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27 July 2006 **BY HAND**

Attention: The Hon. Patricia Forsythe MLC
General Purpose Standing Committee No 2
Parliament House
Macquarie Street
Sydney NSW 2000

Dear Ms Forsythe

Australian Medical Association (NSW) Ltd (AMA (NSW))
Submission on Incident Management and Complaints Handling in New South Wales Health

We act for AMA (NSW).

AMA (NSW) welcomes the opportunity to make a submission to the inquiry into the complaints handling procedures in the New South Wales health system and the implementation of the NSW Patient Safety and Clinical Quality Programme (the **Programme**).

We note that the General Purpose Standing Committee No 2 (the **Committee**) has been convened to inquire into and report, upon the complaints handling procedures within NSW Health, particularly:

- **the culture of learning and the willingness to share information about errors and the failure of systems; and**
- **an assessment of whether the system encourages open and active discussion and improvement in clinical care.**

INTRODUCTION

AMA (NSW) recognises NSW Health's ongoing commitment to advancing quality assurance and disclosure issues. To date, AMA (NSW) has enjoyed an open and

constructive working relationship with NSW Health which has been conducive to significant reform already in the area of incident handling and investigation. AMA (NSW) is optimistic that this culture of co-operation can continue and further agreements on improvement of this regime can be reached to the benefit of health service providers and patients alike.

AMA (NSW) would like to see a number of significant legislative reforms to the *Health Administration Act 1982* (NSW), the *Health Administration Regulations 2005* (NSW), and the *Medical Practice Act 1992* (NSW) aimed at making the medical profession feel more comfortable about participating in adverse event reporting, without fear of recrimination and with appropriate representation where necessary. Many doctors are still anxious about the potential medico-legal, professional and public face implications of open disclosure and feel a degree of distrust and insecurity over the currently available reporting systems.

AMA (NSW) has been and remains supportive of the principles of open disclosure and a 'no blame' approach to adverse incidents. The issue has been how to overcome the institutional, individual, cultural and attitudinal barriers to incident reporting. Our client's submissions address these continuing barriers and our prevailing concerns regarding the technical aspects of open disclosure and the legislative framework (or lack thereof) governing Root Cause Analysis (**RCA**). AMA (NSW) acknowledges that the present system attempts to encourage open and active discussion and improvement in clinical care however the medical profession maintains some reservation about proactive incident reporting which needs to be addressed.

Whilst doctors support the ideals of open disclosure and RCA, namely raising awareness of systemic problems and sensitivity to risks to drive improvements in health administration and patient care, they continue to be concerned (rightly or wrongly) about the following:

- doctors who participate in complaints handling processes are not offered sufficient protection from recrimination;
- the reporting process itself has few perceived benefits as very little feedback on the outcomes of the investigation of the report is given to staff involved in the adverse event or generally; and
- their job security, for example, concerns over black marks on work records, threats to future employment and or contracts.

It is the AMA (NSW)'s principal submission that these concerns are best addressed by simplifying the current legislative provisions with respect to privilege and extending them to protect all participants involved in the investigation of a reported incident. Our client's secondary position is that the privilege provisions be simplified, and that if privilege is

not to be expanded in this way, that clinicians involved in the incident or asked to comment on an incident, are fully advised of the limitations of privilege and that their contributions may be compelled in other proceedings.

EXECUTIVE SUMMARY

Root Cause Analysis

In relation to RCA:

- AMA (NSW) supports the use of RCA as the primary tool for the investigation of serious adverse events.

- AMA (NSW) is particularly concerned that many of the provisions regulating RCA procedures are not formally enshrined in the *Health Administration Act 1982* (NSW) or the *Health Administration Regulation 2005* (NSW). Our client maintains that it is essential that RCA be regulated by statute, rather than by way of guidelines or policy directives, to ensure more comprehensive compliance and to ensure that those statutory bodies, such as the Area Health Services, which apply RCA processes, are accountable.

- In relation to privilege, AMA (NSW) regards the existing provisions under the *Health Administration Act 1982* (NSW) and the Incident Management Policy Directive (**IM Policy Directive**) as being grossly inadequate. The circumstances in which privilege will attach to an RCA process and an RCA team need to be clarified, simplified and legislated. Adjustments to the RCA legislative framework are necessary to enhance the privilege safeguards of the process for doctors participating in an RCA.

- The composition and the functions of the RCA team need to defined in the *Health Administration Act 1982* (NSW).

- The circumstances in which a matter, the subject of an RCA, may be referred to a disciplinary body for action need to be clarified.

- More detailed safeguards need to be incorporated into the legislation to protect those clinicians involved in incidents which become the subject of an RCA.

Legal Representation at s.66 Inquiries, Professional Standard Committee Inquiries and before Performance Review Panels

- As it has done previously AMA (NSW) recommends the *Medical Practice Act 1992* (NSW) be amended to allow for the right of legal representation before **s.66** Inquiries, Professional Standards Committee Inquiries and Performance Review Panels.

Open Disclosure

AMA (NSW) submits that doctors' confidence in the open disclosure process may be improved by:

- A more thorough and comprehensive educative campaign directed at new and existing health care practitioners focussing on the principles of and rationale for open disclosure and RCA;

- Greater clarification of the circumstances in which a matter should be disclosed to a patient and the consequences of doing so;

- Ensuring outcomes of incident investigations are communicated back to clinical staff and between Area Health Services in a timely manner and that Area Health Services are responsive to the reforms these reporting processes highlight; and

- More prominent community education in the occurrence of adverse events, open disclosure and the importance of a no-blame culture.

***SUBMISSION 1 – ROOT CAUSE ANALYSIS – Some specific concerns relating to the NSW Health Department's Incident Management Policy Directive May 2006* (IM Policy Directive) *and the Reportable Incident Definition under Section 20L of the Health Administration Act Policy Directive November 2005* (Reportable Incident Definition Policy Directive)**

As stated above AMA (NSW) as part of its broad endorsement of open disclosure is supportive of RCA. In particular AMA (NSW) is concerned about the legislative framework that governs the RCA process, and some technical aspects of its operation, particularly in relation to the following:

- the legal status and enforceability of the IM Policy Directive and the Reportable Incident Definition Policy Directive;

- the ambiguity surrounding which types of incidents ought to be reported and which types of incidents will be the subject of RCA;

- what information created during or in relation to an RCA will and will not be subject to privilege;

- the lack of clear guidelines directing how and when a matter which is the subject of an RCA may involve the practitioner being referred to the Health Care Complaints Commission and or the NSW Medical Board and how these processes will interrelate; and

- the lack of detail in the provisions setting out in what way the principles of natural justice will be honoured :
  - receive timely notification of the RCA;
  - be given the opportunity to seek legal advice and representation and or union support before and whilst participating in an RCA;
  - respond to the incident and to any adverse findings; and
  - to object if the practitioner has, in relation to one or more RCA team members, a well-founded apprehension of bias

Legal status of a Policy Directive

We note that the NSW Health Department remains concerned that prescriptive legislation may undermine the privileges and protections granted to the RCA process. It is AMA (NSW)'s understanding that the NSW Health Department regards "Policy Directives" as communicating material that is to be complied with and implemented by the NSW public sector health system. Compliance is stated to be mandatory. They are distinct from "Guidelines" which are used to provide advice or guidance to the NSW public sector health system but do not require compliance.

With respect, the legal status of Policy Directives is uncertain – they do not have the force of law and it is not apparent who has the power to enforce compliance with such Policy Directives or to penalise those who do not strictly adhere to their precepts and what the penalties of non-compliance might be.

AMA (NSW) remains concerned that unless the processes, privileges and protections relating to RCA are provided for in legislative form, there is nothing to compel Area Health Services to abide by and observe these processes, privileges and protections.

Section 20T *Health Administration Act 1982* (NSW) provides that the regulations may make provision for or with respect to RCA teams and procedures. As yet however the

Health Administration Regulation 2005 (NSW) does not make provision for the constitution and membership or the functions of RCA teams. AMA (NSW) submits that this would be the more appropriate manner by which to regulate RCA processes.

This concurs with Special Commissioner Brett Walker SC's recommendations in his Final Report of the Special Commission of Inquiry into Campbelltown and Camden Hospitals dated July 2004 (**Final Report**) in which he stated:

> *"Importantly, in many areas of life affected by government authority...including the registration and disciplining of doctors and nurses, Parliament can regulate how much procedural fairness there needs to be, and how it should be observed. Parliament can even defer or abolish what would otherwise be a common-law rule requiring procedural fairness." (at 64)*

Brett Walker SC noted that it is fundamental that a statutory body such as an Area Health Service, understands and obeys these laws when setting about the statutory task of handling complaints – namely the *Health Administration Act 1982* (NSW) and *Medical Practice Act 1992* (NSW) - particularly those which may result in disciplining of doctors and nurses.

Change to the existing statutory framework governing RCA is both possible and the most effective way of providing the fairest and most powerful reform of complaints handling in NSW because it diminishes the risk of piecemeal compliance and ensures that those bodies applying RCA processes are accountable.

Privilege and RCA

AMA (NSW) regards the existing provisions under the *Health Administration Act 1982* (NSW) and, moreover, the IM Policy Directive in relation to privilege in RCA to be grossly inadequate. It is our client's primary position that privilege should extend beyond the protection of the RCA team, to protect all those who participate in the investigation of a "reportable incident". AMA (NSW) submits that this is the most effective way of ensuring that those involved in the incident or asked to comment on the incident, feel comfortable participating fully in the RCA process. AMA (NSW) maintains that if privilege is not to attach to all participants in the RCA process, that doctors be plainly advised of this so that they make take steps to protect their position to ensure that do not unwittingly find their comments or opinions are produced in other forums.

Pursuant to **s.20M**, an RCA team will be appointed where a "reportable incident" has been notified. **Section 20P** provides that a person who is or who was a member of an RCA team must not make a record of or disclose or communicate to any person, any information acquired by the person as a member of the RCA team except for the

purposes of exercising the functions of a member, any recommendation of an RCA team or any report prepared by the RCA team, or in accordance with the Regulations. However neither this provision nor the Regulations stipulate what the functions of the RCA team may be.

Further, whilst AMA (NSW) notes the constraints imposed on an RCA team by virtue of **ss.20N, 20M** and **20P**, which preclude an RCA team from investigating the competence of an individual providing a health service and set out the responsibilities of the RCA team, our client is not satisfied that the manner in which an RCA team is permitted to conduct its investigation, or exercise its functions, is sufficiently delineated. Consequently, the vagueness of **s.20P** presently gives the RCA team broad discretion in determining whether disclosure of information acquired in connection with an RCA may be permissible.

Section 20Q provides that past and present members of an RCA team and the health services organisation for which the RCA team was appointed are neither competent nor compellable to :

- produce documents in their control that were created by, at the request of, or solely for the purpose of the RCA team; or
- divulge or communicate any matter or thing that came to the notice of a member of an RCA team as a team member.

The legislation does not preclude an RCA being conducted into other types of incidents not classified as "reportable" however it is implicit that privilege will not attach to the documents revealed or produced in relation to these investigations.

Part 6 of the IM Policy Directive stipulates that all SAC 1 incidents require an RCA. The IM Policy Directive states that the definition of a "reportable incident" is based on the SAC 1 definition, but does not include incidents with serious or major corporate consequences such as staff injury, financial loss or environmental consequences. In short, the definition of "reportable incident" is narrower than that of a SAC 1 incident. The IM Policy Directive does not preclude an RCA being conducted into other types of SAC incidents, however it does confine privilege to those RCAs into SAC 1 incidents which are "reportable incidents". In our client's submission there are no reasonable grounds for drawing a distinction between the types of investigated incidents to which privilege should and should not attach. Privilege ought to attach to all incidents which are reported, or participants in RCAs for the investigation of other types of incidents need to be clearly advised that their involvement will not be privileged.

Under the IM Policy Directive, privilege means:

- RCA team members cannot be compelled to produce or give evidence of any document created by for the purpose of the RCA team or any matter or thing which came to their attention as part of the RCA team;
- Reports of RCA teams are inadmissible in any proceedings claiming a procedure or practice was careless or inadequate;
- RCA team members acting in good faith for the purposes of the RCA team function are protected from personal liability including actions for defamation;
- All internal working documents including preliminary notes, records of interviews with staff/clinicians, minutes of meetings, records of discussions with people involved in the incident or with knowledge about the incident, are privileged.

Our client understands that the privilege does not extend to pre-existing documents including the Reportable Incident Brief, medical records or other records created providing general care of patients or management of the health service.

Our client has the following concerns about the extent (or lack thereof) of the privilege provided for under the IM Policy Directive:

- Documentation prepared and submitted to the RCA team by a person who is not an RCA team member is not currently privileged. As part of its investigation the RCA team may seek expert medical advice, medical opinions, reports or statements from clinicians involved in the incident. It seems that if a person provides information to an RCA team in writing the document provided to the RCA team will be privileged. However, it is however uncertain whether a person who retains a copy of the document submitted to the RCA, may be compellable to produce a copy of that document.

- Information provided by those directly involved in the incident is not afforded the same protection of privilege as that given to the RCA team.

- If an RCA team is not properly constituted then privilege will not attach to that team's investigation. The *Health Administration Act 1982* (NSW) and the Regulations are silent regarding the "proper constitution" of RCA teams.

- The *Health Administration Act 1982* (NSW) and the *Health Administration Regulation 2005* (NSW) do not stipulate to whom the

> RCA teams report their findings and recommendations in relation to the investigation of a "reportable incident". The IM Policy Directive requires RCA teams to provide a copy of their report to the Chief Executive who may ten decide to submit it to the NSW Health Department. It is not clear whether privilege will attach to reports which were not required to have been made under the legislation and or what, if any, liability RCA team members may expose themselves to by producing an unnecessary report.

As noted by Special Commissioner Brett Walker SC in his Final Report, the willingness of clinicians to participate in and contribute to an RCA corresponds directly with their fear that documents created and words spoken in this forum may be used against them in litigation or disciplinary matters. There is an obvious balance to be struck between the public interest in the community having access to health information and patients having access to information about the way in which they have been treated, and the public interest in health care professionals participating frankly in quality assurance activities and contributing to discussions about adverse events.

It is our client's submission, that privilege ought to attach to all parts of the investigation of all incidents, including but not limited to "reportable incidents" and the more broadly defined SAC 1 incidents. There appears to be no basis for allowing some incidents the benefit of privilege and others not, particularly as many matters may require closer investigation to reveal whether they are in fact a "reportable incident".

Further, AMA (NSW) maintains that blanket privilege for all participants in the RCA process, not only the RCA team members, is more consistent with a systems approach to investigating adverse incidents because it encourages openness and more candid discussion. Doctors involved in an RCA process not forming part of the RCA team, will be more confident participating fully with the RCA process if they can be reassured that their comments and responses cannot be used in other proceedings (disciplinary or civil) against them or others. It is important that if privilege is not to be expanded in this way that participating doctors are advised their reports, advice or comments will not be privileged and the possible consequences of this so that they may seek advice from their medical defence organisations and avoid making inadvertent incriminating remarks.

RCA and professional discipline

It is not clear from either the IM Policy Directive or the legislation how the RCA and the professional disciplinary mechanisms interrelate. The AMA (NSW) endorses the use of RCA as the primary tool for the investigation of serious adverse events. In relation to events such as criminal acts; purposefully, deliberately or egregiously unsafe acts;

negligence; acts raising questions of competency or performance; acts related to substance abuse by clinical staff; or an event involving suspected child abuse, RCA cannot be appropriately used and such matters must be referred immediately to the police, NSW Medical Board or the Health Care Complaints Commission.

Section 20O(1) *Health Administration Act 1992* (NSW) provides that an RCA team *must* notify the health services organisation if it is of the view that the reportable incident it is investigating raises matters that may involve professional misconduct or unsatisfactory professional conduct or indicate that the person may be impaired. Furthermore, pursuant to **s.20N(1)**, and the IM Policy Directive, an RCA team is not authorised to investigate the competence of an individual in providing services and has a discretion whether to refer matters that may involve unsatisfactory performance (but not professional misconduct or unsatisfactory professional conduct) to the Area Health Service.

Questions the legislation and IM Policy Directive raise are as follows:

- When and how the RCA team is to satisfy itself the "reportable incident" raises such matters? That is, will members of RCA teams have experience and or training in applying the legal concepts of "impairment", "unsatisfactory professional conduct" and "professional misconduct" (as defined in the *Medical Practice Act 1992* (NSW)) and recognising when a matter should be referred?

- In what circumstances will the RCA continue into the reportable incident once performance issues are identified and a matter is referred? The IM Policy Directive and the *Health Administration Act 1982* (NSW) give the RCA team discretion to continue investigating systems issues in any incident which may also raise issues of competence. In many instances it may be difficult to separate the two sets of issues relating to performance and systems. What impact if any, will the findings of the RCA in relation to the systems issues have on the professional disciplinary processes. What impact if any will the findings of the professional disciplinary processes have on the RCA? Will RCAs which continue in these circumstances be privileged?; and

- At what stage will the concerned doctor be advised of the referral? Before the matter is referred or after?

AMA (NSW) considers it important that there be more legislative attention given to setting out to whom RCA teams are to report and when a matter may be referred to the

NSW Medical Board and/or the Health Care Complaints Commission. In accordance with Brett Walker SC's recommendations, guidelines must be developed as to when and how matters are to be referred to a disciplinary process.

RCA and Natural Justice

AMA (NSW) is not satisfied that the current legislative provisions and IM Policy Directive offers sufficient guidance on the ways in which the principles of natural justice are to be given practical effect, to protect the rights of medical practitioners who participate in an RCA investigation, not to incriminate themselves or their colleagues. While it is accepted that the principles of procedural fairness are well enshrined in the common law, AMA (NSW) maintains that natural justice can be most authentically achieved by guaranteeing the same protections of privilege for those doctor participants as afforded the RCA team members.

Section 20N(3) provides that an RCA team is to *"have regard to the rules of natural justice in so far as they are relevant to the functions of the RCA team"*. **Section 6.3.3** of the IM Policy Directive also states that the RCA team is to apply the rules of natural justice, namely to act fairly and without bias and not to prejudge the issues before it, *"to the extent they are relevant to the function of the team"*. The AMA (NSW) strenuously objects to this conditional observance of the principles of natural justice. It gives the RCA team an unwarranted discretion to abide by the principles of fairness in its investigation, particularly in circumstances where the *Health Administration Act 1982* (NSW) and Regulations have not set out what the functions of the RCA team are or the manner in which it may conduct an RCA. Furthermore both the IM Policy Directive and the legislation only expressly acknowledge that natural justice is to apply for the investigation of "reportable incidents" which is not conducive to clinicians contributing to investigative processes of the multitude of other types of incidents which may be reported.

It is the AMA (NSW)'s submission that both the legislation and the IM Policy Directive should be amended to address the following:

- **Notice** – the *Health Administration Act 1982* (NSW) and Regulations are silent on what notice and in what form notice is to be given to the staff involved in a "reportable incident". Presumably this could allow an RCA team to conduct its investigation into a complaint without notifying the subject of the complaint or giving him/her the opportunity to respond. **Section 6.2.5** of the IM Policy Directive provides the RCA team will contact staff involved to "discuss the incident" and a template notice form is attached in **Appendix E** titled "Notification of Staff

Involved in Incident". However there is no timeframe given by which such staff should be notified. It is our client's submission that staff involved in any incident which is reported (including but not limited to "reportable incidents") ought to be given written notice of the report prior to any RCA being commenced.

In addition to the matters already set out in the template letter contained in Appendix E, the notice should include:

- how the investigation will be conducted eg the terms of reference, whether the clinician will be interviewed, whether expert reports will be sought and from whom;
- further details on the limitations of statutory privilege, for example the circumstances in which it will not protect participants in an RCA process, or the documents or statements produced to the RCA team but retained by the participant;
- more information about the circumstances in which a matter may be referred to the Chief Executive and then to the NSW Medical Board or the HCCC;
- the right of the clinician to object in writing to any person on the RCA team whom they reasonably perceive to be biased or prejudiced;
- a warning to clinicians to restrict themselves in any communication with the RCA team, to clinical facts which have been verified as far as possible as accurate and to avoid:
    - attributing blame to any other health care professionals or the health care organisation;
    - recording opinions about staff, patients, support persons or others unless those are expert opinions with evidence supporting the opinion recorded; and
    - making statements about another person which are, or are likely to be defamatory; and
- a statement that clinicians may seek advice or support from their professional organisation and their medical defence organisations regarding, for example, whether to participate in the RCA and the limitations of privilege.

- **Right to seek advice** – the *Health Administration Act 1982* (NSW) and Regulations should be amended to expressly allow a clinician involved in any incident which is reported made the subject of an RCA to seek legal advice or guidance and or professional association support, before

and during the RCA and particularly when responding to the incident, participating in any formal interviews and responding to any adverse findings. The IM Policy Directive does not provide for this. This is particularly important if privilege is not to be extended to all participants in the RCA process as doctors need to be aware of the risk of making an admission of liability during the RCA process and of the potential for this admission being later disclosed in legal proceedings or in response to a freedom of information application.

- **Right to respond to the incident** - the *Health Administration Act 1982* (NSW) and Regulations should be amended to provide any clinician involved in an incident which is reported and the subject of an RCA to be given a reasonable opportunity to respond to the incident whether in writing or at an interview. The clinician should also be provided with any reports or documents that the RCA team intends to rely upon when making its findings and be given adequate time to respond to these. Again the IM Policy Directive and the legislation make no provision for this.

- **Unbiased tribunal** - the *Health Administration Act 1982* (NSW) and Regulations should be amended to create a provision which gives a clinician who was involved in an incident which has become the subject of an RCA the right to object to members of the appointed RCA team where they have grounds for a reasonable apprehension of bias. This could arise for example where a doctor involved in an incident and a member of the RCA team have a history of commercial or professional conflict.

Given the present limitations of privilege attaching to RCAs, grave nature of SAC 1 and "reportable incidents" which are to be the prime subjects of any RCA, and the very real risk that a doctor participant may unwittingly incriminate themselves, the Area Health Service, by participating in an RCA, it is chiefly important the rights of the clinicians involved in such incidents are not compromised. The RCA investigatory process must be manifestly procedurally fair if clinicians are to feel confident in participating in this incident investigation regime. AMA (NSW) submits that extending privilege to all participants in the RCA process is the most valuable and effective guarantee of a doctor participant's interests in an RCA process. It is also the most valuable and effective guarantee that the RCA will achieve its present purpose to the benefit of public patients in NSW.

SUBMISSION 2 – LEGAL REPRESENTATION AT S.66 INQUIRIES, PROFESSIONAL STANDARDS COMMITTEE INQUIRIES AND PERFORMANCE REVIEW PANELS

AMA (NSW) continues to seek the right of legal representation at **s.66** Inquiries, and before Professional Standards Committees (**PSC**) and Performance Review Panels (**PRP**).

Our client accepts that the change to **s.177** *Medical Practice Act 1992* (NSW) to allow non-legal presentation to medical practitioners who appear before PSCs is a positive improvement in this regard in that it does restore, to some extent, the balance that is required at these types of hearings, in circumstances where the complainant is represented by a trained HCCC advocate. Nevertheless, AMA (NSW) submits the legislation should expand upon this right to allow for legal representation by leave of the presiding body at PSCs.

The fact that PSCs are inquisitorial in nature and are not bound by the rules of evidence is, with respect, not a sufficient reason to deny a respondent practitioner legal representation in certain circumstances by leave of the PSC. An analogy may be drawn from Coronial Inquiries. Such an inquiry is inquisitorial, the formal rules of evidence do not apply, and interested parties are only entitled to legal representation by leave of the Coroner (**Sections 31A, 32** and **33** *Coroner's Act 1980* (NSW)). Unless there is a particular reason to deny leave, one would ordinarily expect it to be granted.

A consequence of **s.177** as it currently reads has been that medical practitioners appear before a PSC with their non-legal advisor **and** legal advisor.

In AMA (NSW)'s experience, it is not unusual for an issue of law to arise in the context of the PSC hearing. At times it may be in the interests of all parties that the PSC have the ability to grant leave to a legal advisor to address the PSC on a point of law or cross-examine a witness. However, it is accepted that proceedings should not be bound up in legal technicality. One of the benefits of legal representation by leave is that if the leave is 'abused' then the leave can be withdrawn by the PSC.

Of significant concern is the fact that the legislation does not deal with the issue of representation before a **s.66** Inquiry by the Medical Board and it presently appears there is no proposal to grant any right of representation to a practitioner before such an inquiry. Comments made by Ms Scahill (and others) suggest that much may turn upon what one considers to be 'representation' (see transcript page 69 Special Commission of Inquiry dated 24 May 2004).

Section 66 and its related provisions allow the Medical Board to suspend a practitioner pending investigation of a complaint or an appeal being heard before a Medical Tribunal. It is accepted that this process could take some considerable time while a practitioner remains suspended from practice. While it is accepted that this provision is the Board's most effective weapon in the protection of the public it is, with respect, inconceivable in a Common Law system that a person who may suffer a loss of his or her ability to earn a living would not be entitled, as of right, to legal representation. It also remains our view that the public and the Board itself are better served and protected if the practitioner has that basic right of representation. This issue was well recognised by Special Commissioner Brett Walker SC in what he termed *'equality of arms'* (see transcript page 69 Special Commission of Inquiry dated 24 May 2004). It is our client's view that the Special Commissioner in making that comment was not drawing a distinction between PSCs and **s.66** Inquiries, but rather making a general statement about the appropriateness and importance of a fair hearing and the right of representation.

The Special Commission of Inquiry transcript dated 24 May 2004 (pages 69 to 72) indicates that virtually all relevant stakeholders in the health complaints system support the right of representation before a **s.66** Inquiry. AMA (NSW) notes particularly the following exchange between Mr Bozic SC and Ms Scahill:

> Mr Bozic:
>
> *'... One of the problems with a Section 66 Inquiry, for example, is that it can result in the immediate suspension of a medical practitioner. Now, that is obviously something that has a severe impact on their livelihood and it is something which for that reason alone they ought to have access to proper legal representation. The point has been made, and I think it is a very valid point, and that is that there is an element of almost high farce at times about the way which these things end up being conducted, because where there is potentially a very serious outcome from some of these Boards, committees and inquires, the reality is that the nurse or the doctor will obtain some sort of legal advice. The way things stand at the moment, for example, submissions about what ultimately ought to happen are put in note form or put in writing by lawyers, and instead of the lawyer who wrote the submission being able to then address it and articulate it in a proper way, it is left to the professional themselves ... to have to try and articulate the things that are there in writing and to articulate their own defence to the charge. ... It is one of the things that at the moment is of very, very real concern because it is has immense practical consequences, and when you look at it, there is really, at the end of the day, no justification for the situation as it presently stands.'*

Ms Scahill:

> *'... The section doesn't prevent representation. Indeed, it is the practice of the Board – in fact, we have had QCs appearing on a number of occasions at the Board in Section 66 Inquiries ... in all practicality that does happen, that there is representation at Section 66 Inquiries, and that is a matter of practice.'*

Currently whether or not the practitioner gets the right of representation depends on the Board members who are sitting on the **s.66** Inquiry.

It is AMA (NSW)'s view that this issue should not be left unaddressed particularly as the legislation currently provides practitioners with a greater right of representation before a PSC, where the potential outcomes for a practitioner are far less serious than the potential outcome of a **s.66** Inquiry.

Finally, AMA (NSW) submits that for the sake of consistency and fairness, there should be a statutory provision to allow an appropriate level of legal representation of medical practitioners before PRPs, by leave of the PRP. A PRP, whilst ostensibly collegiate and non-disciplinary in its objectives and conduct, has the power under **s.86N** to impose certain punitive conditions on a doctor's registration. The process itself can be particularly hard on the individual doctor. Once again issues of law may arise during a PRP which a doctor may not be sufficiently qualified to address. Given the likeness of outcomes of a PRP with a PSC for a doctor, it seems logical that provision for a similar level of representation be made in the *Medical Practice Act 1992* (NSW).

SUBMISSION 3 – OPEN DISCLOSURE

Education and training of professionals in open disclosure

AMA (NSW) regards the present flow of information from the NSW Health Department to public health organisations on critical clinical pathways, better practice guidelines, treatment regimes and public health issues to be extensive, relevant and commendable. This is consistent with and conducive to a strong culture of learning and willingness to share information promoting good medical practice.

Whilst the AMA (NSW) welcomes the publication of the Incident Management Policy Directive released in May 2006, it notes that:

- Training programmes for new doctors are yet to incorporate competencies regarding quality and safety issues, education in the principles of and implementation of the National Open Disclosure Standard.

- Very little is being done to educate and train existing medical practitioners in incident reporting and open disclosure.

Medical practitioners need to be advised and appropriately practised in communicating with patients about the occurrence of an adverse event, saying sorry, how to identify and grade an adverse event, and what documentation is required. This is essential to giving them the confidence to participate in open disclosure and incident reporting. The fact that medical practitioners continue to feel concerned about litigation and or complaints against them affects their willingness to disclose means that the reforms which have been undertaken may not have been clearly explained to them by their insurers, medical defence associations and NSW Health.

Greater clarification is needed of which incidents should be reported and or the subject of open disclosure

AMA (NSW) is concerned that there are no comprehensive guidelines for health practitioners specifically setting out what incidents should be disclosed to patients. It is not clear for example whether health professionals ought to report 'near misses', when patients need to be notified of an adverse event, and how serious an adverse event or the harm it causes must be before it is reported.

In July 2005, the NSW Medical Board published a code of professional conduct entitled "Good Medical Practice: the Duties of a Doctor Registered in NSW" (the **Code**) which by dint of the composition of the Medical Board, amounts to a form of co-regulation of the medical profession through government, statutory bodies and members of the profession. **Standard 2.5** provides when a patient under a doctor's care suffers 'serious harm', the doctor must:

- explain fully to the patient (or to the patient's parent, guardian, carer, or person responsible where the patient is a child or cognitively impaired) what has happened and the likely short and long-term effects; and
- when appropriate, offer an apology.

"Serious harm" is not defined and is not readily capable of definition. This is particularly significant given breach of this Code will be, pursuant to **s.99A** *Medical Practice Act 1992* (NSW), relevant to any determination of unsatisfactory professional conduct as defined in **s.36(1)** *Medical Practice Act 1992* (NSW).

The Reportable Incident Definition Policy Directive defines "reportable incident" and stipulates that such incidents must be reported to the Chief Executive, however this has not been well distributed or communicated to public health organisations and practitioners. It also does not describe what incidents, falling short of being "reportable"

ought to be disclosed to patients. Furthermore the AMA (NSW) recommends that the definition of "reportable incident" should be incorporated into the *Health Administration Act 1982* (NSW) or *Health Administration Regulations 2005* (NSW) themselves, rather than be the subject of a Policy Directive whose legal status and enforceability is uncertain.

Simple guidelines on how to recognise and report an adverse event and when open disclosure is necessary would assist doctors in this respect and also ensure greater consistency and co-ordination in the type of matters reported.

Cultivating a 'no blame' environment

The co-operation and candour of medical practitioners is pivotal to the efficacy and operation of open disclosure system. More needs to be done to cultivate an environment in which the attribution of blame is discouraged and peers are supported. Staff need to feel reassured that they will not be discriminated against because of their involvement in open disclosure processes. This is probably best achieved by:

- better education and training in open disclosure and RCA;
- providing more information on support systems available to staff involved in open disclosure or RCA processes; and by
- providing more support facilities for staff involved in open disclosure or RCA processes.

Doctors also need greater reassurances that they will be:

- treated fairly and afforded the opportunity to respond to adverse findings;
- allowed to seek appropriate advice and guidance from their indemnifiers and other relevant advisers in relation to open disclosure and participating in an RCA; and
- will be protected from suit or complaint.

A major disincentive for doctors to report adverse events is that reporting processes do not always set out explicitly the way in which open disclosure investigations interrelate with professional disciplinary processes. It would be ideal if clearer guidelines were developed setting out when and how a referral will be made to a disciplinary process once an incident has been reported.

The outcomes of the reporting process need to be better communicated and used

An effective complaints handling system must have a well-maintained record of concerns raised, which are trackable, enable the identification of trends and include opportunities for feedback to those who have raised concerns. Whilst the systems are being improved, there is still a widespread perception that the reporters and staff involved in an adverse event are not given sufficient, if any, feedback on the investigation and its outcomes and that there is a lack of timely feed-back. This is crucial if the reporting process is to be regarded as a valuable tool for risk management and implementing change and if it is to be trusted and utilised by clinical staff.

To this end AMA (NSW) endorses the publication of de-identified information about adverse events and the distribution of this information back to public health organisations and individuals. It also supports the publication of comparative data on healthcare incidents or adverse events to allow a compare and contrast with like entities. At present however, AMA (NSW) is not satisfied that there is sufficient or prompt enough sharing of information about errors and systems failures among public health organisations and the NSW Health Department.

Fostering and promoting community awareness of open disclosure principles

Community awareness of occurrence of adverse events and open disclosure needs to be fostered and promoted. AMA (NSW) accepts that work is already underway to achieve this and that the Australian Council for Safety & Quality in Health Care has published a booklet *"10 Tips for Safer Health Care: What everyone needs to know"* to assist consumers become more involved in their health care, to explain how and why errors may occur and what options they may consider if they have concerns about their health care.

With respect, this document does not discuss open disclosure and nor does it attempt to educate health consumers about the importance of a no-blame culture. Furthermore it does little to promote more realistic community expectations about what medicine can deliver, its limitations and its susceptibility to error, even when undertaken by competent, well-intentioned practitioners. This is important as many doctors fear that as a consequence of their openness about a mistake they may face a civil and or disciplinary action from the patient involved and that there may be detrimental consequences for their career.

Summary

AMA (NSW) is generally pleased with the considerable progress that has been made since 2004 with respect to complaints handling in NSW health and continues to give its strong support to the principles of open disclosure and a systems approach adverse events. There are however, in our client's submission, numerous matters for possible improvement which are not unimportant if the incident investigation models of RCA and open disclosure are to be wholly accepted and practised by the medical profession.

In particular AMA (NSW) has grave doubts about the current adequacy of the privilege provisions and maintains that these should be extended to all participants in the RCA process and participants clearly notified about circumstances in which their contributions or communications will not be privileged. AMA (NSW) also recommends that the current Policy Directives governing the classification of "reportable incidents" and the RCA processes be incorporated into existing legislation to ensure that their provisions are enforceable and that those applying them can be made accountable.

Further education of health care practitioners as well as the public is still necessary to allay many of the concerns practitioners have about open disclosure and participating in RCAs and to level some of the unrealistic expectations health consumers continue to hold in relation to what medicine can deliver.

Finally, AMA (NSW) would like to see additional provisions in the *Medical Practice Act 1992* (NSW), to allow a doctor who is the subject of a **s.66** Inquiry, PSC or PRP, the right of legal representation during these processes. This is particularly critical given the outcomes of these processes can have a significant impact on a doctor's livelihood.

Should you have any queries arising from this submission, please do not hesitate to contact Scott Chapman or Casey-Lee Atherton.

Yours faithfully
TressCox

Scott Chapman