Avant Mutual Group Limited

Submissions to the Minister for Health with respect to the review into the Performance of the QBMBA, MBA and AHPRA

1. Introduction

Avant's role in medicine and the regulation of doctors

Avant Mutual Group Limited ("Avant") is Australia's leading medical defence organisation and one of Australia's leading mutuals, offering a range of insurance products and expert legal advice and assistance to over 60,000 medical and allied health practitioners and students in Australia. Our insurance products include medical indemnity insurance for individuals, practices and private hospitals and private health insurance, which is offered through our subsidiary The Doctors' Health Fund Pty Limited.

We also provide extensive risk advisory and education services to our members, as well as access to medico-legal assistance via our Medico Legal Advisory Service. We have offices throughout Australia, providing personalised support and rapid response to urgent medico-legal issues. Our Queensland office assists Queensland Health Practitioners in complaints managed by the Australian Health Practitioner Regulation Agency (AHPRA),Health Quality and Complaints Commission(HQCC) and the Queensland Board of the Medical Board of Australia (QBMBA).

It is from this perspective that we provide our submissions on the performance of the QBMBA, its agency, AHPRA and the HQCC.

Overview

Avant supports the strengthening of the Health complaints management system in Queensland. It is clearly important from an overriding public interest aspect but also to provide a robust system to protect the rights of the individual health practitioner. The "*Blueprint for better healthcare in Queensland*" is a strong plan full of excellent initiatives for a better health system in Queensland. Part of that Blueprint is providing patients with a voice to be heard whether to compliment or to complain. Strengthening the health complaints system is part of encouraging that voice.

We consider that Queensland does not need to take the step of adopting a co regulatory system simply to strengthen the states health complaint entities. Avant supports the National Registration and Accreditation Scheme for reasons of national consistency and to support health practitioners being able to work freely within Australia. State governments have invested heavily in building the National Scheme which has been recognised as a leading scheme in the international health regulatory field.

In strengthening a health complaint system there needs to be a careful examination of the weaknesses in that system. Justice Chesterman reviewed the potential weakness and was scrupulously careful in making specific findings based on the evidence placed before the Inquiry.

He did not respond to the exaggeration of the press nor was he swayed by witnesses whom he found not to be credible. He made clear findings that there were no concerns in many areas. In particular he found no evidence of systemic failure in the registration of medical practitioners, nor in the investigation of complaints against them. He found "*indications*"[1] that QBMBA may not adequately respond to the substance of complaints and may too readily find complaints to be unsubstantiated.

Furthermore although Mr Hunter's subsequent review resulted in the referral of six medical practitioners to the police, there is insufficient information to state with confidence that there were failures in the investigatory or disciplinary processes taken by the QBMBA in these cases.

Below, we provide some examples of matters which in our view could have been better handled by AHPRA in Queensland. We suggest improvements in processes that aim to resolve these weaknesses without the need to create a separate co –regulatory system of investigation and prosecution of complaints.

The Minister has various means of implementing improvements such as by regulation, standards, practice notes and policy.

2. Background to the review

The Chesterman report and Hunter review

The current review arises from the Chesterman report. That report was in itself a response to allegations by a former Medical Board investigator (Ms Barber) and a former MP that the Queensland Medical Board had failed systematically to properly investigate and take action with respect to instances of serious misconduct, and allowed doctors who were a danger to the public to continue practising. Justice Chesterman found that a number of the allegations by the whistleblower Ms Barber were "*plainly wrong"* and that "*these errors cast considerable doubt on [her] credibility as a complainant*".[2] He also found that her allegation that the QBMBA had comprehensively failed to maintain adequate standards of medical practice was not justified.

Justice Chesterman had limited criticisms of QMB/QBMBA/AHPRA. He was concerned about delays in investigations (a criticism Avant supports for the reasons set out below). He found "*indications*" that QBMBA may not adequately respond to the substance of complaints and may too readily find complaints to be unsubstantiated.

A further review by Mr Hunter SC from a starting point of 3,318 files has resulted in a recommendation that six doctors be referred for investigation by police. Mr Hunter cautioned the reader of his report in the following terms:

[1] Assessment Report into allegations made by Ms Jo-Anne Barber in a statement dated 21 April 2012 and a submission delivered 8 May 2012 contained in *Crime and Misconduct Commission*'s *Assessment of a Public Interest Disclosure,* Report No 87 July 2012, 46

[2] ibid, 42.

> *The identification of each case as one that should be examined by the police should not be taken as suggesting that there exists, at present, admissible evidence that establishes a prima facie case in respect of any criminal offence.*[3]

It should not be assumed that any of the six doctors in question will in fact be found to have committed a criminal act. It is important in such matters that any decision maker strives for a balanced and objective consideration of the issues. There is a tendency with allegations against doctors for media coverage to be exaggerated and sensational in nature. Thus the media reported when the Barber allegations were first aired that there was a doctor on the Gold Coast who had murdered one or more patients. Those matters were referred to Queensland Police who decided that there was insufficient evidence to lay any charges against that doctor.

There are clear areas for improvement, particularly in terms of reducing the time taken to investigate matters. However those improvements can be made within the existing system without opting out of the national system. It would still provide a high level of protection for the public while recognising the professional character of health practitioners, and the need to understand the complex nature of the practice of medicine.

Demonisation of medical error

In terms of general approaches to investigating allegations against health practitioners it is vital to start from the premise that the vast majority of health practitioners are caring professionals whose primary objective is to act in the best interests of their patients. Further, professionals do make errors. Whilst governments, both federal and state, should strive to reduce medical error as much as possible, it is important to seek to achieve this in a way which does not portray errors as automatically indicative of conduct which must be punished. A referral to the criminal system should only be made where there is clear evidence of intent to harm patients or such a gross level of carelessness that criminal sanctions are the only appropriate response. The number of cases which fall into this category are extremely rare.

Avant submits that the following comments, made almost 60 years ago by Lord Justice Denning, an eminent English judge, and some made only 4 years ago by Justice Fryberg, a current Queensland judge, are relevant and compelling in relation to the general approach to such issues:

Lord Denning said in a case of *Roe v Minister of Health*[4]:

> *It is so easy to be wise after the event and condemn as negligence that which was only a misadventure. We are always to be on our guard against it, especially in cases against hospitals and doctors. Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks. Every surgical operation is attended by risks. We cannot take the benefits without taking the risks. Every advance in technique is also attended by risks.*
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> *……These two men have suffered such terrible consequences that there is a natural feeling that they should be compensated. But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to*

[3] Review of file held by the Medical Board of Queensland, Queensland Board of the Medical Board of Australia and the Australian Health Practitioner Regulation Agency, *Report to Minister for* Health, 28 February 2013, 1

[4] [1954] 2 QB 66 at 83

think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospital and doctors work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure.

Justice Fryberg said in a case alleging manslaughter against a gynaecological oncologist[5]:

Finally, in relation to medical negligence, may I just say one thing which may be of assistance to those who are in charge of arranging systems.

The problem of medical negligence in hospitals is a recurrent problem, and one which has caused a lot of stress over many years. In my view, it will not be adequately dealt with until hospitals are able to institute a system of full and frank morbidity and mortality conferences, perhaps on a weekly basis, where all involved in medical operations which go wrong, or which indeed are near misses, can disclose what happened without fear of retribution in much the same way the system for airline pilots and air traffic controllers presently exist.

To achieve that, those involved, the individuals involved, must be protected from liability. If they are not to be made liable for their full and frank disclosures and to have those used against them, there must be a system of no fault compensation for the victims of medical negligence.

One thing is certain: the sort of process that we have had in this trial is not appropriate in such ordinary medical negligence cases.

An effective health complaints system must incorporate principles of transparency, openness and, most importantly, fairness.

3. Case studies

Appropriateness of referrals to the QBMBA

Justice Chesterman was concerned that QBMBA rejected some recommendations for action made by the HQCC or APHRA. In Avant cases where this occurred, we consider QBMBA's decisions were fair and appropriate.

The QBMBA refused to accept a referral from the HQCC where the allegation was that a GP had failed to diagnose a tumour close to the patient's heart. The GP had seen the patient on 9 December when he complained of reduced exercise tolerance and reduced lung function. The GP ordered a chest x-ray which was essentially normal apart from noting the outline of the heart was at the upper range of normal, and suggested possible correlation with symptoms of congestive cardiac failure (CCF). The GP saw the patient on 12 December went through the x-ray report and carried out spirometry to assess the patient's respiratory function. Although he did not record it in his notes he asked the patient about whether he had symptoms of CCF and the patient did not have such symptoms. As the patient still felt unwell he went to local hospital on 21 December where a decision was made to perform a CT scan and the tumour was identified.

[5] *R v Ward* Qld Supreme Court, Indictment 955/08, transcript of hearing (18.08.09)

The HQCC referred the matter to the QBMBA on the basis that the GP had not recorded in the notes for 12 December that he had enquired about symptoms of CCF. The QBMBA rejected the referral as it felt there was no basis for the GP to organise a CT scan earlier, and in any event a diagnosis 9 days earlier would have made no difference to a condition which took many months to develop.

Avant considers that the suggestion of the HQCC that a failure to record the enquiry about CCF should result in disciplinary action against a practitioner who had been in practice for 37 years without a previous complaint was extreme and fully agreed with the decision of the QBMBA.

The discretion to take a different approach from one recommended by the HQCC is an important part of a robust but flexible regulatory system. If a body such as QBMBA does not adopt such an approach there is the potential waste of valuable resources with no public benefit. In cases of serious professional misconduct the QBMBA does take appropriate action. In addition the fact that there is, according to one expert or a regulatory body, some serious misconduct, does not mean that this will be the finding after an impartial and fair hearing. Having the ability to evaluate the medical evidence and to realistically judge the performance of the medical practitioner is vital.

Delay in Investigations

Delays cause significant stress and disruption to the health practitioner concerned, as well as to the complainant, and risks reducing public confidence in the complaints handling system. Below are three examples of delay in investigations.

Case 1 – Dr W

Allegations of serious incompetence about a gynaecological oncologist were made in 2002. The QBMBA became aware of these in 2002. The matter was investigated. In 2006 a decision was made to refer the medical practitioner to a Professional Conduct Review Panel. In 2007 a decision by the Deputy State Coroner was made referring the medical practitioner for manslaughter charges relating to the death of a patient. The manslaughter trial was held in 2009. The charges were dropped by the DPP after four weeks of evidence and an indication by the presiding judge that the evidence did not support the charges. The disciplinary proceedings by the Medical Board are still incomplete.

Case 2 – Dr B

Allegations of serious incompetence in the performance of cardiac surgery were made in 2006. An investigation commenced. In November 2011 a decision was made to refer the matter to QCAT. To date no notice of referral has been received.

Case 3 – Dr G

Allegations of serious errors were made in 2007. The investigation concluded in 2010. The proceedings have only just been concluded, 6 years later.

Denial of Natural Justice

We have assisted members who have been denied natural justice and procedural fairness in not being provided with relevant documentation, both in the context of a complaint and in relation to decisions about renewal of registration. Time is then taken negotiating the release of information, which adds to the cost and impedes the timely resolution of the matter.

For example, on many occasions we have assisted members who have been asked by AHPRA to provide an initial response to an incident which occurred years ago and sometimes in a hospital or clinic in which he or she no longer works. Our member does not have access to the relevant clinical records. These requests come in the context of AHPRA conducting a preliminary investigation prior to deciding whether to take further action, and the practitioner is asked to provide a response within 21-28 days.

Frequently, when asked, AHPRA itself does not have the relevant records. All complainants are asked to sign a consent form allowing AHPRA to gather relevant medical records and to provide these documents to the medical practitioner under investigation. Yet despite having the consent of the complainant AHPRA either refuses to obtain the records, or, if it does obtain the records, to provide them to the medical practitioner under investigation.

The medical practitioner therefore is in the difficult position of having to provide a response from memory. Given the potential ramifications for the medical practitioner's registration/career, this is unsatisfactory. AHPRA should obtain the records and make them available to the medical practitioner.

After investigations are concluded the QBMBA is refusing to release investigation reports – something which previous regulators did. Clearly to understand how a complaint has been dealt with and the evidence gathered a medical practitioner needs to see the investigatory report. This approach is surprising for a body that has transparency as one of its core values.

When the QBMBA receives a referral from the HQCC, AHPRA refuses to release the material provided to it by the HQCC. For a medical practitioner to effectively and fairly respond, all information in AHPRA and/or QBMBA's hands should be produced. When AHPRA declines to provide relevant documentation, the medical practitioner's only recourse is to apply to the Information Commissioner or QCAT for release of these documents. This results in unnecessary costs.

AHPRA's *Service Charter* states that AHPRA will apply principles of procedural fairness in dealing with notifications. A fundamental rule of natural justice requires the disclosure of relevant information to a medical practitioner in relation to the notification to enable him or her to properly prepare a response to the allegations. This also applies to any new issues which may arise during the course of an investigation.

4. A nationally consistent approach

The Queensland system follows the National Law. The NSW system has opted out of Part 8 of the National law. This has created significant difficulties not only in terms of consistency in managing matters across states and the outcomes from such processes

but also in connecting national registration processes with the NSW complaint system. In Avant's submission a nationally consistent approach is preferable.

Appropriate principles to apply

In Avant's submission the principles which should apply for an effective regulation of health practitioners are as follows:

1. There should be a clear process for patients to make complaints or raise concerns about competence or misconduct;

2. Allegations should be investigated by a body with sufficient investigatory powers, an understanding of the practice of medicine, and an understanding of the role of a regulator in protecting the public;

3. The legislation and the process should support the rights of health practitioners to be given all relevant material under consideration by an investigatory body, and to be given a sufficient opportunity to respond to that material;

4. Investigations should be completed within a reasonable period of time. It should only be the exception for investigations to extend beyond 6 months. If it is to extend beyond this, there should be a case management system, overseen by a body such as QCAT. If an investigation is going to go for more than 12 months there should be a detailed review of the investigation by QCAT with a requirement for a time limit to be set for the completion of the investigation.

The current system satisfies principles 1 and 2. However, principles 3 and 4 have not been satisfied in a number of cases, examples of which are outlined above. Avant suggests that the National Law be amended to implement principles 3 and 4.

Suggestions as to the amendments which ought to be made are set out in attachment **A**.

5. Conclusion

AHPRA and the state and territory boards have an important role in protecting the public, but must ensure that health practitioners who are the subject of complaints are treated fairly within an appropriate time frame. Complaints have a significant impact on health practitioners. Delays and administrative errors create further unnecessary anxiety and a loss of public confidence.

Better resourcing, administrative systems and staffing of AHPRA nationally, rather than Queensland seeking its own solution, will provide the National Scheme with the ability to protect the Queensland public.

Avant contact details

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Attachment A – Suggested amendments to National Law

1. In section 166 insert -

(2) The investigation report required by subsection (1) of this section must be provided to the relevant National Board within 6 months from the date of the decision to direct an investigator to conduct an investigation;

(3) If an investigator directed under section 160 to conduct an investigation is unable to complete an investigation within the time required by subsection (2) of this section, the investigator must inform the Board and the practitioner or student the subject of the investigation of this fact at least 14 days before the expiration of the time required by subsection (2),and provide a schedule identifying the what steps remain to complete the investigation and a time table of not more than another 6 months from the expiration of the time required by subsection (2) for the completion of the investigation;

(4) If the practitioner or student the subject of the investigation is unwilling to accept the proposed time table for the completion of the investigation he or she may apply to the Tribunal for directions with respect to the investigation and its completion;

(5) Any investigation which has not been completed within 12 months from the decision to conduct an investigation must be referred to the Tribunal by the relevant Board for directions on the completion of the investigation within 28 days from the expiration of the 12 month period

2. Amend section 179(3)(b)(i) so it reads:

(b)(i) investigated the registered health practitioner or student under Division 8 and the health practitioner and student has in that process being provided with all relevant information and documentation (exculpatory and inculpatory) with respect to the issue being investigated, and a reasonable opportunity to respond to any potential adverse findings raised by the evidence gathered during the investigation, and to make a submission about the appropriate action the Board should take if findings adverse to the practitioner or student are made.

3. Insert a new section – 167A Requirement for full disclosure

(1) Whenever a national board is required to inform a registered health practitioner or student of the receipt of a notification under section 152, a notice to show cause under section 157, a notice of a decision under section 161, a requirement to undergo an assessment under section 172 and a show cause process under section 179, the Board or any entity or person acting as its agent must provide to the practitioner or student any and all of the following documents as are within the Board's or its agent's possession or within its power to obtain:

(a) Copies of any complaint, notification or statement making allegations against the practitioner or student;
(b) Copies of all medical or hospital records including pathology reports, radiology films, correspondence or other clinical records relevant to the issues under assessment or investigation or the subject of possible action;

(c) Copies of all expert opinions or reports or nots setting out the substance of such opinions and reports obtained by the Board or its agent or provided to the Board or its agent by another statutory entity or entity with power to refer matters to the Board such as the HQCC, Coroner, Police, Medicare etc;

(d) A copy of any investigation report provided to the Board pursuant to section 166 of the relating to the practitioner or student together with copies of all documents annexed to that report or referred to in the report and within the Board's possession or power or the possession or power of its agent.