PARLIAMENT OF NEW SOUTH WALES

Committee on the Health Care Complaints Commission

REPORT OF THE INQUIRY INTO PROCEDURES FOLLOWED DURING INVESTIGATIONS AND PROSECUTIONS UNDERTAKEN BY THE HEALTH CARE COMPLAINTS COMMISSION

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Functions of the Committee

The Joint Committee on the Health Care Complaints Commission was appointed in 1994. 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.

The Joint Committee is not authorised:

a. to re-investigate a particular complaint; or

b. to reconsider a decision to investigate, not to investigate or to discontinue investigation of a particular complaint; or

c. to reconsider the findings, recommendations, determinations or other decisions of the Commission, or of any other person, in relation to a particular investigation or complaint.

Terms of Reference

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

This is a not a report which I take great pleasure in handing down. Sadly, however, it is a necessary one. I have been Chairman of this Committee since April 1999. I feel I can speak for the Members of the previous Committee as well as the current one in saying that during that time we have had very serious concerns about many of the key operations of the Commission.

In welcoming in a new Commissioner in 2000 the previous Committee had high hopes that some of the ongoing problems at the Commission such as the culture of general suspicion toward health practitioners, lack of clinical expertise, lack of active investigation, lack of robust legal practices and unacceptable delays in investigations would be appropriately addressed. Sadly this has not been the case. We have seen little improvement in the last four years in any of these areas and this was addressed in some detail in the Committee's last report *8th Meeting on the Annual Report of the Health Care Complaints Commission* which was tabled in New South Wales Parliament in November 2003.

This inquiry was largely begun as a response to some of the concerns that the Committee had about the evidentiary weight of a number of the matters going before the Medical Tribunal. In particular, the case of Dr Juan Sabag.

The Committee received over 93 submissions to the initial inquiry, 35 of these were from practitioners who had had experience with having a complaint about them dealt with by the Commission. We also received many submissions from stakeholders such as the New South Wales Medical Board, the Australian Medical Association, the Health Insurance Commission, the Rural Doctor's Association, various hospitals, Area Health Services and the Health Care Complaints Commission.

After the release of the Committee's *Discussion Paper* in November 2002 the Committee received an additional 33 submissions responding to the issues and suggestions that it canvassed. A notable exception was the Commission.

Most of the submissions were highly critical of the way the Commission conducted its investigations and prosecutions. Practitioners continually reported appalling delays in their investigations. Some were under investigation for between three to five years. There were also many instances in which a practitioner had absolutely no verbal contact with the Commission throughout the entire course of the inquiry. This highlighted a clear lack of *active* investigations by the Commission. The Committee also was disturbed at the lack of procedural fairness given to practitioners throughout the whole assessment, investigation and prosecution process.

There seems to be a prevailing view at senior levels of the Commission that procedural fairness is not to be read into the Act, it must actually be written into it before it is afforded to practitioners. As a result the Committee has recommended that procedural fairness actually be built into the legislation in a number of key areas such as placing all available relevant documentation before peer reviewers, respondents and the relevant

health practitioner registration board in order that informed decisions can truly be made and natural justice is afforded to practitioners.

As I stated in the Chairman's Foreword of the *Discussion Paper* tabled last year, this Inquiry has been one of the most important and detailed inquiries the Committee has thus far undertaken. The Committee has examined closely health complaints handling bodies and their procedures both interstate and internationally in an effort to see how our investigations and prosecutions in New South Wales can be improved.

This report makes a string of recommendations to try and address the key issues which arose throughout the inquiry. A number of these recommendations will require legislative change and it must be acknowledged at the outset that a review of the prevailing legislation is long overdue. The current legislative framework for health professional disciplinary matters is confusing in conjunction with being sometimes vague and even sometimes contradictory.

However, some important recommendations contained in this report will not require any legislative change. These recommendations address such critical issues as reducing delays, increasing clinical expertise and better policies and training for peer reviewers and will only require the will of the Commission to implement them by amending their procedures. I hope that there will be no impediment to them being expedited.

Although the Committee recommendations will go a long way to improve the Commission's operations with regard to investigations and prosecutions we have formed the view that even closer scrutiny of the internal workings of the Commission is needed.

Therefore on 5 December 2003 the Committee wrote to the Minister for Health, the Honourable Morris Iemma MP, and requested that he consider funding an independent external review of the Commission's systems for conducting investigations and prosecutions. The Committee believed that this type of detailed review is clearly outside the Committee's resources. However, the Committee felt that it was imperative that such a detailed review was undertaken as soon as possible. Throughout the inquiry the Committee has received more than enough information to raise concerns about how cases are being managed at the Commission to warrant such external scrutiny.

I would like to thank all who participated in and provided evidence to this Inquiry. I would like to particularly thank former Committee members Ms Marie Andrews MP, Mr Wayne Smith MP, Mr Peter Webb MP, Hon Dr Brian Pezutti MLC and Hon Henry Tsang MLC and the new Committee members for their ongoing dedication to and assistance in this Inquiry. I would also like to thank the Committee Secretariat for its support.

Jeff Hunter MP
Chairman

List of Recommendations

Assessments

1. That the Health Care Complaints Commission be given legislative powers to require health practitioners and providers who are the subject of a particular complaint to respond to that complaint during the making of inquiries during preliminary assessments by the Commission.

2. That the Health Care Complaints Commission be legislatively required to notify both complainants and respondents of the outcome of assessments within 14 days.

Investigations

1. That Section 23 of the *Health Care Complaints Act* 1993 be amended to provide the Health Care Complaints Commission with a discretion as to whether to investigate types of matters listed in that section in certain prescribed circumstances.

2. That the Health Care Complaints Commission tender for and contract a panel of external investigators to address the backlog of investigations.

3. That the Health Care Complaints Commission improve the training of its investigation team.

4. That the Health Care Complaints Commission develop and implement a policy which entails undertaking a more active form of investigations

5. That the *Health Care Complaints Act* 1993 be amended to require that the Health Care Complaints Commission give each peer reviewer **all** the evidence in relation to each case and request that an advice be also given in the alternative.

6. That peer reviewers and other expert witnesses be required to follow the Supreme Court's Code of Conduct for expert witnesses when appearing in a hearing.

7. That the Health Care Complaints Commission's *Guidelines for Professional Reviewers and Advisers* be reviewed to be more accessible and to reflect improved procedural fairness.

8. That external independent training be provided for peer reviewers.

9. That the Health Care Complaints Commission increase the number of clinicians employed on staff for the provision of expert advice.

10. That the Health Care Complaints Commission retain a wide variety of clinicians on contract to utilise during the investigation process.

11. That Section 40 and Section 43 of the *Health Care Complaints Act* 1993 be amended to require that the Health Care Complaints Commission provide the respondent with **all** the information collected during the course of the investigation including any peer review reports. The respondent should be given the right to request and receive a further 28 day extension as a matter of course.

12. That the *Health Care Complaints Act* 1993 be amended to require that, after deciding to proceed to prosecution, in either a disciplinary committee or a tribunal, the Health Care Complaints Commission place **all** the information collected during the course the investigation before the Crown Solicitor for a written independent legal opinion on the merits of the case.

13. That the Act be also amended to require that the Commission provide the relevant health professional board with a copy of the Crown Solicitor's advice along with the investigation summary report and **all** information collected during the course of the investigation prior to the Conduct Meeting. At the Conduct Meeting the Commission will consult with that board as to whether to proceed with the prosecution in each case in light of the Crown Solicitor's advice and that the more severe view prevail.

14. That the Act also be amended to require that the Commission report in each annual report on all instances in which prosecutions are proceeded with before disciplinary committees and tribunals against the Crown Solicitor's advice during that financial year and the reasons for this. This information can be de-identified where appropriate.

Prosecutions

1. That Section 177(1) of the *Medical Practice Act* 1992 and relevant sections of all other health professional legislation be amended to allow practitioners to be represented by a non legally trained advocate during their appearances before internal disciplinary committees.

2. That all persons who are eligible to serve as members of health professional disciplinary committees and tribunals and who do not possess tertiary qualifications in law be required to undertake regular relevant legal training. The costs of this training shall be met by the board for which they serve.

3. That health professional boards attempt to ensure that all disciplinary committees and tribunals have a panel member of a relevant cultural understanding to the respondent in each case.

4. That all persons who are eligible to serve as a member of health professional disciplinary committees and tribunals undertake cultural awareness training. The costs of this training should be met by the relevant board.

5. That health professional boards attempt to ensure that all disciplinary committees and tribunals have at least one panel member of the same specialty or sub-specialty and the same type of the practice as the respondent in each case.

6. That all the health professional registration Acts be amended to expressly exclude current members of the relevant board from sitting on its disciplinary committees and tribunals.

7. That Section 89 of the *Medical Practice Act* 1992 be amended to allow for *de novo* appeals on fact as well as law on the basis of the transcript from tribunals to the New South Wales Court of Appeal.

8. That appeals from disciplinary committees on lesser matters of practical application be heard by another similarly constituted disciplinary committee rather than a tribunal.

9. That a legislative review be undertaken of all the relevant Acts relating to the receipt and handling of complaints against health practitioners and subsequent disciplinary processes.

Chapter One - Receipt and Assessment of Complaints

Introduction

Divisions 3 and 4 of the *Health Care Complaints Act* 1993 provide for the receipt and assessment of complaints received by the Commission.

Section 10 provides that the Commission must notify the appropriate registration authority of the receipt of a complaint about a registered practitioner.

Section 16(1) provides that the Commission must give the person who is the subject of the complaint written notice of its receipt, the subject matter and the identity of the complainant within 14 days.

Section 20 provides that assessment should be for the purpose of deciding one of five things: whether the complaint should be investigated; conciliated; referred to the Director General of New South Wales Health if it involves the breach of any of various Acts under the Health portfolio; referred to another person or body to investigate; or the complaint is declined.

Section 21 allows the Commission to require that the complainant provide further information within 60 days.

Section 28(1) requires that the Commission must give parties to the complaint notice in writing of the action taken or decision made by the Commission following assessment of the complaint.

Responses to initial assessments

In its Discussion Paper the Committee canvassed opinions on the question of whether the Commission should be given the power to make inquiries of all relevant parties rather than just the complainant.

In its submission to the inquiry the Commission argued that greater powers to make inquiries of all relevant parties would result in speedier resolution of complaints.

This question was also considered in the *Review of the Health Care Complaints Act* which was carried out in 1997 when the Commission argued that access to more information during the assessment period enabled it to make the most appropriate assessment decision. The result may be that the complaint would be more likely to be dealt with by another way than investigation. The Review did not ultimately recommend that the Commission be given a wider power in this area.

Most submissions to the Committee did not object to the Commission's powers to gather information being extended during the assessment phase. There was a general

acknowledgement that it was probably in the interests of everyone that a decision to either investigate or not should be based on the most information available.

An examination of the relevant legislation in the other Australian states indicates that all the government bodies which deal with receiving and investigating health care complaints are given the power to seek information from all relevant parties as a preliminary step. In Western Australia, the Australian Capital Territory, Victoria, South Australia and Tasmania such agencies may make all inquiries as they deem fit. The Northern Territory and Queensland may make inquiries of the subject of the complaint.

The Committee could see no compelling reason why the Commission could not have its powers extended to not only seek but also require a response from the subject of the complaint during the assessment period. As pointed out in the submissions it is in everyone's best interests to deal with assessments in the most efficient and timely manner possible.

Recommendation 1: That the Health Care Complaints Commission be given legislative powers to require health practitioners and providers who are the subject of a particular complaint to respond to that complaint during the making of inquiries during preliminary assessments by the Commission.

Notification of outcomes of assessments

The current legislation does not specify a maximum time period in which the Commission must notify the parties to the complaint following the conclusion of an assessment where the complaint does not go to investigation.

Most submissions to the inquiry were in favour of having a statutory timeframe for this. United Medical Protection believed that the timeframe should be should be 14 days in accordance with the relevant Western Australian, Victorian, Queensland and Tasmanian bodies.

Most other submissions also suggested a 14 day timeframe.

Recommendation 2: That the Health Care Complaints Commission be legislatively required to notify both complainants and respondents of the outcome of assessments within 14 days.

Chapter Two - Investigations

Statutory declarations

As mentioned in the *Discussion Paper* the Commission argued in its submission to the inquiry that its performance would be improved if Section 23(3) of the *Health Care Complaints Act* 1993 was deleted. This section of the Act requires the complainant to verify their complaint with a statutory declaration before an investigation can begin.

The Commission argued that as 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. In addition it was argued that as a result of facts revealed in 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 majority of submissions received were emphatically in favour of retaining the legislative requirement of making a complainant sign a statutory declaration before proceeding to an investigation.

The New South Wales Medical Board supported the concept of seeking a statutory declaration but considered that it should be sought at a later stage so as not to delay the investigation:

> *As the Medical Board has previously submitted, it believes there is merit in requiring the signing of a statutory declaration by the complainant prior to a matter proceeding to formal disciplinary proceedings, but it considers that the current requirement to obtain a statutory declaration prior to commencement of investigation is unnecessary and onerous. In many instances it has led to substantial delays, notwithstanding the seriousness of the matters complained of.*

United Medical Protection took the following view:

> *A statutory declaration is essential for the HCCC to begin an investigation. UNITED strongly supports the view that a statutory declaration from the complainant places a legal burden on that complainant to be as truthful as possible. This is particularly so given that the evidence before the Professional Standards Committee is not sworn evidence and the statutory declaration is the basis of the prosecution. The Commission may well argue that it is an unnecessary administrative burden. However, in UNITED's view obtaining a statutory declaration is consistent with having a fair and impartial investigation and proper prosecution.*

The Committee believes that a statutory declaration is appropriate in order to begin an investigation. If a practitioner's reputation is to be tested as a result of a complaint then the complainant should be made to formally and legally reinforce the claims and allegations made against the practitioner.

Mandatory Investigations

Section 23 of the *Health Care Complaints Act* 1993 sets out the instances in which the Commission must investigate a complaint. These are: if the appropriate registration authority considers it is warranted; if following assessment of the complaint it appears to the Commission 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 and treatment given; or if the matter provides grounds for disciplinary action or involves gross negligence.

Compelling the Commission to investigate in all such circumstances arguably results in some matters being forced into an investigation when they may better be dealt with by some other means. There may also be duplication with other agencies involved in the matter such as the Coroner.

Health care complaints bodies and professional registration boards in other states are not compelled to investigate matters of concern in such a prescriptive way. Neither are other New South Wales "watchdog" agencies such as the Independent Commission Against Corruption, the Ombudsman, and the Legal Services Commissioner.

Most of the respondents to this question when it was posed in the *Discussion Paper* indicated that an amendment to the legislation in order to provide the Commission with a discretion in these instances would be desirable. It was most frequently suggested that it would safeguard against unnecessary investigations and reduce delays by decreasing the volume of matters which go to investigation. For instance, the New South Wales Nurses Association considered that the granting of such a discretion would be "prudent".

The New South Wales Medical Board believed that such a discretion should only be exercised in conjunction with the relevant health professional registration board:

> *The Medical Board believes that it is appropriate to have a discretion to proceed in these circumstances, but this should only be exercised in conjunction with the Board. As with other provisions in the legislation, the more serious view expressed by either party should be the determining factor as to whether an investigation should proceed.*

Recommendation 1: That Section 23 of the *Health Care Complaints Act* 1993 be amended to provide the Health Care Complaints Commission with a discretion as to whether to investigate types of matters listed in that section in certain prescribed circumstances.

Greater evidence gathering powers during investigations

The Commission has consistently argued for greater powers in relation to the gathering of evidence during an investigation. It considers that this would expedite the investigation process. In particular, the Commission believes that practitioners are discouraged by their professional organisations and medical defence organisations from providing further information once the investigation reaches its final stages under Section 40 of the *Health Care Complaints Act* 1993.

Sections 32 and 34 of the *Health Care Complaints Act* 1993 provide the Commission with similar powers to investigate matters as New South Wales Police 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 Commission 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;*
- *Provision of a less circumscribed power to enter, search and seize.*
- *A new power enabling the Commission to require a person to present for interviewing.*

As previously mentioned, it is currently open to the Health Care Complaints Commission 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 Commission argued in their original submission to the inquiry 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.*

Commissions 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 Commissioners 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.

Many responses received to the *Discussion Paper* were opposed to granting the Commission more stringent powers to seek information during the investigation phase. A number referred to instances of what they perceived to be abuses of the Commission's current powers.

United Medical Protection, for example, supplied the following two instances in support of the argument that the Commission currently sometimes uses its existing powers inappropriately:

> ***Case study no. 1***
> *Complaint relating to infection control at the practitioner's surgery. The HCCC was advised that UNITED was acting on behalf of the practitioner. UNITED forwarded practitioner's response to the HCCC. HCCC contacted the practitioner directly and inspected his surgery without UNITED's knowledge. Practitioner wrongly assumed that as UNITED was on record as the practitioner's representative that UNITED had agreed to the visit.*
> *Source: Dr F Investigation 2003*

Case study no.2
In 1996 the NSW Medical Board in consultation with the HCCC advised that they would be taking no further action against the practitioner as the matters did not relate to his clinical practice. In 1999 the HCCC reactivated the investigation in consultation with the NSW Medical Board. Between 1999 and December 2003 the HCCC have confirmed that the matter is going to the Medical Tribunal despite the 1996 advice of discontinuing the matter.
Source: Dr N Investigation 2003

However, the New South Wales Medical Board was supportive of the proposal to provide the Commission with greater powers to pursue information:

> *The Medical Board considers that it is in the interest of the Community that the HCCC have at its disposal, evidence gathering powers which will increase the pool of information in relation to the complaint and enable the HCCC and the registration authority to make decisions about the particular complaint. This information may either militate against further pursuit of the complaint or require that the complaint be proceeded with. It is noted that as a statutory body, the HCCC processes are regulated by a number of external bodies such as the Ombudsman, the Anti-Discrimination Board and Judicial Review – thereby providing safeguards in relation to the use of its powers.*

The Committee was ultimately not convinced that the Commission should be provided with further powers of investigation other than the additional powers recommended at the assessment stage.

Speeding up investigations

The time taken by the Commission to investigate matters was a major issue raised in the original submissions to the Inquiry. Since its inception the Commission has suffered serious delays in the time taken to conduct its investigations. Over the years these delays have only marginally improved.

United Medical Protection in its submission to the *Discussion Paper* provided the following case studies as examples of unacceptable delays in investigation times:

Case study no.1
The practitioner was notified of the complaint on 30 October 1998. The Dr responded on 16 January 1999. Dr spoke to HCCC investigator on 24 June 1999. Investigation officer considered that the investigation would take approximately six weeks for a decision to be made. On 16 January 2001 the Dr spoke to the HCCC investigator who advised that the case had "still to be finalised". UNITED contacted HCCC on 2 November 2001 and spoke to an investigation officer who advised that they were obtaining a Peer Review and that it would be at least another four months before any conclusion is reached in the matter. Last contact with the HCCC was 2 November 2001.

Case study no.2

The practitioner received notification of two separate complaints from two hospitals alleging inappropriate conduct on behalf of the practitioner. A full chronology is set out in detail to show the process of the HCCC's investigation in a current matter.

Hospital (1) incident	*Hospital (2) incident*
February 2000 incident	*September 2000 incident*
26 September 2002 – Notification from HCCC re: Complaint	*8 November 2000 – Notification from HCCC re: Complaint*
1 October 2002 – UNITED advised by HCCC that Statutory Declaration would be provided	*16 January 2001 – practitioner's employment terminated as a result of allegations.*
29 May 2003 – UNITED speak to HCCC and a copy of Statutory Declaration finally provided.	*4 April 2001 – Letter to HCCC requesting Statutory Declaration.*
June 2003 – Letter to the Commissioner HCCC re: delays	*6 June 2001 – Letter from HCCC to UNITED in respect of hospital allegations.*
10 November 2003 – Section 40 letter received from HCCC	*8 June 2001 – Further letter from HCCC advising practitioner allegations still being investigated.*
13 November 2003 – Copy of Complainant's statement and Peer Reviewer's report qualifying letter provided	*18 July 2001 – HCCC write to UNITED enclosing copy of patient's complaint and medical records relating to the admission at the Hospital.*
20 November 2003 – Section 40 Response provided.	*September 2001 – Matter investigated by local Police.*
Note practitioner in December 2000 and generally 2001 provided written denials to Hospital regarding the matter and these have been in the possession of the HCCC since that time.	*3 October 2001 – HCCC write to UNITED advising that they do not propose to obtain a Statutory Declaration from the patient.*
Dr has been unable to continue his training through the Post Graduate Medical Council despite UNITED's request to have a position allocated to him whilst the investigation is pending	*1 November 2001 – practitioner writes to Police advising that he denies any inappropriate behaviour.*
	21 February 2002 – UNITED writes to HCCC – practitioner denying that he acted inappropriately in any way towards patient.

	2 July 2002 – Letter to HCCC requesting HCCC investigate the matter as expeditiously as possible and informing them a police investigation was completed a month ago and no action taken.
	23 September 2002 – Letter from HCCC saying they were awaiting a Peer Reviewer's report.
	12 November 2002 – s40 letter received from HCCC attaching Peer Reviewer's report.
	20 November 2002 – Practitioner s40 response sent and an advice that the practitioner was not on duty on 17 or 18 September 2000.
	21 February 2003 – UNITED letter to HCCC raising delays and again confirming practitioner was not on duty on 17 September 2000 and that it was confirmed that another practitioner was on duty.

Source: Dr R Investigation 2003

In January 2001 the current Commissioner, Amanda Adrian, instigated a "Moving Forward" project. The Committee discussed this project with the Commissioner at the annual general meetings held in 2001, 2002 and 2003. At each meeting the Commissioner repeated assurances that investigation timeframes were being addressed.

In 2001/2002 the Commission received a pro rata budget supplementation of $800,000. In June 2002 the Commission was further granted a recurrent increase in its annual budget of $1.4m.

As was outlined in the Committee's recent report: *8th Meeting on the Annual Report of the Health Care Complaints Commission* the Committee is concerned that the expeditious and thorough investigation of complaints should be the Commission's major focus. The Committee sought information at the annual meeting with the Commissioner as to how much of the additional funding received is being directed into investigations and addressing the backlog of cases. On 10 December 2003 the Commissioner responded to the Committee that an additional $267,000 was spent on investigations in the 2002-2003 financial year. The Annual Report of the Health Care Complaints Commission for 2002-2003 notes:

> *As at 30 June 2003 there were 589 ongoing complaints under investigation.*

The Annual Report does not detail the length of time these investigations have remained open, however the Commissioner's letter of 10 December 2003 states:

> *As at 4 December 2003 there is a total of 231 investigations which are over 18 months old. ...a total of 112 investigations have been open for over 37 months ... and the longest period currently for an investigation remaining open is 64 months.*

In her appearance before the Committee on 18 September 2003 the Commissioner stated that it was problematic to address investigation backlogs and turnaround times quickly due to the lack of suitable investigators available:

> *Our primary focus was on increasing the number of investigation staff, or staff with investigation skills, to undertake the investigations. As we are finding, investigation officers do not grow on trees and sadly there is only a small pocket of them, and we are having to invest in development of skills in this area as well as recruiting people with those skills. I think this would be borne out by any of the other investigative agencies.*

In 2001/2002 the Queensland Office of Health Practitioner Registration Boards undertook a threefold strategy to reduce the caseload of investigations and improve investigation completion rates.

Firstly, legal advice was sought to inform the development and introduction of a robust complaints assessment process. This process, which was introduced in the 2002/2003 reporting period was designed to ensure that only those matters that should be investigated for the purposes of the *Health Practitioners (Professional Standards) Act* 1999 are referred to investigators.

Secondly, a project for development and implementation of a complaints management policy and procedure was commenced in the 2002-2003 reporting period. This project established: (a) operational protocols based on quality, efficiency and effectiveness; and (b) guidelines and benchmarks for the complaints assessment and investigation processes.

Thirdly, the Office established a panel of contract investigators to enable a concentrated effort to reduce the current investigation caseload and improve investigation completion rates.

Following a competitive tendering process three companies were selected to provide the services. An induction workshop for the external investigators was conducted in December 2002 and the initial 10 investigators were allocated one investigation each from January 2003. After their knowledge and skills were considered adequate each investigator was subsequently allocated up to five further investigations from March 2003. The investigators are supported and supervised by the Coordinator (Investigations) who is a member of the Office staff.

By 25 November 2003 the external panel of investigators had substantially completed 55 of the 100 investigations allocated to them. The remaining 45 are due by 28 February 2004. The average cost (net GST) of each of these investigations is $2,782. The average time taken for an investigation is five months. Therefore the Office of Health Practitioner

Registration Boards has cleared a backlog of 100 cases in just over a year for $262,000 (net GST).

The types of cases allocated to these external investigators have been at the lower end of the scale of complexity. The next 25 cases due to be allocated will be more complex and are projected to cost collectively around $100,000 (net GST). At this point these investigations will cost approximately the same as complex in-house investigations and following their completion the use of the external investigators will cease.

However, the Office of the Health Practitioners considered that external assistance was extremely necessary to reduce the backlog of investigations so that the internal investigators were freed up to work on more recent cases.

Recommendation 2: That the Health Care Complaints Commission tender for and contract a panel of external investigators to address the backlog of investigations.

Better training for investigators

Criticism of the lack of training given to the Commission's investigators was one of the predominant themes of this Inquiry. This criticism came not only from stakeholders and practitioners who had been under investigation but also from officers who had previously been employed as investigators at the Commission.

United Medical Protection gave the following example in this regard:

> ***Case study no.1***
>
> *In the patient's complaint to the HCCC the patient gave the practitioner's home address. The HCCC failed to check whether the complainant information was correct and sent the complaint to the wrong address*
>
> *Source: Dr S Investigation 2003*

A previous investigator at the Commission told the Committee that after being employed as a temporary investigator she received no formal induction training and virtually no training either in investigation techniques or clinical issues.

The Committee received the following advice from the New South Wales' Crown Solicitor on 17 November 2003 concerning the potential for legal training for disciplinary panel members and others:

> *Appropriate training would cover general legal awareness, including interpretation of relevant legislation, understanding the disciplinary process, the reception of evidence, legal report writing, principles of administrative law (such as procedural fairness) and the interaction between criminal law enforcement and the disciplinary process. My solicitors are available to provide such training and have done so in the past to members of several registration boards through the Health Professional Registration Boards.*

There appears to be a number of options open to the Commission to more robustly train its investigators. It is disappointing that this does not appear to be currently happening.

Recommendation 3: That the Health Care Complaints Commission improve the training of its investigation team.

More active investigations

The *Discussion Paper* highlighted the concerns of not just the Committee but the majority of stakeholders about the passive way the Commission conducts its investigations. During the course of this Inquiry the Committee has been presented with many examples of drawn out investigations which were based upon fundamental misunderstandings from the outset.

Some of these had even progressed as far as disciplinary committees and tribunals on the basis of these misunderstandings.

Similarly, health practitioners who were under investigation often told the Committee that they had not ever spoken directly with a Commission investigator throughout the entire investigation process.

While it is far more resource intensive to travel out to interview parties to a complaint, concerns have to be raised when an organisation largely conducts all its investigations from a central office via correspondence.

The responses to the *Discussion Paper* demonstrated resounding support for the proposal of more active investigations though there was some concern expressed that the Commission could not properly carry out this function without more clinically trained personnel. The New South Wales Medical Board argued that practitioners decline to meet with the Commission. This claim did not appear to be supported by practitioners, many of whom suggested that an "active" investigation in their own instance would have hopefully provided an earlier clarification of issues and misunderstandings.

United Medical Protection was strongly behind the proposal:

> *HCCC investigations may well improve if a more active approach was taken. UNITED has no objection to a more active approach as long as the Respondent's rights are protected.*
>
> *The HCCC is incorrect in its belief that UNITED discourages the practitioners from providing information to the HCCC until the investigation reaches its final stages under Section 40 of the Health Care Complaints Act 1993.*

Recommendation 4: That the Commission develop and implement a policy which entails undertaking a more active form of investigations.

Peer reviewers

The *Discussion Paper* canvassed a number of options for improvement of the peer review system.

There was universal support amongst the submissions for further review of the peer review system. Some parties indicated concern about the process currently employed by the Commission to select appropriate peer reviewers. Others were concerned that true peers of the practitioner under investigation should be utilised in each case. The overuse of city based peers for rural complaints was also singled out for criticism. One submission suggested that the respondent should have a say on the choice of the peer to review his or her case.

Virtually all submissions were in favour of all the information gathered by the Commission relating to the case being sent on to the peer reviewer rather than them just receiving a summary prepared by the Commission. It was also felt that the opinion peers prepare must contemplate alternative scenarios. Throughout the inquiry several solicitors and barristers expressed surprise that this was not done in line with most other areas of the law.

United Medical Protection argued strongly that the respondent must also be allowed to see all the documentation:

> *All documentation provided to peer reviewers including the briefing letter and enclosures should be made available to the respondent to enable a proper response.*
>
> *Alternatively, if the peer reviewer is to comment on only one limited aspect of the case, then this should be clearly identified and all the relevant material should be provided (and made available to the respondent).*
>
> *There needs to be a recognition that to ask a peer reviewer to assume that the factual account given by the complainant is correct, may well result in the production of an expert report of little weight or value. Care needs to be taken to address alternative assumptions or, at the very least to identify transparently the assumptions made.*

The New South Wales Medical Board supported strongly the idea that peer reviewers should be of a compatible specialty and background to the respondent. However it was acknowledged that this is sometimes difficult:

> *The Board agrees with the principle that peer reviewers should ideally practise in the sub-specialty of the subject practitioner if clinical issues are involved. The Board understands that it is often difficult in smaller sub-specialties to find a reviewer who considers him or herself sufficiently independent to comment on a colleague's work. Many practitioners are reluctant to become involved in disciplinary and medico-legal matters as witnesses.*
>
> *The Board considers that peer reviewers should be provided with information relevant to the particular complaint only. It is noted that it is open to a practitioner subject of a disciplinary complaint to provide a peer reviewer of their choice. On occasions the evidence of such a peer reviewer is preferred to that of the peer reviewer engaged by the HCCC.*
>
> *The Board agrees that peer reviewers should be educated as to the disciplinary process procedures at hearing, codes of practice for expert witnesses etc by the party who calls them in order to ensure that the peer reviewer is not disadvantaged by unfamiliarity with the process.*

The adherence to Court Codes of Conduct for Experts was also supported by United Medical Protection:

> *UNITED considers the standards to be set at the level of the District Court Code of Conduct for Experts irrespective of whether it is advisors, peer reviewers or experts.*
>
> *UNITED wishes to draw attention to the Code of Conduct for Experts embodied in the Supreme Court and District Court Rules in New South Wales (and in various other jurisdictions). There appears to be little or no recognition by the HCCC of the need for adherence to a code of this kind (or similar). In particular, such codes do require complete transparency in relation to the briefing of experts.*

Recommendation 5: That the *Health Care Complaints Act* 1993 be amended to require that the Health Care Complaints Commission give each peer reviewer all the evidence in relation to each case and request that an advice be also given in the alternative.

Recommendation 6: That peer reviewers and other expert witnesses be required to follow the Supreme Court's Code of Conduct for expert witnesses when appearing in a hearing.

The Discussion Paper also sought views about whether the Health Care Complaints Commission's *Guidelines for Professional Reviewers and Advisers* needed further review to reduce their complexity, improve procedural fairness and ensure their stronger application. In general there was support for this action. There was particular support for a Peer Reviewer's Declaration, identifying any possible conditions that could result in a biased opinion (for example a philosophical opposition to the method of practice used by the respondent).

Recommendation 7: That the Health Care Complaints Commission's *Guidelines for Professional Reviewers and Advisers* be reviewed to be more accessible and to reflect improved procedural fairness.

Recommendation 8: That external independent training be provided for peer reviewers.

Increased clinical expertise

The lack of in-house clinical expertise at the Commission has long been criticised and this view was reflected in all the responses received to the *Discussion Paper.* It was suggested that the Commission needed to employ far more doctors as investigators or a panel of experts that were available for consultation.

Dr Peter Arnold a previous Deputy President of the New South Wales Medical Board and frequent panellist on both the Medical Board's Professional Standards Committee and the Medical Tribunal made the following observations:

> *The fundamental problem with increasing any of the powers of the HCCC*, vis a vis*, for example, doctors, is that the investigations and "prosecutions" are conducted by persons who lack medical knowledge and training. If doctors are to be encouraged to co-operate with an inquiry into their professional conduct, they are unlikely to do so, willingly or effectively, unless the persons with whom they are conversing have the*

> *background to understand the clinical situations being discussed. Such a change may not be a panacea, but it would go some way towards overcoming doctors' current feeling of being hounded, as if for criminal behaviour, rather than being called before their peers to discuss their medical management of patients.*
>
> *It is quite likely, in view of the original political motivation for the establishment of the Commission (the Chelmsford catastrophe), that an attitude of* quis custodiet ipsos custodes*? remains firmly entrenched within the HCCC. In other words, doctors cannot be trusted to judge other doctors.*
>
> *This is the kernel of the issue. Unless and until the HCCC changes this attitude (and the Act is appropriately amended) and employs its own doctors as investigators, as do the Health Insurance Commission, with its associated Professional Services Review (and the Law Society with its employment of lawyer-investigators), the majority of the problems raised by the Committee will remain unsolved.*

The New South Wales Medical Board reconfirmed what it had said in its initial submission to the inquiry:

> *As previously submitted, the Board supports the increased use of clinical expertise at all points in the assessment, investigation and re-consultation phases.*

United Medical Protection fully supported the previous views:

> *UNITED supports the New South Wales Medical Board's view that the system would be enhanced by increased use of regular independent legal advice during the Commission's investigations of clinical complaints and by medico/legal review of matters prior to finalisation.*

The submission of the Australian Psychological Association Ltd strongly made the argument that what little clinical representation was currently available at the Commission was only useful in investigating doctors:

> *Obviously a retired paediatrician and a general physician (the Commission's in-house clinical expertise at the time the Discussion Paper was tabled) would not be relevant to the investigation of a complaint against a psychologist.*
>
> *Investigations that involve other than peer review with relevant clinical or "other area of expertise" (it should be noted that we have nine specialised Colleges including Sports and Organisational Psychologists that are not included by the term "clinical") would streamline some matters and provide a more sound basis for gathering information since there is significant diversity in psychological disciplines, practice, skills and measures.*
>
> *A panel of approved experts to review investigative data would allow a thorough and fair investigation. In this case there would be no need to redo the investigation.*

The Committee believes it is essential, as a matter of priority, that the Commission should increase its access to and use of clinical expertise at all points in the assessment and investigations stages.

Recommendation 9: That the Health Care Complaints Commission increase the number of clinicians employed on staff for the provision of expert advice.

Recommendation 10: That the Health Care Complaints Commission retain a wide variety of clinicians on contract to utilise during the investigation process.

Longer response preparation times

Most submissions supported the idea that doctors either be given a longer period than 28 days in which to prepare a s40 response to the case following an investigation or that they be given an extension on request as a matter of right. It was considered essential that they be given an appropriate amount of time in which to prepare a good defence.

There was also unanimous support that the practitioner should be given all documentation relevant to the inquiry.

United Medical Protection pointed out that corresponding legislation in the other Australian jurisdictions was far less prescriptive:

> *So far as UNITED can determine, none of the corresponding legislation in other States specifies any timeframe for this step. If a time limit is to apply then it should date from the provision of the complete Peer Reviewer brief of documents.*

The Committee has seen a copy of an internal memorandum in which the Assistant Commissioner Ms Julie Kinross actually stated that the Commission was not under an obligation to provide the peer review report to the respondent at the beginning of the 28 day period.

Ms Kinross wrote in a memo dated 18 March 2003:

> *While it is customary (although not necessary to meet the requirements of procedural fairness), for the Commission to provide a copy of the peer review report, a decision was made to send the s40 letter prior to receipt of a peer report, a recent and deliberate practice of the Commission to help expedite some of the seriously delayed files.*

The Committee is extremely concerned that some practitioners are being currently required to prepare s40 responses without even access to something as essential to their case as a peer report. The Committee is even more concerned about the Commission's view of what constitutes procedural fairness.

Further, it is even more unacceptable when these cases have been delayed for many years by the Commission itself. Yet the practitioner is being denied procedural fairness in order to expedite the matter for the Commission's own purposes.

Recommendation 11: That Section 40 and Section 43 of the Health Care Complaints Act 1993 be amended to require that the Health Care Complaints Commission provide the respondent with all the information collected during the course of the investigation including any peer review

reports. The respondent should be given the right to request and receive a further 28 day extension as a matter of course.

Greater separation between investigations and prosecutions

Most submissions argued that a greater separation, if not a complete separation, between investigations and prosecutions was necessary to ensure objectivity and due process. Some suggested that the current proximity of the two functions serves to ensure that the Commission remains more adversarial than it is investigative.

As canvassed in the *Discussion Paper* the Committee was mindful of the cost involved in completely separating out the functions into two distinct agencies but was sufficiently concerned about the number of matters which were being put before disciplinary committees and tribunals which did not clearly have the necessary weight of evidence behind them to justify being sent there.

The Committee consulted with the New South Wales Crown Solicitor's Office about whether there may be a way that the Crown Solicitor could play a role in the Commission's decision to go to prosecution. The Committee was particularly interested in whether the Crown Solicitor may be able to provide independent advice on the viability of each case proceeding to prosecution.

The Committee met with Mr Ian Knight the New South Wales Crown Solicitor to discuss options for the provision of independent legal advice on Commission investigations prior to a decision being made as to whether the matter should proceed to prosecution.

The advice would then be sent back to both the Commission and the relevant health registration board and a decision would be made between them as to whether the matter should proceed to prosecution.

The Crown Solicitor had previously undertaken all health disciplinary prosecutions for the Commission's predecessor, the Health Care Complaints Unit and conducted some its very high profile cases such as those into Drs McBride and Edelsten. The Crown Solicitor also currently undertakes prosecutions for the Department of Health under the *Public Health Act* 1991 as well as often acting as counsel assisting some of the health professional disciplinary committees and tribunals such as those conducted by the Nurses' Board. The Crown Solicitor told the Committee that he felt confident that his Office could fulfil this role and that it would be a valuable one. In a written response to the Committee on 17 November 1993 he said:

> *Regardless of which option is recommended, I agree with the Committee that the provision of external, independent legal advice would assist to overcome any perception which might exist that decisions in respect to disciplinary matters are based on other than proper considerations.*
> *The Committee also appears to consider that the provision of external, independent legal advice by the Crown Solicitor would assist in ensuring consistency in decision making in relation to disciplinary proceedings and I would agree.*
>
> *I (currently) provide legal advice and representation to State government agencies including many agencies involved in the supply and the regulation of health care*

services. That has included providing legal advice and representation in relation to the bringing of complaints against service providers. Advice can be provided at any stage of the disciplinary proceedings including, for example, advice on the sufficiency of the evidence to warrant the commencement of disciplinary proceedings and advice on particular legal issues arising, such as the extent of relevant statutory powers and functions.

I also (currently) provide assistance to disciplinary bodies in the performance of their duties and functions in hearing complaints where a power to obtain such assistance is conferred upon them.

The Committee considers that it is important that the strength of the Commission's case be tested by an external legal advisor to avoid embarrassing repetitions of incidences such as Drs Atkins and Liu where the case went all the way to the door of the Medical Tribunal before it was finally accepted that it could not proceed due to irrefutable evidence to prove that neither doctor was even in the relevant hospital the day the incident took place.

Similarly the case of Dr C before the New South Wales Dental Board (Tribunal) where the President of that Board (Tribunal) was prompted to say at the conclusion of the proceedings:

…All I am saying is that the evidence that has been presented to this Tribunal is insufficient for us to come to any conclusion other than to dismiss the matter. I will be writing to the Commissioner about that matter (the weight of evidence) because I think it has been handled abominably.

Recommendation 12: That the *Health Care Complaints Act* 1993 be amended to require that, after deciding to proceed to prosecution, in either a disciplinary committee or a tribunal, the Health Care Complaints Commission place all the information collected during the course the investigation before the Crown Solicitor for a written independent legal opinion on the merits of the case.

Recommendation 13: That the Act be also amended to require that the Commission provide the relevant health professional board with a copy of the Crown Solicitor's advice along with the investigation summary report and all information collected during the course of the investigation prior to the Conduct Meeting. At the Conduct Meeting the Commission will consult with that board as to whether to proceed with the prosecution in each case in light of the Crown Solicitor's advice and that the more severe view prevail.

Recommendation 14: That the Act also be amended to require that the Commission report in each annual report on all instances in which prosecutions are proceeded with before disciplinary committees and tribunals against the Crown Solicitor's advice during that financial year and the reasons for this. This information can be de-identified where appropriate.

Chapter Three - Prosecutions

Prosecutions before Professional Standards Committees

The *Discussion Paper* raised issues concerning the power imbalance existing within Professional Standards Committee prosecutions. The concerns about the fact that practitioners are required to conduct their own defence against a prosecutor from the Commission were discussed in detail. Further, the current system allows the practitioner to question his or her patient complainant directly if they are appearing as a witness which may be found to be intimidating by many complainants.

Most submissions supported the idea of the Professional Standards Committees operating similar to a coronial inquiry in that they are truly inquisitorial. The Commission would only send an officer along to assist the panel rather than to prosecute the case.

It was considered procedurally unfair that practitioners, who are unskilled in such matters and probably very understandably nervous, be forced to conduct their own defence.

Dr Peter Arnold provided the Committee with the following response:

> *No (prosecution is not necessary). The matter could be conducted by the Chairman of the PSC, assisted by the other members and, as suggested in the Interim Report, by an officer assisting the enquiry.*

There was also strong support for the idea of a non legally trained advocate to assist the practitioner with his or her case.

United Medical Protection:

> *UNITED submits that whether the HCCC prosecutes the case or not, or whether the officer of the HCCC presents the evidence as an officer assisting the inquiry the fundamental issue is that the practitioner must be allowed to have representation at the PSC to have a fair hearing. Practitioners should be allowed to have an advocate to speak on their behalf. Unless that occurs there will always be a significant power imbalance between the practitioner and the HCCC in the Professional Standards Committee. Whether the HCCC officer presents evidence as an officer assisting the inquiry or prosecutes the case, there will still be an examination and cross examination of witnesses. The practitioner is not trained as an advocate, he is not trained to argue how he considers the inquiry should proceed and he is not trained in examining or cross-examining witnesses. It is inappropriate for the practitioner to act as their own advocate on issues of credit.*

The Committee agrees with the views expressed by United Medical Protection. It would appear to be in the interests of affording natural justice that the defence be afforded the same representation as the prosecution. This is particularly necessary in light of the Commission's past history of employing non-legally trained police prosecutors and solicitors registered in jurisdictions other than New South Wales as prosecutors before Professional Standards Committees.

Recommendation 1: That Section 177(1) of the *Medical Practice Act* 1992 and relevant sections of all other health professional legislation be amended to allow practitioners to be represented by a non legally trained advocate during their appearances before internal disciplinary committees.

Legal training for disciplinary panel members

As canvassed in the *Discussion Paper* equivalent bodies to our health professional disciplinary committees and tribunals such as the Professional Services Review are required to undertake mandatory intensive legal training. This is not a requirement for members who sit on the New South Wales health professional disciplinary panels. The New South Wales Medical Board, for instance, only offers twice yearly two hourly sessions to its members on a voluntary basis.

In its submission to the *Discussion Paper* the Medical Board argued that it considered this to be adequate:

> *The Medical Board was not aware of these concerns (about the lack of legal knowledge displayed by their panel members). They have not been raised with the Medical Board itself.*
>
> *There is regular interaction and provision of advice to panel members, and on an annual basis, the Board provides two training nights for PSC and Medical Tribunal Members and a separate evening for Chairs of Professional Standards Committee hearings as well as a training manual which is regularly updated.*

In contrast United Medical Protection supported the views of most of the practitioners who had written to the Committee.

> *UNITED considers that disciplinary panel members have a distinct lack of legal knowledge. UNITED supports the type of training undertaken by the Professional Standards Review Members.*

The Committee believes that it is extremely important for the disciplinary panel members to understand at a minimum the requirements of the relevant pieces of legislation, the laws of evidence and surrounding natural justice issues. Court of Appeal judgements relating to decisions of the Law Society disciplinary proceedings have shown that even the legal profession finds grappling with the complicated issues surrounding natural justice difficult on occasion.

Recommendation 2: That all persons who are eligible to serve as members of health professional disciplinary committees and tribunals and who do not possess tertiary qualifications in law be required to undertake regular relevant legal training. The costs of this training shall be met by the board for which they serve.

Cultural awareness amongst panel members

Concerns were raised with the Committee throughout the course of the inquiry about the lack of understanding demonstrated by some disciplinary panel members as to the cultural background of the practitioner before them.

As raised in the *Discussion Paper* the General Medical Council of the United Kingdom now requires that members undergo some formal cultural awareness type 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 General Medical Council'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, in fact, the General Medical Council was far more likely to dismiss both complaints and cases against local doctors.

There was a mixed response to this question when it was posed in the *Discussion Paper*.

Dr Peter Arnold argued that he did not believe that the General Medical Council experience was reflected in New South Wales' disciplinary proceedings:

> *Having served on a total of some 60 PSCs and Medical Tribunals. I have seen no evidence to support this statement.*
>
> *I have certainly seen overseas born practitioners being found guilty of unprofessional conduct and misconduct, but for every instance I can think of there have been vastly more, and often worse, offences by Australian-born practitioners, who have been duly struck off the Register.*

The New South Wales Medical Board was of the view that its panel members received sufficient exposure in relation to cultural issues:

> *Board members and panellists work with culturally diverse groups in the community in their professional practice.*
>
> *Issues such as cultural differences in approach to the giving of evidence, are regularly discussed at PSC and Medical Tribunal training nights, as well as Anti-Discrimination Act requirements. The Board has a diverse panel of practitioners and lay members from a range of ethnic backgrounds who sit on Medical Board hearings, Professional Standards Committees, Medical Tribunals etc.*

United Medical Protection was very much of the view that disciplinary panels had demonstrated a lack of cultural awareness:

> *UNITED considers that not only are there concerns about disciplinary panel members lacking ethnic representation at these hearings but there is also a considerable lack of cultural awareness.*

The Committee ultimately feels that as much cultural awareness exposure as possible for panel members can only be a positive thing. Practitioners of a variety of cultures behave extremely differently during official questioning. Likewise the way they communicate with their patients and approach other official clinical and administrative activities may vary. This may be particularly so if some of those patients are of the same ethnic origin as the practitioner. It is obviously especially necessary to be aware of these differences within an inquisitorial system.

Recommendation 3: That health professional boards attempt to ensure that all disciplinary committees and tribunals have a panel member of a relevant cultural understanding to the respondent in each case.

Recommendation 4: That all persons who are eligible to serve as a member of health professional disciplinary committees and tribunals undertake cultural awareness training. The costs of this training should be met by the relevant board.

Specialty peers on panels

Many concerns were also raised about the fact that practitioners often were made to appear before a disciplinary panel which did not include a peer from the same specialty, sub-specialty or type of practice e.g. rural. The Committee strongly supports the use of appropriate panel members wherever possible.

Recommendation 5: That health professional boards attempt to ensure that all disciplinary committees and tribunals have at least one panel member of the same specialty or sub-specialty and the same type of the practice as the respondent in each case.

Registration Board Members on committees and tribunals

The Discussion Paper raised the issue of whether there could be at least a perceived conflict of interest in Board Members sitting on disciplinary committees and tribunals. In fact, a great many of the health registration board enabling Acts such as the *Dental Practice Act* 2001 expressly legislate against it.

The New South Wales Medical Board was the sole submission which argued for retention of the right to maintain members on these panels:

> *Board members are regularly reminded of the necessity to ensure that they both deal with matters impartially and appear to do so. All Board agendas are marked with the requirement for members to declare any potential conflicts of interest at the commencement of the meeting. The Medical Board has 20 members and a number of Committees. Board members generally are members of two or three Committees. The Board considers it important that Board members have some experience on Committees and Tribunals in order to understand the process and the pressures upon practitioners facing such hearings as well as those sitting on them.*
>
> *The Board ensures that no member sitting on a Committee that deals with a particular matter is appointed to a hearing in relation to the same matter.*

Ultimately the Committee felt that the practitioner's perception that he or she was receiving a truly impartial hearing was of primary importance. The matter concerning Dr Sabag was a case in point. The Medical Board put a past Deputy President of the Medical Board on Dr Sabag's panel. This person had been serving as Deputy President at the time that Dr Sabag had previous dealings with Board. As a result it was understandable that Dr Sabag could not except that the decision handed down by the Tribunal was truly impartial.

There appears to be more than sufficient numbers of practitioners currently on the list who can serve on the Medical Board's Professional Standards Committees and Tribunals without needing Medical Board members' involvement.

Recommendation 6: That all the health professional registration Acts be amended to expressly exclude current members of the relevant board from sitting on its disciplinary committees and tribunals.

Administrative Decisions Tribunal

The question of whether health professional tribunals should be moved to the Administrative Decisions Tribunal was canvassed in the *Discussion Paper*.

Ultimately the Committee accepts that as each health professional registration board runs its own tribunals fairly inexpensively apart from the Medical Board which must pay expenses to the District Court. Any move to the Administrative Decisions Tribunal may involve considerably more expense which would have to be passed onto each board's practitioners. This may cause financial hardship for some of the smaller boards such as the podiatrists.

The Committee believes that the benefits probably do not outweigh the additional costs at this time.

De novo appeals

As outlined in the *Discussion Paper* currently appeals from health professional tribunals to the Court of Appeal are on a point of law only.

These types of appeals are narrow and, as they are generally on issues of natural justice, the common practice is to refer the matter back for rehearing to the original deciding body when the plaintiff is successful. This is a somewhat 'pyrrhic victory' for the successful applicant.

The *Discussion Paper* canvassed the idea of allowing appeals to be *de novo* in line with the practice in the other States. Currently all Australian jurisdictions except the Northern Territory allow for *de novo* appeals to be heard in these circumstances.

The New South Wales' Medical Board was opposed to *de novo* appeals:

> *The Board considers it significant that Medical Tribunals provide an opportunity for community members and peers to consider complaints against medical practitioners. Providing for de novo appeals to the Court of Appeal and the Supreme Court, would remove community and peer involvement from these matters. The Board believes this would be contrary to community expectations and to the principle that professional disciplinary proceedings should involve peer expertise*

United Medical Protection in its submission strongly supported the proposal:

> *This is one of the fundamental issues which concerns UNITED. As stated in the Discussion paper de novo appeals are the norm in all the other States. It is noted that a de novo appeal does not mean that new or different evidence is admissible except in special circumstances. In other words the appellate body considers the issues afresh but will ordinarily rely on the transcript of evidence.*

Similarly, the Australian Psychological Society supports *de novo* appeals:

> *Yes, because it allows extensive evidence to be taken and heard under court rules. In this instance uniformity across all other States is desirable.*

The Committee wholeheartedly supports these views. It believes that the result can only be a fairer system of appeals for practitioners and a more robust review of the disciplinary tribunals.

Recommendation 7: That Section 89 of the *Medical Practice Act* 1992 be amended to allow for *de novo* appeals on fact as well as law on the basis of the transcript from tribunals to the New South Wales Court of Appeal .

Lesser matters of practical application

United Medical Protection express frustration at the fact that it was required to take such appeals to the medical Tribunal from the Professional Standards Committees. Examples were given of practitioners being required to undertake training courses within particular time periods when enrolments were full for the next class that fell within the specified time period. There were also examples of practitioners being required to undertake courses which did not exist.

The Committee agreed with United Medical Protection that being required to take such minor matters before tribunals was impractical and unnecessary.

Recommendation 8: That appeals from disciplinary committees on lesser matters of practical application be heard by another similarly constituted disciplinary committee rather than a tribunal.

Legislative Review

Over the years concern has constantly been raised about the inconsistencies, complexities and seeming contradictions in the provisions of the various health professional registration Acts and the *Health Care Complaints Act* 1993 where their functions intertwine. This has much to do with the fact that the Health Care Complaints Act has not been reviewed or amended at all since its introduction in 1993. The Committee considers that it is imperative that all relevant legislation be reviewed to ensure clarity and consistency.

Recommendation 9: That a legislative review be undertaken of all the relevant Acts relating to the receipt and handling of complaints against health practitioners and subsequent disciplinary processes

APPENDICES:

Appendix 1 - Discussion Paper on Investigations and Prosecutions Undertaken by the Health Care Complaints Commission.

Appendix 2 – Minutes of Committee meetings