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7.8.16

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Dear Sir / Madam,

Re: ***Inquiry into the performance of the Queensland Health Ombudsman's functions pursuant to section 179 of the Health Ombudsman Act 2013***

Following is a submission, as invited, in relation to the above Inquiry. This submission has been compiled from my perspective as a psychiatrist actively involved in the field of the health and well-being of health practitioners, particularly medical practitioners. As well as my role with the Doctors Health Advisory Service (Queensland), (DHAS (Q)) a substantial proportion of my clinical practice involves the treatment of colleagues, I provide Independent Medical Reports, and I provide educational presentations for undergraduate students and current practitioners.

This submission represents my own opinions. It has not been formally ratified by the DHAS (Q) Management Committee because of limited available time since we became aware of the opportunity to provide a submission.

Issues considered:

- ***the operation of the health service complaints management system;***

It is readily acknowledged that we have in Australia a system of accrediting and regulating medical practice which provides a very good standard of health care practice, and, as a consequence, a very high level of safety for the public. This is appreciated and strongly supported, including the progressive nature of these activities.

As with all developments, useful adjustments become apparent by reflecting on experience.

There are several concerns brought to our attention regarding the operation of the system as it currently operates.

Foremost among these are the remarkable delays involved in having matters considered and finalised. These delays have a considerable cost in terms of financial expenses, interference with practice, and with provision of services to the community, and particularly from the perspective of DHAS (Q), the effects of prolonged stress on the health of the practitioners involved.

Being subject to a complaint, especially when this involves a legal action, has for decades been repeatedly rated as one of the most severe stressors encountered in medical practice. This is accentuated by the limited, confronting 'legalistic' style of communications frequently

encountered.

When it is necessary for one of my doctor-patients to have a matter notified to OHO, the means available to assist this adopt a surprisingly unhelpful attitude, almost exclusively from the point of view of a patient, whose perspective appears to be accepted at face value. This form of communication does not encourage confidence that the matter will be treated with proper consideration, without bias against the practitioner.

I have had OHO staff caution me while attempting to arrange such a notification, as if I had been negligent in my responsibilities. They had misunderstood that my prime focus of attention was to facilitate arrangements for the practitioner to self-refer. Such self-referral has for a long time, internationally, been associated with better outcomes for all parties in contrast to the adversarial approach which seems to be the default position currently adopted.

There has been a remarkably greater difficulty being able to discuss cases with the personnel of both AHPRA and OHO. Formerly, good working relationships with the Medical Board of Queensland personnel allowed for greater efficiency at all levels of assessment, intervention (including immediate cessation of practice) and subsequent successful return to practice.

My understanding is that the greater the distance between the officer making a decision, and the person affected, the more conservative will be the decision that is made, with this not necessarily being appropriate or efficient.

This is compounded by decisions that seem to be made with insufficient appreciation of the actual situation, as if made by staff relying excessively on protocols, with little clinical experience. A major problem arises when single categories of complaints include wide variations of severity, with the default response being appropriate as if the most severe circumstances applied.

A major concern relates to Notifications that are made, as if the conditions for Mandatory Notification have been satisfied when this is not the case. For instance, a junior doctor who attended the Emergency Department to seek help for personal distress, was notified on the basis that they had a psychiatric disorder, and on the misunderstanding of the referring Hospital Supervisor that the notification was the appropriate means to arrange treatment. The doctor had been on leave, was not treating patients, and readily accepted referral for specialist treatment.

In my opinion, the system has not been sufficiently effective with respect to providing information regarding when to refer, and when not to refer. This failure particularly refers to supervisors in public training hospitals with junior medical staff. Several junior doctors have had the beginning of their medical career jeopardised because of apparently well meaning but unskilled management of personal situations. This is then compounded following referral by the extensive legalistic investigation and supervision, with lingering suspicion and doubt. This is then even further compounded by the attitude of those responsible for ongoing supervision, who too often are influenced by unreasonable prejudice against a practitioner who has attracted the attention of the OHO. I am confident that the supervising practitioner is unduly influenced by their own conflict of interest, being intent on conducting their supervisory role in a manner that reduces their risk of being criticised in a manner that unreasonably compromises the progress of the practitioner notified.

This predicament is noticeably worsening as the competition for Junior Doctor positions increases, such that the ‘no risk’ position of the supervisor is to prefer a doctor who has not

come to the attention of the OHO irrespective of the reasons for this, and of the circumstances since the time of concern. The personal and professional recovery from involvement in the processes following notification is problematic and prolonged, in addition to the recovery from the circumstances which led to the concern being raised.

There is currently insufficient awareness of, and attention to, the processes and systems which optimise such a recovery, with resulting disadvantage to the person and to the community. This will be a focus of attention of the Queensland Doctors Health Programme, operating since 1.6.16, with the support of the DHAS (Q) and the MBA.

I have been acquainted with several situations in which the practitioner had, in a professionally commendable manner, taken leave from practice as soon as they became aware of the scale of their difficulty, accepted treatment and did not return to practice until recommended. Yet notification from another practitioner resulted in an unnecessary, and costly, assessment process. My understanding is that it is feasible for the OHO to advise that, if the practitioner is not practising, notification is not required, unless other reasons are provided that do make this necessary. In my opinion, it is appropriate for the OHO to review their response to referrals made in these circumstances.

In other areas of practice similar situations arise when issues not related to the complaint come to the attention of the investigating officer. This is of course reasonable when the issue can be related to practices that are relevant to the complaint. This includes a generally low standard of several areas of practice. However, the standard against which usual practice is measured should not be perfection, and departures from perfection should not be a basis for OHO intervention. This requires those making decisions to use their discretion, based on clinical experience, rather than applying measures intended originally as guidelines without taking the actual circumstances into consideration.

Awareness of many reports of this nature, including incidents which could reasonably be regarded as trivial, with no harm caused, and very low risk of harm, have substantially raised the concern of many practitioners of good standing. This concern is accompanied by loss of confidence in the approach of the OHO, loss of confidence as to what now constitutes acceptable practice, and a continuing trend to greater investment in self protection, thereby decreasing the use of limited resources for patient care.

- ***ways in which the health service complaints management system might be improved;***

Review the Notification process, and documentation

- to facilitate self-referral,
- to reduce perceived bias,
- to decrease the number of inappropriate notifications
- to improve clarity of documents with fewer words
- to improve the clinical relevance of decisions to actual risk to patients
- more efficient, timely assessment and decision processing of notifications,
- improve ability of notified practitioners, and of treating practitioners to develop working relationships with OHO, AHPRA personnel
- improve training regarding Notification, in particular, supervisors of trainees.
- encourage processes assisting practitioners to return to practice, with appropriate standards
- provide a supportive approach for those assisting a practitioner to return to practice,

when this is appropriate

- ***the performance by the health ombudsman of the health ombudsman's functions under Health Ombudsman Act 2013 Act;***

I know of no reason to criticise the individual performance of the Health Ombudsman.

- ***review the National Boards' and National Agency's performance of their functions relating to the health, conduct and performance of registered health practitioners who provide health services in Queensland;***

Overall we have a system which deserves praise and support, along with ongoing review and adjustment, as described.

Some strange recommendations made in relation to practitioners under supervision suggest that wider consultation would be beneficial when making decisions regarding management. eg perhaps not requiring use of an alcometer immediately *after* a clinical session, in addition to using it immediately before the same clinical session. I expect that if it was considered that there was a significant risk of the practitioner drinking during a clinical session, that they should take leave till greater stability and compliance with expected standards had been obtained.

- ***any other matter about the health service complaints management system*.**

Improved communication between all participants would greatly contribute to better working relationships and outcomes.

The current practice of limited communications is more likely to promote apprehension, unrealistic speculation, distrust, irritation and low confidence in the operations of the health service complaints management system.

It is clear from my comments that I am not clear as to the precise division of responsibilities and activities between the OHO and AHPRA, MBA, despite significant involvement in this area of practice. I am not alone in this regard. This difficulty does detract from the important task of developing confidence in the health service complaints management system as a whole.

I am grateful for the opportunity to contribute to the work to which I, and my DHAS colleagues, continue to have a strong commitment.
I remain willing to provide further information and opinion, as required.

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