Further Submission to Senate Community Affairs References Committee

By Professor Paddy Dewan

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for inquiry and report on the medical complaints process in Australia.

To

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Dear Committee,

I note that I am willing for this submission to be made public under parliamentary privilege, a submission that deals with a range of issues that need to be considered to create the necessary culture change in healthcare.

The major problem:

A lack of transparency, accountability, good governance and appropriate legislative framework at all levels of health administration and regulation.

The solution is to improve each of the above through, but not limited to:

1. Patient-centric measurements of outcomes of CARE
2. Clinical audits with feedback loops.
3. All health service administrators to have performance criteria.
    a. Relate to patient CARE outcomes.
    b. Related to staff welfare.
4. Mediation as a default in all conflicts.
5. Hot-tubbing to be involved in all major disputes related to performance and CARE.
6. Regulators to assess clinical scenarios using clinical experts, including international experts where appropriate.
7. Regulators should insist on medical truth, and not accept legal argument.
8. Management of conflict of interest in and between the organisations listed below.
9. Review and make changes to:
    a. AHPRA
        i. Expressions of concern for a colleague should be handled differently to complaints.
        ii. An single adverse event only under exceptional circumstances be considered to warrant action by AHPRA.
        iii. Default to mediation.
        iv. Evaluation of complaints by medical experts in collaboration with community representative, not “complaints officers”.
        v. Performance criteria, related to impact on quality healthcare, for staff, committees and Board members.
        vi. Limitation to duration of appointments to committees and Boards.
        vii. A Forrester style review of all complaints to all Boards.
        viii. Improve the rules evidence.
        ix. Impose time-lines.
        x. Improve legislation to counter vexatious claims.
        xi. Compensate those harmed by AHPRA’s poor current and past performance.
        xii. AHPRA prosecutes, then manages the “punishment” – there should be division of these powers, and from registration.
        xiii. AHPRA should not punish, they should guide.
        xiv. There should be sanctions for legal Council who run an adverse case that is disproven.
        xv. Compensation should be given to those who are vexatiously litigated against.
        xvi. Sanctions against vexatious claimant by healthcare professionals should be actioned by AHPRA.

b. Civil and Administrative Tribunals
    i. Improve the rules of evidence.
    ii. Conduct a Forrester style review of all Administrative Tribunal cases.
    iii. Performance criteria of all panel members.
    iv. Compensation for those against who adverse action has inappropriately been taken.
    v. Mediation for call cases.
    vi. All hearings should be “in camera” to protect the reputation of the innocent clinician.
    vii. Hot-tubbing for all aspect of medical opinion in medical management cases.

c. National Ombudsman
    i. Performance criteria for all complaints officers.
    ii. A Forrester style investigation of all complaints.

d. Health Service Commissioner
    i. Review of time-lines.
    ii. Performance criteria for complaints officers.
    iii. Improve legislation that goes beyond the provider have to agree to medication.
    iv. Commence a Forrester style investigation into complaints management and outcome.

e. Medical Indemnity Insurance
    i. Legislate so that cases in which there is a targeting of an individual are managed differently to those of clear underperformance.
    ii. Currently, as a result of a series of vexatious complaints, manpower is lost because the practitioner is declared uninsurable.
    iii. Medical indemnity providers should be involved in action against AHPRA.

f. Health Service Administration
    i. Ensure that a finding by a regulator that does not limit the work opportunities of a healthcare professional is not inappropriately used by a health service.
    ii. Hospital administrators should be prevented from making complaints to AHPRA against their own staff.

g. Coroner
    i. Review time-lines.
    ii. In medical management outcomes, mediation between the family and provider should be facilitated.
    iii. Evidence should be collected from hot-tubbing.
    iv. Cases should be able to be set aside by the provision of new evidence, not because of errors of law.

h. Supreme Court processes

i. Cases related to medical management, including Administrative Tribunal and the coroner's court should be able to be overturned on new evidence, not just errors of law.

Other problems are:

a. The blame mentality.
    i. When there is a workplace cultural problem, an individual is expected to mount a case against an individual and accuse them before action is taken. Such an approach creates an attack and counter attack, blame mentality.
    ii. When an adverse event occurs the questions focus on "who" not "what": audit meetings in surgical units do not usually have a feedback loop, and almost never involve a root-cause-analysis. Any lessons learnt are soon lost.

b. A legalistic frame-work
    i. To practice medicine it is mandated that you have to have insurance; by AHPRA.
    ii. Discussions of bullying, harassment and mobbing are given "legal" definitions, rather dealt with in the understanding that if someone has had their career inappropriately harmed, it is bulling.

c. Health provision governed by budgets, not quality.

d. The media tells a story, libel laws don't provide adequate protection, and yet another healthcare professional is lost.

e. Suicides while under investigation by AHPRA.

Yours sincerely

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