The lack of familiarity with complaint handling and the board processes of dealing with complaints through committees, which generally meet monthly and consist of working practitioners, with little or no legal or investigative expertise, also contributes to administrative delay, impacting on both complainants and respondents to complaints.

## 6. Alternatives to peer review and self-regulation

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6.1: As can be seen from the material set out above, independent bodies that have had cause to investigate cases where peer review and self regulation have failed, assume, that peer review is generally a rigorous and robust process. This is despite the evidence to the contrary in the cases they examine. This was the assumption by both the Victorian Ombudsman and the Presiding Member of the South Australian Parliamentary Committee inquiring into the Medical and Nurses Board of that state. The assumption appears to be made without examination of relevant evidence of the broad operation of peer review and appears to be based on the high level of public trust that is extended to health service professionals.

6.2: What can also be seen from the material set out above is that peer review cannot be said to be an accountable or consistent regulatory mechanism. It is conducted largely in private and is not governed by clear and transparent procedures. It places little if any weight on the experiences of patients and its outcomes cannot be measured. If the practitioner the subject of peer review sets out to deceive or frustrate the process, it can be ineffectual or interminably delayed.

6.3: As the Presiding Member of the South Australian Parliamentary Committee also noted – health consumers are becoming more informed, aware and demanding and this demand is only likely to increase. Peer review and its application through health registration board processes will not be sufficient to meet this demand in future.

6.4: The responses to the failure of self-regulation have been various. In New Zealand the task of investigating and prosecuting has been given to a completely independent Commissioner and, while there is consultation with health registration Boards, the crucial decisions rest with the Commissioner. Regulation of health professionals in New Zealand has not fallen apart as a result. Queensland has left the general investigations and prosecution with the Boards but retains the right to conduct investigations into the conduct of individual practitioners. A more detailed explanation of the system in NSW follows.

## 7. The co-regulation model in New South Wales

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7.1: New South Wales has a complex system of co-regulation in conjunction with health registration boards. The Commission handles complaints against both organisations and individuals. All complaints against individual practitioners received by either a board or the Health Care Complaints Commission must be notified to the other. On receipt of the complaint the Commission conducts a detailed assessment of the complaint, the first step of which is to contact the complainant, clarify the nature of their concerns and provide assistance to them, if required. Copies of complaints will be sent to the providers the subject of complaint, unless there are legislatively defined reasons not to, and a response sought, including clinical records, where indicated. The Commission also employs medical and nursing advisors for expert advice.

7.2: At the end of the assessment, the Commission consults with the relevant registration board as to the outcome and, where there is disagreement, the most serious option prevails. The available options at this stage are to discontinue dealing with the complaint; refer the complaint for resolution by the Commission; refer it to the registration board for action or the complaint becomes the subject of a formal investigation by the Commission. The complainant has the right to require a review of the assessment decision for every option except investigation.

7.3: In 2007-08, the Commission resolved 7% of complaints during the assessment process; assessed 27% for alternate dispute resolution; referred 20% to registration Boards; sent 9% for full investigation and discontinued 34%. Reasons are required to be provided by the Commission to the complainant. During the same year, 8% of complainants who were notified of the result of the finalised assessment requested a review. Reviews varied the original assessment decision in 11% of complaints. The Commission finalised 88% of assessments within the statutory 60 days, at an average of 39 days.

7.4: The Health Care Complaints Act 1993 requires the formal investigation of complaints that raise a significant issue of public health or safety; may result in disciplinary proceedings against, or involve gross negligence by, a practitioner. The Commission is under a statutory obligation to continually assess its handling of a complaint referred for investigation, may add allegations and other providers not contained in the original complaint, but disclosed as the investigation proceeds. Before adding any individual providers, the relevant registration board must be consulted.

7.5: At the end of an investigation the Commission may make recommendations to health organisations, aimed at addressing systemic and organisational failings. Where individual practitioners are involved, the Commission must again consult with the relevant registration Board as to the outcome for individual practitioners but the final decision rests with the Commission.

7.6: The Commission also acts as the prosecutor of complaints against individual practitioners before disciplinary bodies, presided over by legal members with practitioners and community members appointed by the boards.

### **Recent developments**

7.7: Recent legislative change to the system resulted from the case of Graeme Reeves. In 1997, the Commission prosecuted nine complaints against then Dr Reeves before a Professional Standards Committee of the Medical Board. The Commission

submitted that Mr Reeves be restricted from practising obstetrics, gynaecological surgery or any invasive procedure. The Professional Standards Committee only restricted him from practising obstetrics, a decision the Commission did not appeal.<sup>47</sup> In July 2004, the Commission prosecuted Dr Reeves before a Medical Tribunal for lying and deceiving his employer about the conditions on his registration. In its decision deregistering Dr Reeves, the Tribunal said that he:

... was prepared to whatever steps he deemed expedient to place himself in a position whereby he could resume practice as an obstetrician [including] bare faced lies and calculated omissions.<sup>48</sup>

In 2008, a series of patient complaints became public and received considerable media attention. The result was a number of inquiries and the charging of Mr Reeves with numerous criminal offences.

7.8: The inquiry with the most direct impact on the legislation governing the handling of complaints against doctors was conducted by the Hon Deirdre O'Connor.<sup>49</sup> The report resulted in legislative amendment to further increase the transparency of the complaints system in NSW. The most notable changes are mandatory reporting by medical practitioners of serious misconduct by colleagues and conduct of the previously private Professional Standards Committees of the Medical Board to be held in public and chaired by a legally qualified person. The O'Connor inquiry also recommended strengthening of the Commission's investigation powers and a broader review of the model of co-regulation in NSW. The Joint Parliamentary Committee on the Health Care Complaints Commission also recently decided to inquire the operation of the co-regulatory system in NSW.

## 8. The advantages of co-regulation in New South Wales

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8.1: The principal advantage of co-regulation is that it can achieve a more appropriate balance between the interests of the relevant health profession and the public interest. It does this by ensuring that decision making at crucial points in complaint handling are made independently of, or in co-operation with, the relevant health profession.

8.2: The crucial points in complaint handling occur continually throughout the process – they include the initial assessment of complaints, their investigation and prosecution. Apart from its independence, a complaint handling process not controlled by separate boards with different interests, brings to bear skills and approaches that are not employed by Boards.

8.3: These include assistance to complainants and the fair, quick and thorough assessment of complaints and before a decision is made as to whether further action is appropriate. The investigation of serious complaints by an independent body allows the development of specialised skills and methods and the employment of specialist investigators rather than investigators recruited from the profession, who are more

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<sup>47</sup> Parliamentary Committee on the Health Care Complaints Commission, report No 3/54, June 2008, Report on the Investigations by the Health Care Complaints Commission into the complaints made against Mr Graeme Reeves, pages 28 - 30

<sup>48</sup> NSW Medical Tribunal, Decision regarding Dr Graeme Reeves published at [www.nswmb.org.au](http://www.nswmb.org.au)

<sup>49</sup> Report on the employment of Graeme Reeves, published at [www.health.nsw.gov.au](http://www.health.nsw.gov.au)

likely than not to have inherent bias and to substitute their own clinical experience for evidence rather than obtain relevant expert evidence.

8.4: The benefits for practitioners include procedural fairness and outcomes that are free of bias. The benefits for complainants are that their complaint is more likely to be taken seriously, investigated thoroughly, if warranted, and a fair and reasonable decision made as to the outcome.

8.5: There are also considerable efficiencies as well as public benefit in a single independent body handling complaints against all health service providers. Some of the most serious adverse outcomes occur in cases of complex care where numerous individual health service providers work together as a team in a health organisation.

8.6: The data from the New South Wales Health Care Complaints Commission is that 28% of its investigations, which raise serious public health and safety issues, concern multiple organisational and individual respondents and 12% of investigations involve individual practitioners from different disciplines or professions. All of these different health service providers can be dealt with through a single investigation process that is more likely to take into account relevant contributing factors than separate investigation processes.

## 9. Comparison of co-regulation with self-regulation – NSW and Victoria

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9.1: It is an extremely difficult to compare the relative effectiveness of the different systems currently operative in Australia. Complaint handling procedures differ widely and the level of transparency in the reporting of outcomes varies considerably. Despite these considerable obstacles, the Commission has undertaken a comparison of the outcomes of complaint handling procedures with respect to medical practitioners in New South Wales and Victoria.

9.2: The reasons for comparing NSW and Victoria are that they both have the highest numbers of registered practitioners and the greatest volume of complaints. Further, the Victorian system most closely reflects the essentially self-regulatory scheme proposed by the consultation paper and NSW has the co-regulatory system set out briefly above.

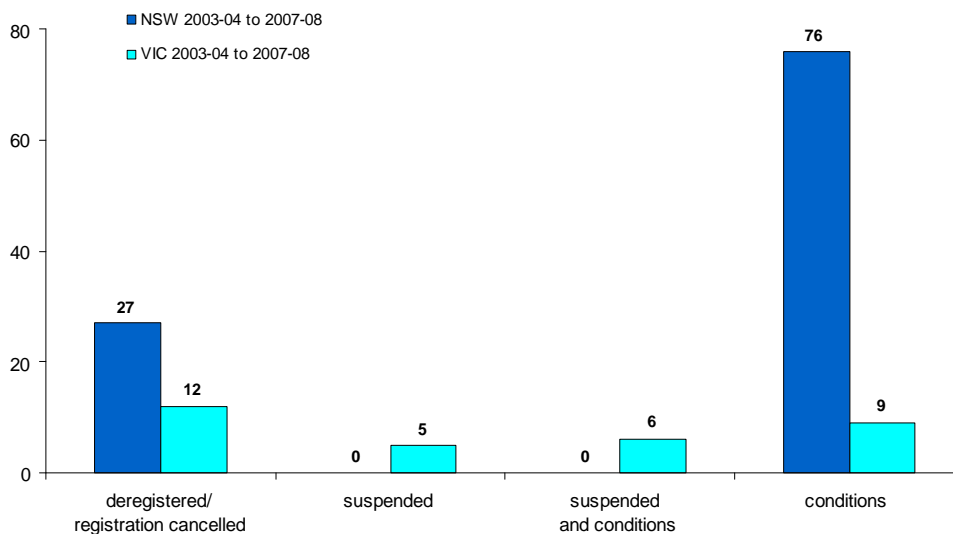
9.3: The outcomes of two complaint-handling processes are many and varied. Given the variability of the outcomes and the lack of objective criteria on which to compare them, the comparison carried out for this paper has taken into account only outcomes that appear to be objectively comparable and have legal consequences. Results of complaints procedures such as counselling, caution and reprimand have not been included because of the essentially private nature of the outcome, the lack of an objective basis to distinguish between them and compare the way they are applied in the two jurisdictions to different cases. They are also applied at different stages within the two jurisdictions. Counselling in NSW, for example may occur without full investigation. Consequently, this paper compares the most serious adverse disciplinary outcomes of complaints - being deregistration (NSW) / cancellation (Vic), suspension of the right to practice and the imposition of conditions or restrictions on practice.

9.4: Attachment “A” to this paper contains a table detailing the results and the methodology used to arrive at the figures in the table. The data reproduced in the table is taken from the relevant annual reports and includes all written complaints about medical practitioners dealt with by both the relevant health complaints commission and medical board.<sup>50</sup> The outcomes are reported by practitioner rather than number of complaints proved against a single practitioner. It appears that the numerical tables in the annual reports of the Medical Practitioners Board of Victoria count these serious adverse outcomes by number of complaints proved and it is necessary to read the published summaries of decisions to ascertain the number of actual practitioners and provide a legitimate comparison with the outcomes in NSW.

9.5: It can be seen from the table that, over a five-year period, there was a higher rate of complaints per practitioner in Victoria than NSW.

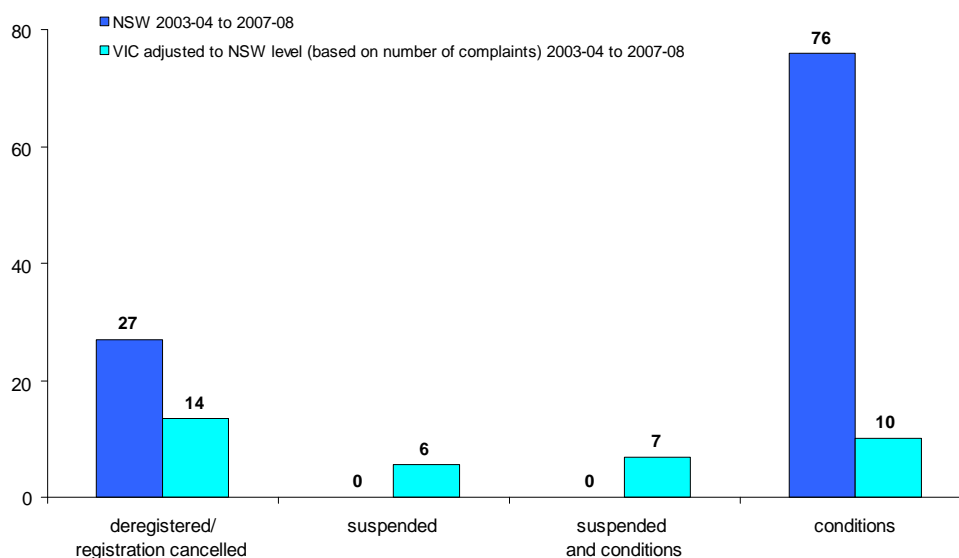
9.6: As shown in Chart 1, on raw figures, the number of practitioners deregistered in NSW is more than twice the number who had their registration cancelled in Victoria. When the figures are adjusted to consider the different numbers of complaints (Chart 2), the figure from Victoria is slightly more than half that for NSW.

**Chart 1 - Serious adverse outcomes of disciplinary proceedings against medical practitioners in NSW and Victoria in the period 2003-04 to 2007-08**



<sup>50</sup> It must be noted that the data regarding complaints received by the Victorian Health Services Commission excludes complaints against medical practitioners working in public hospitals. These complaints are classified only as a complaint against the hospital. When collating complaint cumbers the Health Services Commission advised that most complaints against hospitals involve a medical practitioner. However, if only half these complaints were counted as a complaint against a medical practitioner, then complaint numbers in Victoria would increase by 140-150 over the last two years.

**Chart 2 - Serious adverse outcomes of disciplinary proceedings against medical practitioners in NSW and Victoria in the period 2003-04 to 2007-08 (adjusted based on number of complaints)**



9.7: It should be noted, however, that both Victoria and NSW also have, as a potential outcome of their respective complaints processes, the suspension of the registration of a practitioner. This outcome has not been reached in NSW with respect to a medical practitioner in the last five years. Although it is applied in Victoria. The decisions published on the website of the Medical Practitioners Board of Victoria show that suspensions are generally for lesser periods than cancellations. In some cases, suspended registrations revive on lapse of the suspension period without conditions on practice. In others, conditions come into effect when the registration revives. In NSW, a deregistered practitioner must apply to the Medical Tribunal in order to resume practice. The NSW Medical Board or Commission may contest such applications for re-registration before the Tribunal.

9.8: Although suspension is a milder penalty than cancellation/deregistration, for the reasons set out above, if the two are counted together for Victoria and compared to deregistration in NSW, the proportion of practitioners suffering these penalties when adjusted for the number of complaints in each jurisdiction, is equal (see chart 2).

9.9: The other serious and comparable outcome of a complaints disciplinary process is the imposition of conditions on a practitioner's registration. Conditions on registration are also publicly available through the websites of the Medical Boards in each jurisdiction. Comparing the imposition of conditions in the two jurisdictions, the rate in NSW is over five times greater than in Victoria.

9.10: As shown in Attachment "A", NSW has a far higher rate of the serious adverse outcomes compared in this paper for practitioners in raw figures, as well as when calculated in relation to the number of practitioners, and the number of complaints received.

## 10. Comments on the proposed model

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10.1: As noted at the outset, the model proposed is essentially a self-regulatory model, with the exception that serious matters must be prosecuted before an independent tribunal. The effectiveness of self-regulation in health has been considered above and the evidence leads to the broad conclusion that the more independence brought to the regulation of health practitioners the better. The following comments reflect this general position.

10.2: Page 4 of the consultation paper notes that the key factors outlined by Ministers for the further development of the scheme is that it needs to:

- ensure that public protection is paramount
- maintain a high degree of transparency
- be appropriately accountable.

The model proposed does not meet these objectives to the extent that a co-regulatory model could.

10.3: Page 7 of the consultation paper sets out five principles (at proposal 1.5.1.) relating to the management of complaints. Putting aside Australia's international commitments and agreements, the proposed scheme does not meet the principles set out. In particular, it does not provide as robust a system as possible to protect public safety; does not build on the best aspects of state/territory schemes and does not fairly balance the rights and interests of consumers with those of health practitioners.

10.4: The model essentially vests the management of complaints against practitioners with the registration boards and is a fundamental problem with the scheme. In short, health consumers and complainants cannot be assured that their complaints will be dealt with impartially and effectively and that appropriate action will be taken. It cannot be asserted with any confidence that prosecution of complaints by a registration board before an independent state tribunal brings a sufficient degree of independence and impartiality to the management of complaints in general. An independent perspective should be brought to bear through the entire complaints process.

10.5: Page 11 of the consultation paper deals with preliminary assessment of notifications and says that the relevant board would determine whether the notification is a consumer complaint. Only such complaints would require consultation with the responsible state/territory Health Complaints Commission (HCC). Although not entirely clear, the proposed scheme also appears to leave the determination as to whether the notification is one that could be conciliated by a HCC or raises unsatisfactory conduct issues to the relevant registration board.

10.6: The requirement for consultation should not be limited to consumer complaints, nor should the categorisation of complaints be left entirely to the discretion of the relevant Board. Complaints of possible misconduct by individual practitioners from health organisations should also be the subject of notice and consultation with the HCCs, as should complaints involving possible health and performance. HCCs should also be consulted about whether or not a complaint should be dealt with as a health or performance issue, rather than a conduct matter. Clear procedures must be in place as to how complaints will be dealt with. The New South Wales consultation process provides an applicable model. The legislation should also specify public interest criteria requiring investigation of serious matters that raise public health and safety concerns or

could support disciplinary proceedings. Such matters should not be dealt with by conciliation.

10.7: Page 13 sets out that complaints must contain particulars of the allegations and identify the practitioner against whom the complaint is made. The proposal is unduly restrictive on complaints and, as framed, will allow boards to dismiss complaints that do not meet the criteria. Similarly, on page 14 the paper sets out matters that “may be the subject of a notification.” Again, specifying particular grounds for complaint in legislation will provide boards with the opportunity to dismiss complaints because they have not been framed in the terms of any proposed legislation. While the paper does propose that boards have a duty to reasonably assist complainants, unnecessary restrictions on what complaints should contain or what they should allege, are likely to result in complaints being unfairly rejected. Restricting the categories of conduct about which complaints can be made can also lead to under-reporting, with complaints not falling within the categories not being counted. Complaints should be able to be made by any person about any conduct and should not need to specify the legal characterisation of any alleged misconduct. The complaint handling body should make reasonable efforts to identify practitioners the subject of complaint, rather than reject them where a complainant fails to identify the practitioner. As well, the complaints handling body should be able to determine the legal character of the conduct complained about as normal administrative practice.

10.8: Page 14 of the consultation paper sets out options for mandatory reporting. The problem sought to be addressed by mandatory reporting is a cultural problem and mandatory reporting on its own will be insufficient to address this problem. That being said, mandatory reporting for serious misconduct of health problems (including alcohol and drug addiction) is desirable and in the public interest. It should also apply to employers. Protections for notifiers should obviously apply.

10.9: Page 16 of the paper deals with the suspension of practitioners. Powers of suspension should reside with the boards, who are best equipped to immediately assess whether or not a practitioner is a danger to the health and safety of the public. As an alternative to suspension, boards should also be empowered to impose conditions on practice to protect the public health and safety. Undertakings are not a sufficient substitute for conditions on practice, which should then be published. It is also relevant at this stage to note that undertakings are referred to in a number of places in the paper occasionally also referred to as enforceable. The power to impose conditions removes the requirement for consent of the practitioner and should be exercisable as an alternative to suspension.

10.10: Pages 17 to 20 of the paper deal in more detail with the preliminary assessment of notifications. The comments in this response at paragraph 9.5 above are applicable. In addition, there should be legislative requirements to consider the relevance of any previous or other current complaints against the same practitioner in the assessment process. Although not entirely clear, it appears from the paper that the preliminary assessment is carried out solely on the written complaint, without any further inquiry of the complainant or of the practitioner. This is likely to lead to an inadequate and flawed assessment, which will generally be based on insufficient evidence. The process is potentially unfair to both complainants and practitioners. The process in New South Wales, where prior to assessing the complaint, the practitioner provides a response and clinical records where appropriate, is preferable.

10.11: The proposal to provide power to refer a matter directly to a tribunal after preliminary assessment, without any investigation or preparation of a brief for prosecution, is unlikely to ever be used in practice, or, if it were, would probably

prejudice the prospects of successful prosecution. Suspension of a practitioner after preliminary assessment, without providing the practitioner with the opportunity to respond, would be procedurally unfair. Legislation should require the giving of reasons for decisions after preliminary assessment and there should be a right of review of the decision. It is noted that later in the paper, boards are required to give reasons to practitioners for the outcome of performance and health processes.

10.12: The paper includes proposals regarding the board's requirement to give notice to the complainant and practitioner of the decision, and the reasons for the decision after a complaint has been assessed. The paper does not include any requirement for the board to notify an employer if it decides to investigate the conduct the subject of the complaint, as is currently the case in NSW.

10.13: Pages 21 – 26 of the paper concern the management of performance and health matters and the New South Wales Health Care Complaints Commission does not deal with these areas in great detail. With respect to performance matters, the boards should be able to require, rather than request, a practitioner to undergo a performance assessment. Failure to comply with a requirement should constitute unsatisfactory professional conduct and thereby become grounds for a conduct complaint, which could then be investigated and prosecuted if necessary. For the reasons set out above, the imposition of conditions on practice, rather than undertakings, is preferable. The same applies to health matters.

10.14: Section 8 of the paper deals with that handling of complaints about practitioner conduct. The Commission does not believe investigation by boards is in the public interest for the reasons set out extensively above. That being said, the paper proposes adequate powers for investigations although at page 29 the paper refers to an inspector, rather than an investigator. It should be recognised that legislation cannot mandate the incisiveness of investigation and the extent to which powers will be used. It is unlikely that boards, particularly smaller boards, can maintain the staff and skills to apply the investigative expertise and impartiality required. It should also be legislated that investigations be required to take into account previous complaints, performance or health issues and to re-open closed matters and include them in a current investigation, where appropriate. It should also be mandated that investigations are empowered to add allegations and other practitioners where necessary. Existing provisions to this effect, which could provide a model apply in New South Wales.

10.15: Section 9.2 of the consultation paper deals briefly with the investigation of complaints involving multiple practitioners from different professions. As noted above, these represent a significant amount of the Commissions investigations of serious complaints and the necessity of a multiplicity of investigations of a single matter by multiple authorities is serious defect in the scheme proposed. The solution suggested, that boards be allowed to deal jointly with such matters has obviously received little careful consideration. The paper does not appear to have explored how such matters are currently dealt with in states/territories where boards conduct investigations or the mechanisms by which joint investigation might be efficiently achieved. Complaints of this nature are likely to be inadequately investigated and subject to delay and administrative obstacles.

10.16: It is proposed that at the end of an investigation a conduct management committee could take no further action. If this is the outcome, legislation should require reasons to be given to the complainant for a decision and a right of review.

10.17: The paper also proposes that a conduct management committee can appoint a panel to hold a hearing. The outcomes of panel hearings could be, among other things,

impose conditions on practice. Undertakings are also mentioned but should be rejected in favour of conditions. The paper proposes that panel hearings be held in private and that complainants, if not appearing as witnesses, may make a submission or speak only with the leave of the panel. The argument in favour of this proposed procedure is that the board is concerned with protecting the public health and safety rather than resolving individual complaints.

10.18: The procedure and powers proposed for panels replicates the defects apparent in peer review processes. There is no provision for a prosecutor to represent the public interest, complainants have limited if any input and the proceedings are held in private. There are no rights of appeal apart from the right accorded to the practitioner to seek a review. The process proposed does not protect the public health or safety and does not provide a reasonable balance between consumer and practitioner interests. Alternative models are available and in practice but appear to have received no consideration by the consultation paper. The position of a Director of Proceedings could go some way towards addressing these problems, including the power to appeal a panel decision to a state tribunal, but the paper limits the potential role of this option to tribunal proceedings. This issue is particularly important because the extension beyond the existing Victorian scheme to allow the imposition of conditions at this stage increases the power of this relatively informal and closed process.

10.19: The paper also proposes, at page 30, that these panels be required to take into account previous performance assessments in their proceedings. It is unclear whether this is limited to panel hearings arising out of referrals from the performance area of the relevant board or to hearings generally. Panels should be required to consider previous complaints and other matters where relevant. Again, existing provisions in New South Wales could provide a model.

10.20: The proposals in the consultation paper regarding the external independent tribunals are unexceptional and largely replicate existing procedures in New South Wales. The Commission's position is that the boards should not be investigators. Obviously, the Commission does not believe that the boards initiating and conducting prosecutions is in the public interest and supports the Director of Proceedings option.

## 11. Conclusion

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11.1: The traditional method of dealing with concerns about the professional conduct of registered health practitioners, whether or not arising from complaints from patients, is through peer review. The peer review process lacks clear procedural rules and does not apply objective standards or criteria in reaching its outcomes. As has been demonstrated, it can be completely ineffective when confronted with a non-compliant practitioner.

11.2: The regulatory processes applied by registration boards rest heavily on peer review. This results in a lack of, and a reluctance to develop, clear procedural rules and standards or criteria against which conduct can be objectively assessed and that can be applied from case to case. This militates against the development of an accountable regulatory scheme that applies consistent standards and is fair to both complainants and practitioners. There is significant evidence from external sources that registration boards are not sufficiently responsive to patient and complainant concerns.

11.3: The model proposed by the consultation paper is fundamentally a self-regulatory model with the addition that serious complaints must be prosecuted before an external tribunal. The existence of an independent tribunal at the tail end of the complaint handling process is not sufficient to displace the overwhelming control of the complaints process by practitioners. Given that traditional peer review and board processes have been largely closed to independent evaluation, the degree of independence required for an effective regulatory scheme is that much greater.

11.4: The scheme proposed by the consultation paper is not in the public interest nor is it, ultimately, in the best interests of practitioners.

## Comparison NSW and Victoria

Disciplinary action with outcome of deregistration / cancellation of registration, suspension and/or conditions against medical practitioners

| State | year    | Highest outcome                            |           |                                |            | No. of adverse outcomes | No. of medical practitioners registered (including medical students) | % of complaints received per registered medical practitioner | No. of complaints received against medical practitioners* |
|-------|---------|--|-----------|--------------------------------|------------|-------------------------|--|--|---|
|       |         | deregistered/<br>registration<br>cancelled | suspended | suspended<br>and<br>conditions | conditions |                         |  |  |   |
| NSW   | 2007-08 | 4  |           |                                | 13         | 17                      | 30,036   | 3.72%  | 1,118   |
| VIC   | 2007-08 | 1  |           |                                | 1          | 2                       | 24126**  | 4.09%  | 986   |
| NSW   | 2006-07 | 6  |           |                                | 16         | 22                      | 31,918   | 3.40%  | 1,085   |
| VIC   | 2006-07 | 3  | 1         | 1                              | 1          | 6                       | 23,251   | 4.04%  | 940   |
| NSW   | 2005-06 | 3  |           |                                | 17         | 20                      | 27,918   | 4.19%  | 1,171   |
| VIC   | 2005-06 | 2  | 1         | 2                              | 2          | 7                       | 22,079   | 4.22%  | 932   |
| NSW   | 2004-05 | 6  |           |                                | 20         | 26                      | 27,089   | 4.22%  | 1,100   |
| VIC   | 2004-05 | 2  | 3         | 2                              | 4          | 11                      | 21,407   | 5.32%  | 1,139   |
| NSW   | 2003-04 | 8  |           |                                | 10         | 18                      | 28,220   | 4.35%  | 1,190   |
| VIC   | 2003-04 | 4  |           |                                | 2          | 6                       | 20,515   | 5.00%  | 1,025   |

## 5-year comparison

| State   | year               | Highest outcome                            |           |                                |            | Total No. of serious adverse outcomes | Average No. of medical practitioners registered | Total No. complaints received | % of complaints received per registered medical practitioner |
|---|--------------------|--|-----------|--------------------------------|------------|---------------------------------------|---|-------------------------------|--|
|   |                    | deregistered/<br>registration<br>cancelled | suspended | suspended<br>and<br>conditions | conditions |                                       |   |                               |  |
| NSW   | 2003-04 to 2007-08 | 27   | 0         | 0                              | 76         | 103                                   | 29,036  | 5,664                         | 3.90%  |
| VIC   | 2003-04 to 2007-08 | 12   | 5         | 6                              | 9          | 32                                    | 21,813  | 5,022                         | 5.76%  |
| VIC adjusted to NSW level (based on number of complaints) | 2003-04 to 2007-08 | 14   | 6         | 7                              | 10         | 36                                    |   |                               |  |

\* Does not include complaints received by the NSW Health Care Complaints Commission that solely raise issues of access to records or privacy, or complaints received by the Victorian Health Services Commission under the Health Records Act 2001 (Vic)

\*\* Information not yet publicly available. Calculation based on average growth rate of number of registrants for Victoria in the previous four-year period 2003-04 to 2006-07

The above comparison is based on publicly available data for five financial years (2003-04 to 2007-08) sourced from the annual reports of: the NSW Health Care Complaints Commission; the NSW Medical Board, the Medical Practitioners Board of Victoria; and the Victorian Health Services Commissioner.

Data regarding the outcomes of disciplinary hearings in Victoria was sourced from the decisions of formal hearings held by the Medical Practitioners Board of Victoria made available on its website. In addition, three formal hearing that were reported in the Medical Practitioners Board of Victoria annual reports have been included, even though these decisions did not appear amongst the decisions published on the website of the Board. Although the exact date of these decisions is not provided in the annual report, it was assumed that the decisions fell within the financial year they were reported.

Decisions of the Victorian Civil and Administrative Tribunal (VCAT) were also reviewed, as from 1 July 2007 under the *Health Professions Registration Act 2005 (Vic)* this body now has the responsibility for the management of hearings into matters of serious unprofessional conduct into registered health practitioners in Victoria. As yet there have been no decisions handed down by VCAT in relation to this jurisdiction.

### **Methodology used for data in relation to the outcome of disciplinary matters**

The comparison in relation to outcomes of disciplinary hearings is based on the most serious outcome per matter. A matter is considered to be a hearing into the conduct of an individual medical practitioner regardless of whether the conduct was proven or not proven.

If there were several particulars raised in the hearing and several decisions made in relation to individual particulars, only the most serious outcome has been counted. However, if multiple practitioners were mentioned in the same hearing and a decision was handed down in relation to each of these practitioners, these have been counted separately.

Starting with the most serious outcome, the order of seriousness for the outcome was defined as:

1. deregistration/cancellation of registration
2. suspension of registration and conditions
3. suspension of registration
4. conditions imposed on registration.

Other outcomes, such as reprimanding, requiring further education or cautioning were not included in the count, as they do not place legally enforceable restrictions or a legal obligation on the practice of a medical practitioner.

Disciplinary forums that were considered in the comparison were forums that have the power to impose conditions; this applies to formal hearings of the Medical Practitioners Board in Victoria, as well as hearings of the Professional Standards Committee of the NSW Medical Board and the NSW Medical Tribunal

In NSW, as distinct from Victoria, deregistered (cancelled) practitioners have to apply to the Medical Tribunal for re-registration. If the Medical Tribunal decides to allow the re-registration, it may impose conditions on the re-stored registration of the practitioner to safeguard against any remaining concerns about the professional conduct of that practitioner. Outcomes of any re-registration processes before the Medical Tribunal in

NSW have not been included in the comparison, as any conditions imposed at the re-registration stage relate to a matter already covered by the Tribunal's decision to deregister the practitioner. To include data regarding re-registrations would result in double-counting of outcomes per matter.

### **Number of registered medical practitioners**

The Data regarding the number of registered medical practitioners is publicly available in the annual reports of both the NSW and Victorian medical boards. For consistency, the total number of registrants at the end of each financial year including the number of student registrants was considered. The student registrants were included, as both in NSW and Victoria, complaints about medical students providing health services can be addressed through the given complaint mechanisms. As the number of registrants for Victoria for 2007-08 is not yet publicly available, it was calculated using the average growth rate of the previous four-year period 2003-04 to 2006-07.

### **Number of complaints received about medical practitioners**

If a complaint about the same medical practitioner raises several issues, it has been considered one complaint.

Complaints considered for NSW are written complaints that were received by, or notified to the NSW Health Care Complaints Commission by the NSW Medical Board. As part of the co-regulation between the Commission and the NSW Medical Board, each body has to notify the other body of any complaints received about a medical practitioner. Please note that distinct from Victoria, there is no difference in the management of complaints depending on whether the medical practitioner is working in the private or public system in NSW.

In Victoria, the Medical Practitioners Board of Victoria receives complaints under the *Health Professions Registration Act 2005 (Vic)* about medical practitioners and may refer some, which are suitable for resolution through conciliation to the Victorian Health Services Commission.

The Victorian Health Services Commission receives complaints under the *Health Services (Conciliation and Review) Act 1987 (Vic)* as well as the *Health Records Act 2001 (Vic)*. The Victorian Commission may refer complaints about medical practitioners that are not suitable for conciliation to the Medical Practitioners Board of Victoria for its management.

As this comparison only relates to professional conduct issues of medical practitioners, complaints received by the Victorian Commission that fall under the *Health Records Act* have been excluded from the analysis. In addition, complaints received by the NSW Commission about medical practitioners that solely raise issues of privacy and access to medical records have also been excluded.

Information regarding the number of written complaints received by the Health Services Commission under the *Health Services (Conciliation and Review) Act 1987 (Vic)* was provided by the Health Services Commission. The Commission advised that the number of complaints about medical practitioners only relates to private medical practitioners. When complaints are received about medical practitioners working in the public system, these are recorded as complaints against the hospital, not as complaints about the individual practitioner. This practice is based upon the assumption that if the complaint would lead to a compensation claim, the hospital as employer would be the respondent in such proceedings rather than the individual practitioner.

As noted above, the NSW numbers include both public and private medical practitioners, whilst the Victorian numbers only include private medical practitioners. The comparison has been based on the reported data, as it is impossible to accurately identify the proportion of complaints in Victoria that are recorded as complaints about public hospitals which in reality relate to an individual medical practitioners working in the public system. The HSC advised The Commission that most complaints about public hospitals are complaints about the actions of a doctor. If only half the complaints received by the Commission were assumed to be about medical practitioners, then complaint numbers would increase by 143 for 2007-08, 152 for 2006-07 and similar numbers for other years.

### **Differences in reporting periods**

It should be noted that the NSW Medical Board, NSW Health Care Complaints Commission and the Victorian Health Services Commissioner report on its financial year ending 30 June, whilst the Medical Practitioners Board of Victoria reports on the year ending on the 30 September. The data affected by the difference in reporting periods is the number of complaints received by the Victorian Board and the number of registered medical practitioners in Victoria. Any concerns regarding the difference in reporting periods is negated by using a consistent comparison period of 60 months for all data in the analysis.

To ensure the best possible comparability of the outcomes of disciplinary matters against medical practitioners in both States, the actual date of the decision where available was taken as reference using a financial year ending on the 30 June.