Submission

No 21

INQUIRY INTO THE OPERATION OF THE HEALTH CARE COMPLAINTS ACT 1993

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NEW SOUTH WALES MEDICAL BOARD

Submission to the Parliamentary Joint Standing Committee Inquiry into the operation of the Health Care Complaints Act, 1993

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Introduction

The Parliamentary Joint Standing Committee has invited the Board to make a submission to its Inquiry into the operation of the Health Care Complaints Act, 1993

National Registration and Accreditation Scheme

The Board notes that the process of establishing a National Registration and Accreditation Scheme as announced by COAG is proceeding apace, and that the Board and its staff are heavily involved in consultation, responding to issues papers, and advising the National Registration and Accreditation Implementation Project Team. This process, which will lead to the abolition of the Board as it currently exists in July 2010, covers the whole range of the Board activities, of which its relationship with the HCCC and handling of complaints is but a part. The Parliamentary Committee would be aware of the Consultation Paper issued by NRAIP in relation to *Proposed arrangements for handling complaints, and dealing with performance, health and conduct matters,* and a copy of the Board's response to that paper is attached. The Parliamentary Committee will note that the main thrust of the Consultation Paper is to replace the NSW model of an independent Health Complaints Body handling the most serious investigations with the model that prevails in most other jurisdictions, namely a Health Complaints Body dealing with less serious complaints via ADR mechanisms, with investigation and prosecution of serious complaints being undertaken under the auspices of the Professional Boards. The NSWMB response to this proposal has been to support the NSW structure, although it does so with some reservations and some proposals for change as set out below.

Shortcomings of the Co-regulatory Model

The "Co-regulatory Model" was introduced into NSW with the creation of the Complaints Unit in 1986, and was enshrined in legislation in the Health Care Complaints Act in 1993. The NSWMB has supported the principle behind the model on the basis that it provides checks and balances and demonstrates a clear separation of functions between the investigatory/prosecutorial functions, and the adjudicatory function. This model is sound both from the point of view of jurisprudence, and also from the point of view of public perception of independence.

As outlined in the Board's oral presentation to the Parliamentary Joint Standing Committee on 6 June 2008, the Board considers that there is a need for amendment to the co-regulatory arrangements which while relatively minor in terms of legislative change required, will have a significant impact on improving the ability of the system to protect the public and to provide appropriate professional regulation for doctors in NSW. These changes centre around what has emerged as an unequal relationship between the Board and the Commission at the point of determining how the most serious matters which have been investigated are to be dealt with at the conclusion of the investigation.

Consistent with the concept of checks and balances, at the time of initial consultation on complaints, either the Board or the Commission can insist that a matter is investigated. In this way, the charge which is sometimes levelled against regulatory regimes that they have a tendency to sweep matters under the carpet is avoided. By and large, this arrangement works well, and consensus is reached at the regular assessment meetings.

At the conclusion of the investigation, the Commission is required to consult with the Board regarding the outcome of investigation, as well as advising the practitioner of its intended course of action and inviting further submissions.

The Board considers that the current legislative provisions regarding post investigation consultation do not provide an appropriate balance between the views of the Board and the views of the Commission. While for most of the fifteen years in which this legislative model has applied, there has been a process of consensus, there have been times when the Board's strongly held views about whether a matter should not proceed to a hearing (or to the Director of Proceedings since the post-Camden/Campbelltown legislative changes), have been substantially discounted or ignored.

This has occurred where the Board has been of the strong view that a matter ought to proceed to a hearing because of significant issues relating to professional regulation, professional conduct, etc, in circumstances where there is dispute regarding evidence, and the Commission has decided not to proceed. On the other hand, there have also been instances of matters being referred on for hearing in circumstances where the Board has been strongly of the view that the cases have not raised issues of professional conduct or professional standards, but are being referred to hearing for political or other extraneous reasons. This was particularly the case in the Camden/Campbelltown matter where several doctors were referred to the Medical Tribunal over the Board's strong disagreement (on the basis that the conduct alleged did not warrant suspension or deregistration as set out in the Act), but the Commission persisted. The outcome of these matters justified the Board's concerns that they were not appropriate for hearing in this forum.

The Board notes that there has been an improvement in the degree of consensus recently, but considers that the legislation should be amended so that the character of co-regulation is not dependent upon the goodwill or whim of the Commission. There are several ways in which this could be achieved, for example by requiring consensus at the time of determining the outcome of investigations, or replicating the requirement that the highest call wins, so that if either body considers that a matter should be referred on to the Director of Proceedings with a view to a hearing, then this should occur.

Director of Proceedings

The role of the Director of Proceedings has by and large worked well, although the backlog of cases which have been referred to the DP with a view to a hearing needs to be monitored carefully to ensure that cases are not being unduly delayed. In keeping with the previous comments concerning the process at the conclusion of investigation, the Board considers that the charter of the DP should explicitly include a requirement to take into consideration the purpose and objectives of professional regulation, namely the protection of the public and the maintenance of standards, rather than being limited by a prosecutorial "are we going to win this case?" approach.

Devaluation of Board expertise

The Board continues to express concern at the use of experts/peers by the Commission, and in particular the way in which the Commission feels bound to follow the opinions expressed by the expert or peer in an investigation notwithstanding the sometimes unanimous divergence from those views expressed by the medical members of the Board at the time of consultation. The question of selection of experts and peers is a practical matter, and the difficulty of always getting this right is acknowledged, but in situations where the Board's Conduct Committee (which includes seven medical and two lay members) considers that the wrong expert/peer has been chosen, or that he or she has applied the wrong standard, the Commission ought to be obliged to at the very least seek a further view. A requirement to this effect would in the Board's view have a positive impact on the question of post-investigation consultation considered above.

Disciplinary or Performance Pathways?

The interaction of the disciplinary and performance and health pathways is also an area where the Board considers that legislative change is required. The Board's view is that in a professional regulatory system, a clear distinction needs to be drawn between matters which can be characterised as requiring disciplinary action (reckless, unethical, wilful or criminal conduct) and those where the public is better served by remedial and/or restrictive processes but which do not involve a sense of bad professional conduct. This is the principle that underpins the Board's Performance Program, and forms the basis of Performance Programs in other jurisdictions around the world.

The difficult question has been how to determine which matters should be dealt with as disciplinary, and which as performance related. The legislation as it currently stands leaves it open for matters which are about a doctor's professional performance and which do not carry any overtones of bad conduct to be dealt with through the disciplinary pathway. Furthermore, a decision as whether the decision is to be treated as a disciplinary or a performance matter is ultimately one for the Commission which can effectively override the Board. This should be a consultation mechanism with criteria to determine which is the appropriate pathway, rather than simply leaving it in the hands of the Commission.

In the Board's view, the Performance pathway is generally a more effective way of establishing deficits in a doctor's professional performance, leading to more broadly based outcomes which are more in the public interest. This is because a doctor in the Performance pathway may be subjected to a full practice audit which involves peers sitting in on consultations and procedures, inspecting records, asking clinical and other questions, etc, and generally undertaking a thorough review of the doctor's performance in a real setting. This should be contrasted with the Disciplinary paradigm where a particular incident is focused on in great detail, while other information about the doctor's overall standard of practice will be excluded. This "keyhole" approach does not enable a proper view of the doctor's practice to be obtained, leading to narrow outcomes which cannot take into account the broader picture. This is not in the public interest.