

Complaints Arrangements Submission from the Royal Australasian College of Surgeons

The Royal Australasian College of Surgeons welcomes this opportunity to comment on the Practitioner Regulation Subcommittee's consultation paper concerning "Proposed arrangements for handling complaints, and dealing with performance, health and conduct matters".

The proposed structure is such that under the national board will sit 4 committees. The College notes that the make up of these 4 committees is not clear at this stage.

The committees are:

- Notifications assessment committee (2.1.3).
- Performance management committee (2.1.5). This committee will have powers to "oversee the management of practitioners whose performance may be unsatisfactory". There is an argument to be made that, in the case of Australian surgeons, the proposed responsibilities of this committee, including performance assessment, are already and very effectively exercised by the College through its Executive Director for Surgical Affairs.
- Health management committee (2.1.8).
- Conduct management committee (2.1.11).

The notification terminology proposed in 2.1.1 is supported.

The framework of reviews of performance, health and conduct is also broadly supported. However, there is a lack of clarity in the presentation, particularly in the close linkage of conduct and discipline in several areas of the document. It is suggested that at an early part of the document it is clarified that discipline is an outcome following investigation. For example, the explanation in 3.1 paragraph 5 could be given more prominence. 3.1 does not address the thresholds of evidence that would be required and does not recognise performance review in the workplace.

The College strongly supports identification of underperformance, and health and conduct problems in the workplace with a view to remediation and preservation of the practitioner in the workforce. Prevention rather than response should be the objective and although in 1.5.1 it is stated that there is a focus on prevention and early intervention, it is obvious that complaints handling is the true focus. There need to be significant investment in ongoing performance review by properly resourced peer-reviewed audit. The college has an established record in this activity and has recently published a document on assessment of competence and performance (available at www.surgeons.org) that could be adapted for all health professions.

The College has some concerns regarding mandatory reporting obligations (4.4). Specifically, adoption of Option 1a would force a treating practitioner to report a registrant who may have various health complaints or substance abuse problems. While the College recognises the purpose of this requirement, it raises the fundamental issue of doctor-patient confidentiality. It could also serve to discourage a registrant with potentially serious health issues from seeking care. A registrant, concerned that his or her livelihood will be jeopardised by a treating doctor's obligation to report, could opt instead to continue practicing and, in so doing, place patients at risk. In this section option 1(b) would be preferred and

also 2(a) rather than 2(b) that pre-empts a determination that should only follow investigation.

The college also queries what arrangement are envisaged for the situation where a medically qualified advisor employed by a medical defence organization handles a matter on behalf of a member where information regarding reportable matters is revealed?

Regarding students, the responsibility of Universities should be recognised and matters of student performance should be referred to Universities in the first instance.

While notifiers are to be protected from defamation, malicious prosecution or conspiracy charges (4.5), what recourse do practitioners have to protect their reputation from frivolous or malicious allegations? 5.3 merely provides for the Board not to investigate. We advocate that if the notification has been made public, it would be fair if there was public disclosure of the decision not to proceed.

Proposal 5.4.1 (a) (ii) of the consultation paper indicates that a “responsible board” will appoint persons to notifications assessment committees using a “list of persons who have been approved by the Ministerial Council”. This raises obvious and critical questions: Who will these approved people be, from what areas will they be drawn, and what expertise will they bring to the proposed committees? The College hopes that at least some of these persons would be health practitioners involved in clinical practice.

In 5.6, option 1 that confers no right of review of preliminary assessment decisions by the notifier is supported.

As indicated above, proposals 6.3.1 and 6.3.2 address performance assessment responsibilities already exercised very effectively by the College. 6.3.1 is supported but requires the expertise and engagement of the professional body accredited to determine the practice standards of the registrant. In the case of a medical practitioner on the specialist register, this should be the relevant specialist medical college. The consultation paper neither recognises this nor proposes any role whatsoever for specialist medical colleges in these assessments. Given the colleges’ record of excellence, this is a serious oversight.

6.4.1 specifies that no more than half the panel may be from the same profession as the registrant. In performance review the expertise of peers is paramount and cannot be generalised. It is recommended that this section is revised to specify that a majority of the panel is from the same profession as the registrant, and in the case of a medical practitioner on the specialist register must contain a member from the same specialist register.

Proposal 7.3.3 proposes withholding certain medical information from registrants. Is this a reasonable thing to do in the circumstances described?

In proposal 9.1.1, the College favours option 1 and in 9.3 favours option 4(b) in order to ensure natural justice and procedural fairness for the notified practitioner. In 9.4 we strongly support closed hearings. In 9.8 the consistency that would exist under the Commonwealth Ombudsman act 1976 is favoured.

Proposal 11.5.1 appears to propose a new class of offence, that of directing or inciting a registered practitioner to act in a manner that might constitute unsatisfactory professional conduct or professional misconduct. This proposal will require tight definition. For example, what will be effect of this provision on trainees and students acting under supervision or on supervising practitioners?

In 11.6.1 option 3 is preferred.

In conclusion, the Royal Australasian College of Surgeons notes with dismay that this consultation paper, like the earlier paper addressing registration and accreditation issues, acknowledges no role for specialist medical colleges. This should be a matter of the greatest concern to the Australian public. The colleges have ensured the highest standards of clinical care for generations of Australians. We understand from consultations that this oversight is now understood and we therefore look forward to appropriate recognition of the role of specialist medical colleges in future documents.