PARLIAMENT OF NEW SOUTH WALES

Interim Report Of The Committee On The Health Care Complaints Commission

Discussion Paper

on

Investigations and Prosecutions Undertaken by the Health Care Complaints Commission

November 2002

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COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

Inquiry into the Procedures Followed During Investigations and Prosecutions Undertaken by the Health Care Complaints Commission

The Committee has produced a Discussion Paper addressing issues raised during the Inquiry. Copies of the Discussion Paper may be obtained on request from the Secretariat (telephone (02) 9230 3011), or via the Parliamentary website:

www.parliament.nsw.gov.au

The Committee is seeking submissions on the Discussion Paper (in writing, typed or on disk) to further assist the Inquiry.

Submissions should be addressed to:

Committee Manager
Committee on Health Care Complaints Commission
Parliament House
Macquarie Street
SYDNEY NSW 2000

Alternately, they can be sent by FAX to (02) 9230 3052

The closing date for submissions is: 21 February 2003.

Jeff Hunter MP
Chairman

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Functions of the Committee

The Joint Committee on the Health Care Complaints Commission was appointed in 1993. Its functions under Section 65 of the Health Care Complaints Act 1993 are:

a. to monitor and to review the exercise by the Commission of the Commission's functions under this or any other Act;

b. to report to both Houses of Parliament, with such comments as it thinks fit, on any matter appertaining to the Commission or connected with the exercise of the Commission's functions to which, in the opinion of the Joint Committee, the attention of Parliament should be directed;

c. to examine each annual and other report made by the Commission, and presented to Parliament, under this or any other Act and to report to both Houses of Parliament on any matter appearing in, or arising out of, any such report;

d. to report to both Houses of Parliament any change that the Joint Committee considers desirable to the functions, structures and procedures of the Commission;

e. to inquire into any question in connection with the Joint Committee's functions which is referred to it by both Houses of Parliament, and to report to both Houses on that question.

Committee Membership

Legislative Assembly

Mr Jeff Hunter MP - Chairman
Ms Marie Andrews MP – Vice-Chairman
Mr Wayne D Smith MP
Mr Peter W Webb MP

Legislative Council

The Hon Dr Brian Pezzutti, RFD, MLC
The Hon Henry Tsang OAM , MLC
The Hon Dr Peter Wong AM, MLC

Secretariat

Ms Catherine Watson – Committee Manager
Ms. Jackie Ohlin – Project Officer
Mr Keith Ferguson – Committee Officer
Ms Glendora Magno – Asst. Committee Officer

Terms of Reference of the Inquiry

The Committee is to inquire into and report on:

(a) the procedures followed by the Health Care Complaints Commission during the investigation process;

(b) the amount of evidence currently considered sufficient by the Health Care Complaints Commission and the NSW Medical Board to prosecute a case before the NSW Medical Tribunal;

(c) the treatment of cases referred by other government agencies such as the Health Insurance Commission;

(d) possible ways in which the investigation and prosecution process can be improved;

(e) the investigation and prosecution process in comparative jurisdictions;

(f) other relevant matters.

Chairman's Foreword

For many years a significant number of concerns have been raised with the Committee by stakeholders about the operations of the Health Care Complaints Commission, its enabling legislation the *Health Care Complaints Act* 1993 (NSW) and the associated health professional registration acts.

The current New South Wales system of dealing with health care complaints, particularly the investigation, prosecution and discipline of health care professionals, was unique when it was introduced.

I am aware of only one other jurisdiction, New York State in the United States, which had previously placed investigation and prosecution of health professionals in the hands of a government agency. In New York these functions are performed not by a separate autonomous government agency but by a Board within the New York State Health Department.

The Australian Capital Territory and New Zealand have subsequently borrowed from the New South Wales model.

New South Wales is to be applauded for adopting the system that it has. It was, at the time, a very controversial move to take over responsibility for investigation and prosecutions from the registration boards but this action did much to restore public confidence in the health system in the years following the Chelmsford Royal Commission.

Investigating and prosecuting the health professions has been a large cost and responsibility for the New South Wales government to undertake. Self regulation remains the norm in virtually all other Australian jurisdictions (except the ACT) with registration boards undertaking investigations and prosecutions.

In the other Australian States and Territories the role of government health care complaint bodies which are called either Commissions, Offices or Ombudsmen, is mainly to conciliate non disciplinary complaints.

As would be expected with any entirely new scheme, the New South Wales system has been for some time in need of refinement. This was anticipated in 1993 when the *Health Care Complaints Act* was introduced. Section 104 of the legislation provided for a legislative review after three years of its introduction. One such review was undertaken in 1997. However, to date the legislation has not been amended.

When the Committee began this inquiry it anticipated that it would be issuing a final report at this stage. However, as the inquiry has progressed it has become increasingly clear that there are a significant number of strong stakeholder voices who want their views to be heard. There have also been many serious issues which have emerged during the inquiry.

The Committee gradually took the view that many of the recommendations of any report it produced would involve amending the relevant pieces of legislation. It further took the view that legislative amendment should not be anecdotal or piecemeal. Rather, the Acts should be looked at as holistically as possible in light of the issues which have arisen.

Many of the over 100 written and oral submissions that the Committee received during the course of the inquiry tended to focus on one or two issues which were pertinent to the stakeholder. By producing a Discussion Paper the Committee would like to focus all interested parties on the main issues which have emerged.

The *Health Care Complaints Act* and the complimentary sections of the health professional registration Acts are important pieces of legislation. They not only protect the public but effect professional careers and livelihoods. Therefore it is important to get any proposed legislative and administrative changes as right as we can. Hence, the compilation and tabling of this Discussion Paper.

The Committee looks forward to receiving submissions on the Discussion Paper over the next three months.

In conclusion, I would like to thank all those who have participated in the Committee's inquiry to date. This has been one of the most important and detailed inquiries that the Committee has thus far undertaken. In particular the Committee thanks the Health Care Complaints Commissioner, Amanda Adrian and her staff, the New South Wales Medical Board and United Medical Protection for their detailed written submissions and supplementary oral evidence. I would also like to thank my fellow Committee Members and the Committee Secretariat for their enthusiasm and dedication to this inquiry.

Jeff Hunter MP
Chairman

Assessment of Complaints

Should the HCCC be given the power to make preliminary inquiries of all relevant parties?

The Health Care Complaints Commission believes that it is currently hampered by its lack of power to compel responses from health providers and professionals before going to a full investigation.

In its submission to the Committee it was argued that greater powers would result in speedier resolutions of complaints.

Currently Section 21 of the *Health Care Complaints Act* 1993 allows only for the HCCC to require that the complainant, not the provider or practitioner which is the subject of the complaint, provide further particulars in relation to the complaint. A decision to proceed to investigation is therefore generally made on the evidence produced by the complainant alone.

Providing the HCCC with greater powers to seek responses from all relevant parties would arguably stop many matters proceeding to full investigation as a fuller picture of the substance of the complaint should emerge during the assessment stage. Other resolution options such as conciliation can then be better utilised.

This would have the effect of, in many cases, turning the assessment step into a type of "preliminary investigation."

An examination of the relevant legislation in the other Australian states indicates that all Commissions/Ombudsmen/Offices which deal with health complaints are given the power to seek evidence from all relevant parties at the preliminary stage. Western Australia, the ACT, Victoria, South Australia and Tasmania allow their agencies to make all inquiries as they deem fit.

The Northern Territory and Queensland agencies are more curtailed but are allowed to make inquiries of the subject of the complaint.

The New Zealand Health and Disability Commissioner has similarly asked for powers to make preliminary inquiries in the review of the New Zealand legislation which is presently being undertaken.

Should the HCCC be given coercive powers to seek responses at the assessment stage?

In its submission to the Committee the HCCC further specifically requested that it be given a new provision making failure to co-operate with a preliminary investigation professional misconduct. The HCCC believe that professional associations and defence organisations currently encourage practitioners not to provide responses until the final stage of investigations.

An examination of government health complaint bodies in other states indicates that only the Northern Territory and South Australia currently possess coercive powers to seek responses at the preliminary inquiry stage. In South Australia the Ombudsman deals with health complaints and therefore the Ombudsman's powers which are analogous to that of a Royal Commission apply. In the Northern Territory the Ombudsman, who deals with Northern Territory health complaints, may impose a penalty of $5,000.

The health professional registration boards which conduct the investigation and prosecution of serious complaints in the other states do possess coercive powers to require responses to complaints at any stage as do the New South Wales health professional registration authorities. The New South Wales Medical Board, for example, is given this power under Section 127C(1) of the *Medical Practice Act* 1992.

It is currently open to the HCCC to request that the registration boards utilise this power on their behalf should they be given greater powers to make preliminary inquiries of parties other than the complainant. However, the HCCC consider this to be a *cumbersome and unnecessary barrier.*

Should the timeframe for assessment of complaints be changed?

Under Section 22 of the *Health Care Complaints Act* 1993 the HCCC is given a maximum of 60 days in which to assess a complaint.

Many of the government health complaint bodies in the other states which have greater information gathering powers at the preliminary inquiry stage are given shorter timeframes for complaint assessment.

The Victorian, Western Australian and Queensland agencies have 28 days with an ability to extend for another 28. Tasmania has 45 days to complete an assessment. The South Australian and ACT agencies have no time limits imposed.

The deadline operates from the time all responses have been received.

If the HCCC is given greater powers to gather and/or require information at the preliminary assessment stage should the assessment timeframe be shortened to ensure that the assessment does not become a quasi investigation?

Should there be a timeframe to notify complainants and respondents about the outcome of assessments?

Under the current legislation the HCCC is not given a timeframe by which it must notify complainants and respondents of the outcome of assessments.

The Victorian, Queensland, Western Australian and Tasmanian government health complaint bodies are all required to do this within 14 days.

Should the HCCC similarly be given a maximum time period in which to notify the relevant parties?

Should the more severe view of the matter prevail in decisions to proceed with investigations?

Section 13(1) of the *Health Care Complaints Act* provides that *if either the Commission or the appropriate registration authority is of the opinion that a complaint should be investigated, it must be investigated.*

This effectively means that a matter can be forced into the investigation phase as a result of only one of the agencies' views. There have been concerns raised that this provision is unfair and/or overly stringent. A concern was also raised about transparency as it is not known which body ultimately made the decision to investigate in each case.

In Queensland the Minister for Health decides a matter when a registration board and the Health Rights Commission cannot agree.

Should decisions to investigate be by consensus of both the Health Care Complaints Commission and the relevant registration authority only?

Should an independent arbiter or panel of experts be appointed to decide when the Health Care Complaints Commission and the relevant registration authority cannot agree?

Investigations

Should a statutory declaration remain necessary to begin an investigation?

In its written submission to the Committee relating to this inquiry the Health Care Complaints Commission argued that its performance would be improved if Section 23(3) of the Act was deleted. This section of the Act requires the complainant to verify his/her complaint by statutory declaration before an investigation can begin.

The Commission argued that because it had already formed a view about the complaint in the assessment stage and the decision to investigate was then mandatory the requirement of the statutory declaration was an unnecessary administrative burden. It was also argued that following an investigation the details of a complaint when it ultimately goes before a disciplinary body may be very different from those provided by an original complainant.

The counter argument would be that the damage which may be done to a health professional's career as a result of an ongoing investigation can be significant even if the case is not eventually found to be substantiated. Apart from the obvious stress involved for the practitioner, career opportunities may be missed. In some cases, Area Health Services have even suspended practitioners for the duration of the investigation. Requiring a statutory declaration from the complainant places a legal burden on that complainant to be as truthful as possible.

Should the HCCC have a discretion to investigate matters which may fall under Section 23?

Section 23 of the *Health Care Complaints Act* 1993 provides that the HCCC must investigate a complaint in the following circumstances: if the appropriate registration authority considers it is warranted; if following assessment of the complaint it appears to the HCCC that the matter raises a significant issue of public health and safety; if the matter raises a significant question as to the appropriate level of care or treatment given; or if the matter provides grounds for disciplinary action or involves gross negligence.

A strong argument can be made that compelling the HCCC to investigate in all these circumstances rather than providing a discretion results in matters being forced into investigation which may have been better handled by alternate means. For example, a matter cannot be referred to conciliation once it has

gone to an investigation. There may also ultimately be a degree of duplication with other agencies such as the Coroner. Ultimately this ties up resources and contributes to delays.

Health care complaints bodies in other states are not compelled to investigate in such a prescriptive way. Similarly, other watchdog agencies in New South Wales such as the Independent Commission Against Corruption, the Ombudsman and the Legal Services Commissioner are given a discretion to investigate.

The New Zealand Health and Disability Commissioner, the model which is arguably most similar to the HCCC, has been required to investigate every complaint alleging substandard health care or disability services since 1 July 1996. Already the system is considered too onerous and the requirement is being replaced by a discretionary power. In the words of the New Zealand Health and Disability Commissioner *"the current process is slow, results in too many investigations, and is stressful on all practitioners….pending legislation will give a discretion to determine whether an independent investigation is necessary or appropriate, and will ensure better information sharing between key agencies involved in the complaints process". (Paper presented at the 14th World Congress on Medical Law 11-15 August 2002)*

Should the HCCC be provided with greater powers to gather evidence during an investigation?

The HCCC have long argued for greater powers in relation to the gathering of evidence during an investigation. It is considered that this would expedite the investigation process. The HCCC believes that practitioners are discouraged by their professional organisations and medical defence organisations from providing information to the HCCC until the investigation reaches its final stages under Section 40 of the *Health Care Complaints Act.*

Sections 32 and 34 of the *Health Care Complaints Act* 1993 provides the HCCC with exactly the same powers to investigate matters as the New South Wales Police Service and the Director of Public Prosecutions. This essentially means that investigation and evidence gathering must be by consent of the owner or occupier or by search warrant awarded by an authorised officer of the court.

In its submission to the inquiry the HCCC argued that it should be awarded with the following powers:

- *A new power allowing the Commission to require the production of key information;*
- *A new power allowing the Commission to obtain a response from a practitioner about specified matters;*
- *A new power enabling the Commission to require a person to present for interviewing;*
- *Provision of a less circumscribed power to enter, search and seize.*

As previously mentioned, it is currently open to the HCCC to request that the New South Wales Medical Board compel the evidence from medical practitioners on their behalf. Penalty for non-compliance can be a charge of unprofessional conduct.

However, the HCCC argue that:

> *…this is a cumbersome and unnecessary barrier to the expeditious investigation of complaints. As the Commission acts in the public interest and has a statutory obligation to investigate, it would be appropriate that such a provision also exist in the Health Care Complaints Act 1993.*

Government bodies which deal with health care complaints in other states possess an array of evidence gathering powers. In Victoria Section 25 of the *Health Services (Conciliation and Review) Act* provides the Commissioner with a power to subpoena for documents under the *Evidence Act.* Search and seize warrants must be issued by a magistrate.

Queensland, Western Australia, South Australia, Northern Territory, Australian Capital Territory and Tasmania provide their health care complaints bodies with the power to require a practitioner to produce documentation, give information or attend at a place or time to answer questions. A variety of financial penalties apply.

Speeding up investigations

The time taken for the HCCC to investigate complaints has been an major issue raised in submissions. In 38 per cent of the submissions received, delays in the investigation process was a major theme.

The Commissioner has outlined a process to reduce the backlog in investigations in the immediate future. This process includes engaging additional investigations staff and restructuring within the HCCC. This restructuring includes improvements in workplace relations; improvements in relationships with other stakeholders; revised practice manuals for investigations and prosecutions; organisational restructure and changed reporting arrangements.

The Committee is also seeking comment on other ways that the HCCC may speed up their investigation process.

While the Committee acknowledges that each investigation will have its own unique set of facts and circumstances which make it impossible to conform with an externally imposed timeframe, there are still a number of possible ways to improve the process. Some of these methods have been touched on elsewhere in the discussion paper in other contexts.

Could the establishment of targets and benchmarks assist the HCCC?
There are a myriad of watchdog agencies against which the HCCC could benchmark its investigation times.

Would boosting internal clinical expertise available to investigators throughout the investigation enable more structured analysis of the issues and a more incisive inquiry?

As previously mentioned, is there scope for re-assessing Section 23(1) of the Health Care Complaints Act 1993 which apparently compels the Commission to investigate?

Would shortening the timeframes within the Health Care Complaints Act have any significant effect?

Would providing the HCCC with greater coercive powers to require responses and/or gather evidence speed up the process?

Should the HCCC conduct more "active" investigations?

An ongoing issue throughout the inquiry has been the lack of "active" investigations done by the HCCC. The HCCC is perceived by many stakeholders as an agency which merely "writes letters". During the course of the inquiry the Committee saw quite a number of examples of drawn out investigations which were based upon fundamental misunderstandings which were not cleared up until the final stages of the investigation or until they went before a PSC or Tribunal.

Further, health practitioners who were the subject of investigations continually told the Committee they had not spoken directly with a HCCC investigator throughout the entire investigation process. All communication was done by correspondence.

While an investigation process which requires investigators to leave the office and travel out to interview the relevant parties is more resource intensive, it is difficult to imagine the police, for example, conducting entire investigations from a desk in a central office.

The Professional Services Review, the investigative and disciplinary arm of the Health Insurance Commission, always sends a clinician out to interview a health practitioner who is under review.

Would HCCC investigations improve if a more active approach was taken?

Peer reviewers

The HCCC recently updated its *Guidelines for Professional Reviewers and Advisers* (May 2002). The Committee has welcomed the guideline review, noting that it addresses some of the concerns raised about peer reviewers in the course of this Inquiry.

In submissions and evidence provided to the Committee concern was expressed about a range of issues involving peer reviewers: These include:

- Peer reviewers have previously been instructed that they are required to 'help prove the case" against the respondent;
- Peer reviewers are not provided with all of the information relating to a case (rather they receive an edited version from the HCCC investigator);
- Peer reviewers have not received sufficient guidelines and training as to what is expected of them in their report and potentially their role as a witness;
- Peer reviewers are not directed to exclude themselves on the basis of a lack of expertise;
- Peer reviewers have not been selected on the basis of being a "true peer" of the respondent;
- Peer reviewers have been restricted in the opinion they could offer;
- Peer reviewers are not kept fully informed of the respondent's responses;
- Peer reviewers have had no continuity (ie they are not engaged to provide comment on the response to the peer review report as a matter of course).

Addressing these points in turn:

Clearly the guidelines referring to helping to 'prove the case' have changed.

Is there a need for the intent that the peer reviewer to provide independent opinion to be made more explicit and how could this intent be better supported?

In some other Australian jurisdictions peer reviewers are provided with the whole file relating to a complaint. Others emulate the practise of the HCCC in providing a circumscribed range of documents including the medical record, original complaint, records from other treating practitioners and a response from the provider together with a brief and questions from the complaint authority. One concern raised about this latter approach is that in spite of best intentions

the selection of records from the file involves editing the material sent to the peer reviewer.

Should all material be sent to the peer reviewer even if it may seem prima facie extraneous to the complaint?

During the Inquiry the Committee has also received complaints that in investigations involving record keeping the Commission was only selecting a very small sample of patient files for peer review. It was felt that this could lead to a biased finding. The Health Insurance Commission, the Professional Services Review, and the statistician advising the Professional Services Review each confirmed the essential importance of selecting a representative sample of patient files. It was considered that 30 files was the minimum that could constitute a representative sample. Their views were supported by research to indicate the optimum sample size.

Should the HCCC determine what constitutes a representative sample of patient records to send to peer reviewers when cases where peer reviewers are being asked to comment on clinical or behavioural trends or record keeping?

Currently training and guidance is provided for peer reviewers by the HCCC. However, it is clear that at least some of the peer reviewers who responded to this Inquiry were unprepared for their role as a witness before disciplinary bodies

Should training include simulations of appearances before disciplinary bodies?

Currently peer reviewers must disclose any personal, financial or professional connection with the person against whom the complaint is made. The Committee notes and supports the HCCC's recommendation for a strengthening of the statement by peer reviewers and expert advisers regarding personal, financial or professional connection with the respondent to a complaint.

Should this declaration be expanded so that peer reviewers in specialised areas can acknowledge the extent or limits of their particular expertise?

It is noted that in all jurisdictions every effort is made to select peer reviewers with similar expertise. However this remains a concern for respondents in New South Wales who observe that the subtleties of their specialty remain misunderstood by non-specialists in the prosecutorial process.

Should a peer reviewer's declaration identify clearly any possible conditions that could result in a biased opinion (for example, a philosophical opposition to the method of practice used by the respondent)?

In matters where there is contradictory evidence, the peer review guidelines should clearly request that opinion be provided canvassing a range of options or scenarios. Wording to this effect is outlined in section 4.15.3.1 of the HCCC's *Investigations Manual* but there may be a need to strengthen this direction in the

guidelines to ensure that the circumstances as described in the complaint are not merely accepted at face value. While peer reviewers may be given a practitioner's response to a complaint they also need to be told when that practitioner has not been privy to the same amount of information as the Commission. The Committee received a number of submissions and evidence complaining about this unfairness and indicating that the peer reviewer's opinion had changed when confronted with this information at the disciplinary hearing.

Currently the terms of engagement for peer reviewers do not specify as a matter of course the inclusion of a commentary on the respondent practitioner's response to the peer review report.

Should this be included as part of the contract irrespective of whether 'new evidence' is identified asking specifically whether this changes or confirms the peer reviewer's opinion?

Should further check and balances be evident within the Commission about the types of evidence set before a peer reviewer? Clearly there will be circumstances in which information needs to be de-identified.

There may be a need to better ensure that peer reviewers are routinely selected from across the entire range indicated in that pool as opposed to a narrow band of 'willing hands'.

The guidelines for professional reviewers and advisors contain a great deal of introductory material which is not central to the role of the peer reviewer.

Is there a need for three separate and succinct documents – directed at professional advisers, peer reviewers, and experts, respectively?

Would the documents also benefit from a *pro forma* report or checklists reflecting the key points in the guidelines?

Increased clinical expertise

The need for the HCCC to increase the basis of its medical expertise beyond the current Equivalent Full Time of 0.8 persons has been identified by the New South Wales Medical Board and in other submissions to the Inquiry. Currently the HCCC utilises the services of a retired paediatrician and a general practitioner on a part time basis.

The NSW Medical Board has indicated that the system would be enhanced by increased use of *regular, independent medical advice during the Commission's investigations of clinical complaints and by a medical/legal review of matters prior to finalisation*.

Several witnesses have indicated to the Committee that it is important for experts in clinical matters to be appropriately qualified and currently in practice. The New South Wales Medical Board proposes that a breadth of clinical

expertise is required. While there may be resource implications arising from increasing the level of clinical expertise available to the Commission such a move could help to streamline investigations of clinical matters.

Importantly, this outlay could help to curtail investigations which proceed on an incorrect basis. Several submissions identified instances in which the investigation was ultimately flawed because experts in clinical matters were not involved at an early stage if at all. Therefore investigations appeared to have proceeded based upon uninformed or misinformed premises.

The consequences of long drawn-out investigations which are unnecessary are difficult for all parties.

Should greater effort be made to ensure that in all complaints involving clinical matters the optimum levels of relevant clinical expertise are provided?

Greater separation between investigations and prosecutions

The combination of both these functions within the HCCC has always been controversial. The argument has continually been made, primarily by health practitioners and their professional associations, that the two functions should be separated into entirely different agencies similar to the criminal model of the police and the Director of Public Prosecutions. It is considered that such a model would ensure maximum objectivity in the process.

However, it must be acknowledged that in virtually every other jurisdiction in the world complaints against health practitioners are investigated, prosecuted and adjudicated by their respective registration boards.

Separating out the functions would not be without a significant amount of additional cost to the NSW taxpayer. As there are no comparable models within the health field it is difficult to evaluate what the true benefits of separation would be.

However, the Committee has seen a number of examples of cases throughout the course of the inquiry which have collapsed through lack of sufficient evidence, either just before they were due to go before tribunals or before the tribunals themselves. The recent case of Drs Atkins and Liu (heard in the Medical Tribunal 6 May 2002) is an example of this.

Costs of appeals lost in the Supreme Court by the HCCC have been rising significantly. From nil in years 1997-1998 and 1999-2000 to $244,926.09 and $231,934.72 in 2000-2001 and 2001-2002 respectively.

Cases appear only to be usually given to Senior Counsel by the HCCC in the last few days prior to a tribunal hearing as a way of minimising legal costs. In a

number of cases, such as Drs Atkins' and Liu's, problems about the weight of the evidence put forward have then been identified.

The Committee also noted the large number of times complaint particulars are amended when a matter is before a tribunal.

Would the process be more robust if the evidence supporting the case was tested by placing it before external legal Counsel at an earlier stage?

Additional costs incurred may well be offset with a drop in losses on appeals.

Alternatively, is it necessary to separate the functions into two separate agencies to achieve a better "strike rate" in disciplinary matters?

Should practitioners and providers be given longer to make submissions following an investigation?

Sections 40(2) and 43(2) of the *Health Care Complaints Act* provide 28 days for practitioners and providers respectively to make submissions to the Health Care Complaints Commission.

None of the corresponding legislation in other states specifies any timeframe for this step.

Throughout the inquiry practitioners and their defence organisations complained about the difficulties of obtaining a peer review and generally preparing a good defence within such a short timeframe.

Most practitioners who had been the subject of investigations told the Committee it was only at this stage that they were told what all the facts surrounding the case actually were.

Their frustration was exacerbated by the fact that the Health Care Complaints Commission had often taken many years to investigate the complaint. Expecting a response within 28 days merely compounded the feeling of a vast power imbalance between the HCCC and the practitioners involved.

Should the 28 days currently required for a response be lengthened to better allow practitioners more time to prepare a good defence?

Prosecutions and Other Disciplinary Procedures

Procedures of Professional Standards Committees

Complaints referred to Professional Standards Committees (PSCs) after the investigation phase must be determined by way of an inquisitorial hearing. Submissions to the Committee suggest that while proceedings before a PSC may be conducted with little formality they are nevertheless adversarial in nature. Health practitioners, however, are not allowed to be represented. They face questioning by individual members of the Committee and a representative of the HCCC and must cross examine their witnesses themselves without having the benefit of legal representation.

Broad powers have been conferred on PSCs by the health practitioner registration acts *Practice Act* in the relation to these inquiries. For example, the PSC may conduct the proceedings of the inquiry in the manner it deems fit; the proceedings are not open to the public unless satisfied that it is desirable to do so in the public interests of that particular inquiry; and the PSC may issue a direction suppressing the evidence given to the Committee.

The *Medical Practice Act* and similar relevant health professional legislation provide detailed directions in respect to legal representation before the Committee. The respondent practitioner is *entitled……to be accompanied by a barrister or solicitor or another adviser,* but is not entitled to be represented by that adviser. An adviser who is not a barrister or solicitor may be granted leave to address the Committee, and leave may be granted for a person to appear at the inquiry provided that person is not a barrister or solicitor.

Currently an officer represents the Health Care Complaints Commission by leave of the PSC. That officer takes the role of a quasi-prosecutor presenting the evidence of the complaint, examining and cross examining witnesses and making submissions to the Committee. At this stage of the proceedings the Commission has become the legal complainant. Acting on behalf of the Commission that officer's role is to attempt to win the case. While he or she is not legally qualified these officers are specifically trained and have experience in prosecuting cases before the PSC on behalf of the Commission. Many submissions suggested that this process is unfair upon respondents who are usually appearing before a PSC for the first time.

Inquiries conducted by other organisations which undertake inquisitorial type hearings such as state coroners and the New South Wales Police Integrity Commission use officers employed independently of their office to assist in the gathering and presenting of evidence. An inquiry (inquest) conducted by a Coroner in New South Wales is done with the assistance of a police sergeant. That officer appears by leave of the Coroner with a role to facilitate the pre-inquiry investigation of the circumstances surrounding the death and the

presentation of the evidence before the Coroner at the inquiry including tendering of all statements and calling and examining witnesses etc. In complex cases the Coroner might grant leave for a senior barrister to appear to assist the Coroner.

Is prosecution of a case before a PSC really necessary given the freedom that PSCs have to illicit further explanations and evidence?

Could PSC inquiries operate more like a coronial inquiry where an officer of the HCCC presents the evidence as an *officer assisting the inquiry* rather than prosecuting the case?

Alternatively, should health practitioners be allowed non legal representation at PSCs? Would this put them on a more equal footing with HCCC prosecutors in putting forward their defence?

Greater transparency in disciplinary hearings other than tribunals

Professional Standards Committees and hearings held under Section 66 of the *Medical Practice Act* and corresponding sections of other health registration Acts afford practitioners the opportunity to have their matters heard in a closed environment. However, concerns have continually been raised throughout the course of the Inquiry about the lack of transparency in the process.

Further, as the only appeal from PSCs is in open court practitioners are understandably reluctant to challenge PSC decisions.

Concerns have been raised by many practitioners about the routine practice of the granting and placement of suppression orders over the names of parties and findings of disciplinary panels. This is allowed for under Schedule 2 of the *Medical Practice Act* and other relevant health registration Acts. The New South Wales Medical Board argued to the Committee that they were not concerned about disclosing the findings of PSCs and that suppression orders were generally at the request of the doctors themselves.

However, throughout the inquiry doctors told the Committee that they felt intimidated by the Medical Board into not discussing the outcome of their case when they felt that they had been treated unfairly. In one instance the Medical Board wrote to a doctor threatening him with professional misconduct for discussing the details of his PSC case with the Parliamentary Committee.

Should the placing of suppression orders over the names of parties brought before PSCs and the findings of PSCs be granted routinely?

Suppression orders granted in other jurisdictions are not routine. Good reason must be shown for withholding the names of the parties and the orders of the court even in cases where the court is closed.

Even if, as the Medical Board argues, suppression orders are requested by the doctor to protect his or her reputation, should practitioners be punished for discussing a matter which will only ultimately effect themselves?

Should disciplinary panel members have more legal training?

Throughout the inquiry concerns were raised about lack of legal knowledge displayed by some Medical Board panel members. In the recent case of Dr Fleming which was heard on the 16 July 2002 the Medical Tribunal found that a PSC of the Medical Board had acted without authority in continuing with a complaint when the HCCC had tried to withdraw it. The PSC had been advised by Medical Board legal officers that it had the ability to do this.

The New South Wales Medical Board is currently only offering twice yearly two hourly sessions of training for their panel members. Participation is voluntary and largely conducted by Medical Board staff.

In contrast, the Professional Standards Review, the investigation, prosecutorial and disciplinary arm of the Health Insurance Commission, requires its panel members to undergo intensive compulsory training over one entire weekend each year. Dr John Holmes, the Director of the Professional Services Review, told the Committee that the necessity to provide detailed training for panel members was recognised early on as doctors and lawyers are trained to think very differently. The view was further taken that training should be conducted away from the distractions of their medical practice.

Dr Holmes observed that doctors tend to begin training believing that lawyers have nothing to teach them but soon realise the importance of understanding basic principles such as natural justice etc. The PSR training model has been based on those of the New York State Board of Medical Practice and the General Medical Council.

Senior Counsel are invited as guest speakers and panel members are required to undertake practical simulation exercises in areas such as hearing techniques and legal report writing which are then critiqued.

Should internal disciplinary panels have access to external advice?

Following on from the above issue, would it be more appropriate for internal disciplinary panels to receive legal advice external to the relevant registration board to eliminate a situation where boards are seen to be in a conflict of interest situation when called upon to give legal advice.

The case of Dr Fleming which has been previously discussed is an example of a situation where the Medical Board legal advisers wrongly advised one of their PSCs about its basic powers.

In the past various professional registration boards have been required to retain external counsel to advise their panels on legal matters.

Should disciplinary panel members be required to undergo "cultural awareness training"

Concerns were raised with the Committee about the lack of ethnic representation on health professional registration boards. In contrast, there are a disproportionate amount of overseas born practitioners appearing before disciplinary panels

The United Kingdom General Medical Council (GMC) has acknowledged this contrast and is now requiring its panel members to go through relevant training. This was a result of the United Kingdom Policy Studies Institute conducting research into why there was such a large representation of overseas born and/or qualified doctors in the GMC's Fitness to Practice program despite the fact that complaints about such doctors were proportionate with those against locally born and trained doctors. The Institute study found that the GMC was far more likely to dismiss both complaints and cases against local doctors.

Is there a need for disciplinary panel members here to similarly undergo cultural awareness training?

Should registration board members sit on tribunals?

Section 147 of the *Medical Practice Act* currently provides that Members of the Medical Board may sit on the Medical Tribunal.

However, most of the other health professional registration acts such as the *Dental Practice Act* 2001 (NSW), the *Nurses Act* 1991 (NSW), the *Psychologists Act* 2001 (NSW) and the *Chiropractors and Osteopaths Act* 1991 (NSW) expressly forbid their Members sitting on Tribunals.

Similarly, the United Kingdom General Medical Council (GMC) has instituted new procedures which require all disciplinary panel members to be external to the GMC.

Concerns have been expressed to the Committee about a senior Member of the Medical Board sitting on a Tribunal where the respondent doctor had previously been in the Board's impairment program. Although, the Board assured the Committee that the Member in question knew nothing about the respondent's

previous history there were still concerns that the appearance of impartiality may have been breached.

Further, the fact that Medical Board Members sit on Tribunals requires the Medical Board to be to careful to establish and maintain "walls" in relation to cases they are dealing with. This creates administrative restraints.

Are there any clear advantages gained by Medical Board Members sitting on the Medical Tribunal particularly given that it does not happen in the other health professions?

Would respondent doctors consider the process fairer if they appeared before peers who have no involvement in the Medical Board's activities?

Should health professional tribunals move to the Administrative Decisions Tribunal?

When most of the original health professional regulation acts were introduced the obvious venue for tribunals was the District Court.

However, New South Wales has since established an Administrative Decisions Tribunal which, as its name suggests, expressly deals with administrative law matters. Administrative Decision Tribunal judges are equivalent in status to those in the District Court.

Moving the health professional tribunals to the Administrative Decisions Tribunal should offer lower court costs, expedited cases, less formality and greater consistency.

Are there any compelling reasons for the health professional tribunals to remain in the District Court?

Should appeals from tribunals be de novo?

Currently appeals from health professional tribunals to the Court of Appeal of the Supreme Court are on a point of law only.

This means the reasons for which an appeal can be brought are very narrowly defined to areas such as denial of natural justice.

It has also been the practice of the Court of Appeal to send matters back to the relevant tribunal when the appeals have been upheld. This is common practice when dealing with point of law appeals as the original deciding body is considered to only have erred in a narrowly defined area and the appellate body is not required to look at the case as a whole, merely the alleged error.

This system tends to discourage appeals and puts those appellants which are successful in the frustrating position of ending up back before the body they were appealing about.

An option to make appeals fairer would be to make them de novo (reheard again from the beginning) on any aspect of the case.

De novo appeals from health professional tribunals are the norm in all the other states.