HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE

Members present:

Ms L Linard MP (Chair)
Mr MF McArdle MP
Mr SE Cramp MP
Mr AD Harper MP
Mr DC Janetzki MP
Mr JP Kelly MP

Staff present:

Mr K Holden (Research Director)
Mr J Gilchrist (Principal Research Officer)

PUBLIC BRIEFING—INQUIRY INTO THE PERFORMANCE OF THE HEALTH OMBUDSMAN'S FUNCTIONS PURSUANT TO SECTION 179 OF THE *HEALTH OMBUDSMAN ACT 2013*

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 31 AUGUST 2016

Brisbane

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Committee met at 10.18 am

CHAIR: Good morning, ladies and gentlemen. I declare open this public briefing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee. I acknowledge the traditional owners of the land on which we meet and pay my respects to elders past, present and emerging. My name is Leanne Linard. I am the chair of the committee and the member for Nudgee. The other members of the committee are: Mr Mark McArdle, the deputy chair and member for Caloundra; Mr Joe Kelly, the member for Greenslopes; Mr Sid Cramp, the member for Gaven; Mr Aaron Harper, the member for Thuringowa; and Mr David Janetzki, the member for Toowoomba South.

Today's briefing is a part of the committee's inquiry into the performance of the Health Ombudsman's functions pursuant to section 179 of the Health Ombudsman Act 2013. Issues to be considered by the committee as part of our inquiry include the operation of the health service complaints management system; ways in which the health service complaints management system might be improved; the performance by the Health Ombudsman of the Health Ombudsman's functions under the act; a review of the national board's 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; and any other matter about the health service complaints management system. This morning we will hear from representatives and officers from the Australian Medical Association Queensland, the Australian Health Practitioner Regulation Agency, the national boards and the Health Ombudsman. The committee intends to hold further public hearings and briefings as part of our inquiry. Submissions accepted by the committee are published on the committee's inquiry webpages.

A few procedural matters before we start: the committee is a statutory committee of the Queensland parliament and as such represents the parliament. It is an all-party committee that takes a nonpartisan approach to inquiries. This briefing is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. The committee will not require evidence to be given under oath, but I remind you that intentionally misleading the committee is a serious offence. You have previously been provided with a copy of the instructions for witnesses, so we will take those as read. Hansard will record the proceedings and you will be provided with a copy of the transcript. This briefing will also be broadcast. I remind all those in attendance today that these proceedings are similar to parliament to the extent that the public cannot participate. Please also note that this is a public briefing and you may be filmed or photographed. I remind witnesses to speak into the microphone.

ZAPPALA, Dr Chris, President, Australian Medical Association Queensland

CHAIR: Thank you for the submission that you made to the committee's inquiry. I invite you to make an opening statement of up to five minutes and then we will open for questions.

Dr Zappala: Good morning and thank you very much for the opportunity to speak this morning. The AMA Queensland feels very strongly and doctors feel very strongly about this issue. We hope that you find our submission in front of you a thoughtful document that we have put a bit of work into.

I think it is very important that we just linger a moment on the history of what led to the creation of the Health Ombudsman's office. Of course, there was a perception that the health quality complaints commission at the time was not working efficiently and that timelines for clients and investigations were becoming inappropriately prolonged and there was some ambiguity to decision-making. The establishment, then, of this second layer of medical regulatory bureaucracy in the form of the OHO was devised. The perception of doctors and the AMA Queensland is that, really, unfortunately, nothing has changed in the last couple of years. The situation has in fact worsened to the extent that we are seeing a dramatic escalation in the number of complaints that are being handled.

The OHO was ushered in at a time when the medical chairperson and majority membership of doctors on the medical board in Queensland were deliberately stripped away. There was a concerted move towards marginalisation of doctors in the medical regulatory system, and the difficulties at

maintaining medical membership on the medical board in current times underlines this ongoing problem. It is therefore, we think, by design the creation of an overly bureaucratic system that has marginalised doctors which is an affront not forced on to any other professional group.

It is worth noting that there are only two other states in Australia that have a dual regulatory system. All the other states and territories seem to manage just fine with the national Medical Board and the state boards. There is no evidence whatsoever that the problems of misconduct and unprofessionalism are any greater and definitely not increasing at the rate suggested by the increasing complaints being handled by the OHO in Queensland. Therefore, there is probably no need for a cumbersome system that has given rise to much greater inefficiencies and much greater cost.

I am sure the committee has before it the reporting numbers from the Health Ombudsman's office, which clearly show the significant increasing trend in complaints and the glut of assessments in the system—for example, in the third quarter last year 1,130 complaints compared to 1,477 and in the third quarter 470 assessments started compared to only 388 repeated. Still approximately half of investigations are sitting at approximately one year still being sorted out. We have to remember that, even having gone through the OHO system, a matter can still be referred on to the Medical Board and the whole investigation and scrutiny process starts again. It appears that there is limited, potted and sometimes absent transfer of work product and investigation product and that doctors are repeatedly asked for the same information by the two bodies. Our doctors give a repeated and very clear experience of being provided with only quite short time frames to give replies, despite the inordinate delays in the system overall—an overly persecutory system where the doctor is felt to be guilty rather than innocent until proven otherwise, frivolous claims are given credence when they should be dismissed early on at the filtering triage stage and, of course, inordinate delays overall.

The profession actually has great confidence in the potential for the Medical Board Queensland to administer a fair and more timely system, especially with the restoration of the medical chairperson and majority membership. This issue is not off point when one considers the duplication that currently exists between the two tiers in the medical regulatory system and the possibility for an inconsistency in standards between those that are nationally agreed through the medical board process and those that are applied in a fairly opaque process through the OHO. Of course, this is compounded with the growing transfer of cases through.

If we were to keep the OHO, even in view of its efficiency, the AMA Queensland would suggest that to work properly there needs to be much greater cooperation between the OHO and the Medical Board Queensland so that some of the duplicated functions within the OHO can be scaled back to save some money—that is, subsume some of the OHO functions into the operations of the Medical Board Queensland to prevent needless duplication and reduce inefficiency and extended time frames.

A much greater medical involvement at every stage of consideration of each matter needs to be contemplated and enacted, particularly at the early triage stage, so that vexatious or trivial matters can be dealt with decisively without lengthy investigations, there needs to be greater effort to engage positively with the profession—because we do have a credibility problem at the moment with the medical regulatory system—and we need to build a group of reputable senior practising clinicians to give advice and a transparency around the standards that are applied by the OHO that clearly match those that are applied in all other states and territories through the Medical Board. We think in doing this we will see greater efficiency, greater credibility and, hopefully, a reduction in those time frames.

CHAIR: Thank you kindly, Dr Zappala. As I mentioned in my opening statement, we may well invite you to come back for a further hearing after we have had additional time to consider other submissions et cetera. We will ask some initial questions now, before we hear from other witnesses. Thank you for the submission. I found it very helpful and very clear in terms of your concerns and suggestions.

The comment in the submission—and you made it verbally again today—is that, in your view, the OHO has succumbed to the same inefficiencies and poor complaints management processes that drove the government's decision to replace the HQCC. Have there been improvements? Is there anything that is clearly working better than the previous system that you could comment on?

Dr Zappala: I pondered exactly that point and I really struggled to think of anything that could be said to be a redeeming feature of the system. It costs more, there are way more complaints, there is no reduction in the time frames for the matters to be resolved and there is a lack of understanding around the standards that apply. All of this we were hopefully going to improve. It has not. I think the short answer to your question is, no, I cannot see it and I am definitely not hearing it from the doctors on the wards and in the practices and institutions out there, on their interaction with the OHO.

I recognise that it is a regulatory system and therefore has a disciplinary nature to it. However, when you think about it, for a medical regulator to be fair it has to protect the doctors as much as it does protect the public and support safe practice. One of the big things is that that has gone out the window. Doctors feel absolutely beleaguered in this new process and somewhat at sea. The short answer to your question is, no, I do not think there has been any improvement since the days of the HQCC.

CHAIR: When you say there has been no improvement, obviously you have been quite clear in your submission and again this morning that you feel certainly it is not serving the interests of or protecting doctors. Do you think in any way, shape or form it is better serving the public interest and protecting the public?

Dr Zappala: No, I do not know. There is no evidence that we actually had a bigger problem with negligence, misconduct and poor professionalism before, compared to other states or internationally. There is no evidence, as far as I am aware, that there has been any significant change in recent times. What we have seen is a structure that has just fed on itself without actually achieving those key outcomes that you have mentioned. No, I do not think there is any evidence that there is that problem.

CHAIR: I come back to a comment you made in your opening statement. You said that the situation has worsened. What were you referring to? Were you referring to the OHO's operation or the increasing number of complaints, which you also mentioned?

Dr Zappala: Both, and the credibility of the system. I think doctors feel that when their cases are being considered they are not being given due thought and deference by practising clinicians who will understand the nuance of clinical practice and the subtlety of the decision-making that they sometimes have to make. They then have to submit large reams of paper, often repeatedly, in a fashion that seems to be quite persecutory, whereas with the medical board, when it had a medical preponderance, there was a focus on not only protecting the public but also saying, 'Okay, we have found some outlier behaviour. Let's help you fix that.' That sense has gone. I think that is one of the real things that we have lost in the current system and that is why we are worse off, because it is a system that seems to assault us rather than support and help and fix the outlier behaviour when it occurs.

CHAIR: What about the increase in the number of complaints? What is the AMAQ's view on what is driving that?

Dr Zappala: Part of it is possibly perception. As I said to you, there is absolutely no evidence that we have increasing problems with worsening outcomes for poor conduct. In fact, if we look at the revalidation exercises going on at the moment in the UK and Canada, there is no actual evidence that that is going to make any difference. We all recognise that continuing professional development and all those sorts of things are important, but the ease with which one can make a complaint—if you go on to the OHO website to make a complaint, it might only take you two minutes. The example has been given to me by the OHO of a doctor raising their voice to a patient and you say, 'Surely that is going to be one of the vexatious ones that you just knock out.' We have to make sure that we deal decisively with the important stuff and get rid of the non-important stuff. The reply to, 'Surely you just knock it out,' would be, 'I don't know if it is a serious matter or not if I do not investigate it.' In other words, it is take all comers. We have created a troublemakers/complainers letterbox with this open-ended system that obviously is now struggling under the weight of those complaints.

CHAIR: You also made the comment that the system has given rise to inefficiencies. What has done that? Is it the legislation? Is it internal processes?

Dr Zappala: It is internal processes. You get a round of assessment investigations and so on within the OHO and then, in many cases—you have the figures in the reports—it gets referred on to AHPRA and you get another round of investigation and assessment. That is obviously quite a lot of duplication, so that is creating inefficiency. A colleague of mine is currently the subject of a matter. He gave a very detailed and well thought out reply to the OHO and then was asked to do exactly the same for the medical board. He actually said to them, 'Have you read my submission to the OHO?,' and the answer was, 'No, we haven't seen it.' It is that sort of duplication that I think is a real problem, as is the lack of medical input early on to say, 'Actually, this is not a big issue here. Let's just try to deal with this quickly and investigate the real stuff that is going to make a difference.' It is those two things.

CHAIR: Dr Zappala, in your submission you make a comment with regard to suspension of natural justice. It says—

Our members have repeatedly indicated that they have had negative experiences with the conduct of the OHO in how it undertakes investigations.

That is a theme that I have seen coming through a number of submissions. Given that the guiding principle of the OHO is to protect the public interest—that is the paramount principle—how is that best balanced with the issues you are raising around natural justice for doctors or medical professionals who may be the subject of complaints?

Dr Zappala: If we look at the work around complaints, 15 per cent of doctors account for about 50 per cent of all complaints and four per cent account for about one-quarter. If you estimate the number of doctors within that group that you can rehabilitate or retrain or return to gainful safe practice, it is probably around 80 per cent. We need to approach these circumstances with a view of, 'Where has the problem been and how can we actually correct that practice and help that doctor to practise better, and then get them back to the benchmarks where we expect them all to be,' rather than, 'You've done something wrong and you need to pay for it.' It is that philosophy that is different. It is a lack of recognition that we actually achieve a lot in the long term if we correct practice and improve practice rather than just punish bad behaviour. That philosophy is what doctors perceive coming through very clearly when they have their dealings with the OHO.

I am not meaning to dramatise, but, quite honestly, you agonise over these decisions sometimes. They keep you awake at night and then you become the subject of a complaint. I think we all understand that decision-making can be subtle, nuanced and difficult sometimes. It is very difficult for doctors often to go through those processes. I think you will find that the huge majority of doctors, if they have drifted away from mainstream or benchmark, want to come back. That is not going to be as easily achieved if we are just punishing, punishing, punishing the whole time. It is the philosophy.

CHAIR: Dr Zappala, certainly I have further questions in regard to the comment you made about the dual system operating in the other states and how that appears to operate better and any thoughts the AMAQ may have on that, as well as threshold, triaging and clinical input into that process. I am mindful and want to allow my colleagues to have time, too, so whether I put those on notice to you or ask them when you come back, I want to signal that I am particularly interested in the AMAQ's input into that. Thank you very much.

Mr McARDLE: Dr Zappala, thank you very much for being here today and for your submission, which was very thorough and well researched.

Dr Zappala: Thank you.

Mr McARDLE: I think the chair is right: to bring you back would be quite important later on in the inquiry process.

CHAIR: Yes.

Mr McARDLE: In response to the chair's question you made the comment that you struggle to find a redeeming feature in the new regime. You also say in your letter of 3 August that the AMAQ believes the OHO has the potential to be an effective regulator. They seem to be inconsistent statements. You also make a similar comment in your submission—I cannot find the exact quote—where you repeat that you believe the OHO is an effective regulator or could be an effective regulator. Can you clarify for me: are you saying to the inquiry today that you stand by your letter, that it can be an effective regulator and that the amendments need to be undertaken to ensure that that can occur, or are you and the AMAQ now changing your perspective and saying that, no, it cannot be? They are quite inconsistent statements, at least at face value.

Dr Zappala: I understand what you are saying, and I guess the view that we put in the submission was based on the assumption that there would be a reluctance to completely unwind a new structure and that we probably were wedded to it for a period. If we were stuck to it, there are definitely ways to make it better. However, in our overall contemplation of the system, because we clearly cannot divorce the operation of the OHO from the Medical Board and how they interact and the outcomes and all the rest of it, there perhaps is value in taking a step back from this and asking, 'What is actually the best system for us to have?' Rather than trying to mash the current one—and I am just putting it forward as a suggestion—I do not think there would be too much weeping if the OHO was changed or rolled into the Medical Board structure. I guess the point that I am making, just to clarify, is that if we are to stick with the dual regulatory system then, yes, we definitely need to

make improvements. However, if there is an appetite to look at a rejuvenated system as a whole that re-emphasises the central role of the Medical Board, as in every other state, then that is worthy of consideration.

Mr McARDLE: My concern lies with this sequence of events. This letter is dated 3 August. In a matter of four weeks you have changed your outlook significantly because, if I recall correctly, nowhere in this submission is the Medical Board portrayed to the extent you are saying today. You certainly indicate that is one of the elements in making the OHO a more robust and perhaps equitable body. What has happened in four weeks to make that change? It is quite dramatic, and I am really leaning towards your words saying—and putting words into your mouth here—'No, get rid of the OHO.'

Dr Zappala: The submission was focusing particularly and solely on the OHO. I guess I have approached today's conversation in that I did not feel that I could limit my comments to just the OHO, because if we are outcome focused on managing genuine complaints well, protecting the public and supporting doctors and all those sorts of things, we cannot divorce that from what happens in the Medical Board. I wanted the committee to know that the profession supports the Medical Board Queensland. That document was specifically about the OHO, but in the wider considerations of medical regulation as a whole, as I said, I want it to be very clear that we support and need a profession-led medical board that articulates with the national Medical Board system.

Mr McARDLE: Let us go back to my question, then. You say in your letter that you believe the OHO has the potential to be an effective regulator. Do you now move away from that? Do you now say that, really, the Medical Board should be taking the prime function, with an oversight by the OHO of that body? I want to clarify it, because it is quite confusing, what you said here today in conjunction with this document, on my reading of it on two occasions. The comment that I make is that that is not what you are saying now, though. I am at a loss to understand what you are trying to put in place.

Dr Zappala: If we are outcome focused and we want a system that works well—and, to that end, if we are able to adequately resource, in all the definitions of that word, the Medical Board Queensland to do the functions of medical regulation within Queensland—then that is a reasonable option to consider. I guess the wording perhaps could have been a little better in that document to say that if we are to persist with a dual regulatory system then there are ways to make it more effective. However, since writing that—and that document is about one year old now, remember, from when we first—

Mr McARDLE: Dr Zappala, your letter is dated 3 August. Therefore, you re-endorse the content of the document.

Dr Zappala: That is true, but when we first contemplated all of this, that document—our submission—as you know, our thoughts on improving the regulatory medical system, or, rather, the OHO specifically, was first written a year ago. The point that I am trying to make there is that, if we are trying to get a good system—and I did not mean to confuse the issue, and I apologise if I have done that, but I just wanted the committee to be clear that I do believe that there is support for the Medical Board Queensland and if we were to go down that way then there are no problems with that. There are clearly problems with the dual regulation with the OHO and there are ways to fix that. Whichever way we are going to go, there are changes that obviously need to be made.

Mr McARDLE: Dr Zappala, I am quite concerned that we have here a document from you which is undated. I cannot find the date outside the letter, on the submission. You have now told us that it is a year old. In that time you have not updated the content to express the stated view of the AMAQ. That does worry me, because I have taken this to be a current document. That is now not the case, as I understand your commentary.

Dr Zappala: As I say, my apologies for the confusion, Mr McArdle, and I did not mean to cause that confusion this morning. The issues in that document—and I definitely do not think we should minimise them—are as real today as they were when we first wrote it a year ago. Obviously, we have done a lot of contemplation, particularly in recent times. All I sought to do was just say that if we are genuinely looking at change then we have options and they do not only necessarily include reform of the OHO.

Mr McARDLE: There would not be a regulatory body in Queensland or, indeed, the nation that has not come under some sort of criticism. AHPRA was subject to a potential Senate inquiry before the election campaign. The Medical Board was subject to criticism in relation to the Davies report and the Forster review, given the employment of Dr Jayant Patel. There would not be a body that has not suffered some criticism, including the AMAQ, from doctors and other people. This would be a correct comment to make, would it not?

Dr Zappala: Yes.

Mr McARDLE: You made the comment that the OHO should get rid of the non-important stuff when a complaint comes in. I think the words you used were 'non-important stuff'. Would you agree with me that that is a subjective comment, not looking at the objective point of view from the side of the complainant?

Dr Zappala: Not entirely. You have to draw the line somewhere. It is always going to be difficult to say that every complaint is potentially worth investigating and therefore needs to be investigated and create that open-door policy. There will be a proportion of complaints that are frivolous or vexatious. There will be repeated complainers who need to be identified within the system, and there needs to be an appropriate mechanism to sensibly identify where the threshold for a genuine complaint has not been met so that it does not then obligate us through a whole investigation pathway. Yes, that threshold might have some subjectivity about it, but if we have agreement among the profession as to where that level is—amongst the Medical Board, for example, which has community and legal representatives on it—then I think the profession would have some confidence in where that was being drawn.

Mr McARDLE: We will come back to that. As president of the AMAQ you would meet with the regulatory bodies on a regular basis—AHPRA, the Medical Board, the colleges, the OHO et cetera. How many times have you raised this issue with the OHO in the last 12 months in a one-to-one meeting?

Dr Zappala: Zero. We did have meetings with the OHO regularly until our document came out. It has been very difficult to have meetings subsequent to that.

Mr McARDLE: So you have had no meetings with them. Did you send them a copy of the document?

Dr Zappala: Yes, of course and invited a reply. Can I make the point that the points we raise in our document we had made in prior meetings when they were occurring regularly.

Mr McARDLE: I will leave it there for the time being.

Mr KELLY: Thank you, Dr Zappala, for your submission. I was not confused; I think I am now. I am going to try to clarify my thinking in the way that I read not just your submission but also the many other submissions that I have had the chance to go through so far. It seems to me that your submission is suggesting that you have some concerns with the co-regulatory approach being taken in Queensland and have a preference for a system that is not co-regulatory, but if we are to maintain a co-regulatory approach you have made some suggestions around how that could be improved; is that fair to say?

Dr Zappala: Correct.

Mr KELLY: We have two systems that I am aware of in Australia now across the various jurisdictions, and that is not unusual in the Commonwealth. We often have different approaches to the same challenges. That is often good fodder for academics. Has any evaluation or academic research been done into the various approaches to regulation of health practitioners that you are aware of that we could rely on?

Dr Zappala: Not to my knowledge.

Mr KELLY: It seems to me that some of the other submissions have suggested that we should be flipping the system on its head a little. From my understanding, in Queensland at the moment the Health Ombudsman must retain all serious matters and has the discretion to send non-serious matters to AHPRA and the boards. Other submitters have suggested that it should be the other way around, that serious matters should be dealt with by AHPRA and the boards and that matters that can be dealt with by local resolution or conciliation should be dealt with by the OHO. Do you have a view on that issue and why other states have chosen to go a different way?

Dr Zappala: I think they have confidence in the Medical Board structures and processes and the committee structure. The professional representation is quite strong on those bodies to give a fair view on those serious matters, as you mention. I do not have a firm view on whether or not it is a simple case of reversing the order in which things are done. For me, there is a body of work that needs to be done, and the problems start right at the gate end when we look at how the complaints come in, how they are sorted and how they are accepted. From there it probably is appropriate that they be handled by whichever body is set up to handle those things. If it is going to go straight to conciliation then, fine, it can go straight to conciliation. If it needs more in-depth investigation and it is about a medical practitioner then, yes, the Medical Board is well set up to do that and has been doing it for decades. There is some value in doing that, but I think just to reverse it would miss the critical steps around triage and initial assessment that are so important in what flows afterwards.

Mr KELLY: It is interesting that you say that. I am not sure if you have had a chance to read the Australian Lawyers Alliance submission, but it talks about the initial assessment and triage. My reading of what they are saying is that there is almost an investigation process that is now starting to occur as part of that initial assessment which is slowing the process down. They are of the view that if a matter cannot be triaged within 60 days it should be automatically passed for investigation. Is that an area where we could improve the system currently in terms of assessment and triage?

Dr Zappala: Yes. I think the view amongst doctors is that there needs to be a medical determination made with the clinical information that was available to the clinician at the time to say, 'Was this a reasonable decision? What was going on at the time?,' and to really understand the nuance of the decision-making rather than saying, 'This might be a true matter. We had better refer it on for further investigation.'

When I am talking about triage, I am talking about getting that medical perspective applied early so that the nuance of the decision-making can be brought to bear early. Even if something has led to a poor outcome but the decision-making was not faulted, it can be clearly said medically that is not an inappropriate decision that has been made, although the outcome was regrettable. The sense from clinicians is that they have to provide a huge amount of information and then it eventually just gets kicked on for further investigation. It is that early medical review, in particular.

Mr KELLY: How do you respond to criticisms of the previous system whereby we have members of any health profession—nursing, medicine or physiotherapy—regulating their professional colleagues? That has been held up as a system that can lead to less than optimal outcomes due to the sympathies that people may hold for each other from a professionals perspective.

Dr Zappala: Obviously that needs to always be guarded against, but I still think self-regulation is the best way forward in terms of maintaining standards in quality care. If we really want to drill down to the system that we want, where we need to be focusing our attention is what happens on a daily basis in practices and institutions, and investing time and energy in what is happening in hospitals and in units so that we are getting good practices and processes there. Hopefully nothing, or very little, comes through to the medical regulator and it is only dealing with the difficult stuff. In other words, the concept of clinical governance and self-review does not just exist at the medical regulator level; it is right through the system. If you get it right at that level and create the right culture, it will be easy, I think, for it to go all the way through the system and have all that peer review. It is not to say that it is the perfect system, but I think that ideal is what we should be heading towards.

Mr KELLY: The Australian Lawyers Alliance also pick up on the issue you raise about the lack of medical professional involvement in the decision-making process. They come at it from a slightly different angle, though. They talk about the fact that when a decision is made the people they are representing are unable to access the information that the decision has been based on. They cannot get access to what questions have been put to the expert, what advice has been provided by the expert, or even the qualifications or experience of the expert or experts. They have made some suggestions that if those things were addressed there could be greater transparency in the system. Would that go some way to addressing the concerns of the AMA?

Dr Zappala: Yes. I think greater transparency is definitely required. What constitutes a serious breach, what is seen as misconduct: the definitions and standards around that and how that decision is arrived at should be transparent. We should also have confidence in the level of expertise that has been brought to bear to make that determination, including in terms of medical clinical input. The profession, for example, feeling comfortable with the types of experts is important and being transparent around that as well. If there is someone who does not have overly modern practice or recent practice, even if they might be an academic giant, it might not be unreasonable to say, 'Maybe they are not the best person to give an adjudication in this case,' but as you have mentioned there is no opportunity to do that. Transparency around standards and processes for experts would definitely be useful.

Mr KELLY: One of the assertions made is that the reason for the increase in the number of cases coming before the OHO is that there is a greater level of confidence in the system. How would you respond to that?

Dr Zappala: Confidence on behalf of whom?

Mr KELLY: I assume complainants.

Dr Zappala: I am not sure that I can speak for complainants in general, but, as I said, my feeling and the association's feeling is that we do not have a greater problem with misconduct and poor professionalism in Queensland compared to other states but we do have this problem with

increasing complaints. That assertion would suggest that other cases are perhaps under-reported and, therefore, because we have such a fantastic system people are coming in droves. I guess that is a hypothesis. I am not sure that I believe it because, as I say, in terms of the outcomes, if we look at the standards of medicine and the outcomes we are producing, there is no real difference there. I am not sure that I would buy that, to be honest.

Mr JANETZKI: Thank you for your contribution and forthright views. I will perhaps build a little on the member for Caloundra's questioning. It is your opinion that the function of the OHO could be subsumed into the Medical Board of Queensland? Is that your view?

Dr Zappala: I think a large component of it could be, yes. We are talking about medical practitioners, just to be clear, because there is obviously all the other work that the OHO does. In terms of that practised, profession-led view of complaint handling and resolution, yes, as happens in other states, that could be handled by the Medical Board. When matters are referred straight through to AHPRA, that is happening to a large degree currently anyway.

Mr JANETZKI: In respect of medical practitioners, you have talked a little about the duplication of process between the OHO and the Medical Board of Queensland. What are the broad differences between those two adjudicative processes? Is it easy to summarise?

Dr Zappala: It is around the perception of the processes and the standards that apply. The Medical Board has clearly enunciated principles. For example, they are on all the walls in their offices. They are well published. As I have said, they are focused on not just protecting the public but also correcting outlier behaviour and improving doctors' performance and retraining when it is needed. They are clearly stated. I do believe you can see that ethos and those principles come through in their processes and decision-making. No such clarity exists for the standards or processes that are applied in the OHO, and there is no such confidence of the articulation with the national system and those national standards that are applied through the Medical Board structure.

Mr JANETZKI: I am always concerned when you see a suspension of natural justice or a reversal of the onus of proof—concepts of that nature. Can you give us practical examples—or just one practical example—of a clinician that has felt that those principles may have been suspended or they may have been deprived of them?

Dr Zappala: Last night I was at a function and a GP very courageously got up and said that he had been fully investigated and ultimately cautioned through the system for not doing a rectal examination after a patient mentioned that he had rectal bleeding. This was at the end of a half-hour interview where he had sorted out the mini stroke episodes the patient was having and the uncontrolled hypertension. He was one of those big double semitrailer commercial licence holders who drives around. Having spent a full half an hour sorting all of that out, it was a throwaway line at the end. He organised a colonoscopy for the patient for 10 days later, which is quick. The partner of the patient—not the patient—complained and that went through the whole system. The GP was actually cautioned. He to this day cannot work out what he did wrong because he moved the patient to a definitive investigation, the rectal cancer that he had was diagnosed and he had treatment quickly, and there were no problems in terms of the quality of care and the outcomes and all those sorts of things. That GP, as an example, is still left wondering what on earth they did wrong, and they had their life tied up for a year plus to sort all of that out.

Mr HARPER: I did not think I would be agreeing with the member for Caloundra so quickly in the day—

Mr McARDLE: It is still early in the day yet!

Mr HARPER: I do take the point that the comments in your letter are in contrast to your statements today in regard to saying that there is no need for such a cumbersome system to exist when you do in fact say in that letter that it 'has the potential to be an effective regulator'. Those two statements are in stark contrast. However, parking that for a moment, does the AMAQ have confidence in the OHO?

Dr Zappala: No.

Mr HARPER: Is it the AMAQ's view that the Health Ombudsman must be a medical practitioner to effectively fulfil the role?

Dr Zappala: The ombudsman themselves—no, not necessarily.

Mr HARPER: You talk quite a bit about the Queensland Medical Board—and I understand your comments about duplication. The Queensland Medical Board could follow similar lines. A lot of your submission is around the suspension of natural justice and procedural fairness. Would the Queensland Medical Board not follow similar lines in terms of an investigation into a clinical error or

matter? Would it not also follow procedural fairness and natural justice? Would it not follow the same lines as the Health Ombudsman into a clinical investigation, or are you basing everything on the Medical Board as peer review?

Dr Zappala: No. I think a couple of things around that comment are the lack of transparency that exists in the OHO processes, the persecutory nature of the inquiry and deadlines and all those sorts of things, and the perceived and real lack of collegiate input into the decision-making and investigative pathways. Those poor perceptions doctors have with regard to the OHO they do not have to anywhere near the same degree—I will not say not at all—with the Medical Board Queensland. That is why they feel, because of all of those things, that their complaints are handled more fairly and more appropriately.

Mr HARPER: It is the complex nature of the OHO investigations?

Dr Zappala: The lack of transparency and the lack of the medical input. Take the example I have just given. Where did that view come from that not doing that digital rectal examination was appropriate or not? For example, we have our National Bowel Cancer Screening Program, where we all do our faecal occult blood sample and send it off. The action after that is not a digital rectal examination; it is to go and get a colonoscopy. That is what we do in our national program. Where did this view come from? That is the sort of thing I am talking about.

CHAIR: Thank you, Dr Zappala, for your time today. The committee looks forward to inviting you back to give more evidence.

FLETCHER, Mr Martin, Chief Executive Officer, Australian Health Practitioner Regulation Agency

O'DWYER, Dr Susan, Medical Practitioner Member, Queensland Board of the Medical Board of Australia

STENZEL, Ms Tracey, Acting Queensland State Manager, Australian Health Practitioner Regulation Agency

CHAIR: I welcome representatives from the Australian Health Practitioner Regulation Agency and the national boards. Mr Fletcher, I invite you to make an opening statement of up to five minutes and then we will open it up for questions.

Mr Fletcher: Thank you for this invitation to speak to our joint submission, which represents the shared view of AHPRA, the 14 national boards and the Queensland board and committees that work as part of the national scheme for practitioner regulation. I would like to introduce my colleagues. Dr Susan O'Dwyer is a medical practitioner appointed to the Queensland Board of the Medical Board of Australia by the former Queensland health minister. Dr O'Dwyer is also a practitioner member appointed to the national Medical Board of Australia by the current Queensland health minister. Dr O'Dwyer is an experienced doctor and medical administrator and is the Executive Director of Medical Services, Metro South Hospital and Health Service. Ms Tracey Stenzel is the Acting Queensland State Manager for AHPRA. Ms Stenzel in her usual role is the Director of Notifications in Queensland, so the director of our complaints function, and has extensive experience liaising with the Office of the Health Ombudsman about complaints involving registered health practitioners.

As the committee is aware, boards and AHPRA have a shared responsibility with the Office of the Health Ombudsman to manage complaints about registered health practitioners in Queensland and to protect the health and safety of the public. We believe that change is needed to the current arrangements for complaint handling in Queensland. We do not agree that the Office of the Health Ombudsman is delivering a best practice model for managing complaints about registered health practitioners. The current model is not effectively achieving the intent of the Queensland parliament for a better system for health complaints management in the key areas of timely and appropriate actions to protect the public. However, we do not recommend wholesale replacement of the current model. Changing the system entirely would create unnecessary disruption and would be a costly exercise. Instead, we recommend building on specific strengths of the current arrangement while addressing areas that require urgent attention.

We submit that a single track for complaints about the health, performance and conduct of registered health practitioners should be introduced, with AHPRA and the boards taking carriage of those matters including the most serious allegations that may require immediate action and referral to the Queensland Civil and Administrative Tribunal, QCAT. This should be supported by a new joint consideration process between the OHO and AHPRA to efficiently stream complaints to the most appropriate body. This would mean less double handling, swifter action and an overall clearer picture of complaints. This would mirror arrangements in every other state and territory including New South Wales.

The need for change reflects our concern that the model is not fully delivering on its promise of improved public safety. Why do we say this? The published data suggests that the OHO is less likely to take regulatory action by a significant amount, despite having responsibility for the most serious matters. Let us take the example of immediate action. Immediate action is taken to restrict or suspend the registration of health practitioners in those matters where there is a serious and immediate risk to public safety. In 2015-16, the Queensland Medical Board completed 25 immediate actions in relation to 20 doctors, while the OHO reports he took immediate action in relation to two doctors.

Turning now to tribunal referrals, referrals to tribunal occur for the most serious matters on questions of professional misconduct. Over the past two years the OHO has referred one medical practitioner to QCAT, despite again having the legal obligation to retain the most serious cases and keeping a higher volume of matters. This includes serious matters we referred to the OHO as required by the Health Ombudsman nearly two years ago, a number of which were close to completion at the time of referral. In the same period, the Medical Board has referred to QCAT 14 doctors concerning 53 matters.

Secondly, the OHO is unclear about what it considers to be a serious matter to be retained and which matter should be referred to us. As we outline using case examples in our submission, this is leading to unacceptable delay, duplication and unnecessary distress for practitioners and complainants alike. If I take, for example, data in relation to assessment, one-third of the medical matters that are being referred to the Medical Board for action are taking over 60 days to reach us. Seven per cent of those are taking more than 180 days. The model is cumbersome. It is costing more, using more resources and may well result in increased registration fees for Queensland health practitioners as we receive no government funding.

Thirdly, there are concerns about a lack of transparent clinical and community input into the work of the OHO. There is already expertise in place for this in Queensland. Under the national scheme, complaints are investigated by AHPRA and the regulatory decisions are made by board committees, which are made up of practitioner members of the relevant profession and community members. They meet very regularly. For example, the Medical Board in Queensland has three medical notifications committees that meet on a rotating basis over a fortnightly cycle. They have a weekly stop for immediate action and they have a monthly board meeting. Board members have a deep understanding of professional issues, community expectations and the Queensland Health context. No new entities need to be put in place; the process just needs to change.

There are important elements of the current model in Queensland that we believe should be maintained and built upon. Firstly, retain the OHO as the single front door in Queensland for health related complaints. This will make it easy for the community to raise concerns and for the OHO to identify and report on systemic issues. Secondly, the OHO should remain responsible for complaints that are appropriate for conciliation, local resolution or referral to another body with jurisdiction to deal with the matter. This is the case in other states and territories and offers clarity for patients and consumers. Thirdly, the OHO should continue to have an oversight role of AHPRA and the board's performance for managing complaints and for assurance reporting. The OHO's oversight role would not be watered down but rather it would be strengthened by addressing the current conflict of interest for the OHO, being both the co-regulatory partner and having oversight of our performance.

Public protection is at the heart of everything the boards and AHPRA do. Over the past four years we have made significant improvements in our management of complaints about registered health practitioners. The changes we now propose are necessary to ensure the overall approach to complaint handling in Queensland protects the public through timely and appropriate regulatory action on serious matters, to reduce recurrent and unnecessary duplication and delays, to improve efficiency and reduce cost, and to capture consistent data for performance reporting, evaluation and research. We believe the public is owed a system in Queensland which is of the same quality as those available in other jurisdictions. We may not always agree with the OHO on the best and most efficient way to protect the public; however, there has been significant collaboration and goodwill between our offices to date and I trust that will continue.

CHAIR: Thank you, Mr Fletcher. I invite the member for Gaven to open the questioning.

Mr CRAMP: Thank you for your submission. Mr Fletcher, in the last part of your statement—Dr Zappala noted it earlier—you were talking about using the OHO as a single front door mechanism, so that people have an official point of complaint, but then utilising OHO only for low-level complaint resolution where it can be localised and all the more serious complaints and investigations moved to AHPRA; is that correct?

Mr Fletcher: Essentially. We would see that concerns about registered health practitioners that relate to health performance or conduct should come to the boards and AHPRA for all of the health professions in the national scheme. There may be examples of complaints that may be more appropriately dealt with through local conciliation. For example, they might be issues around the cost of treatment. They might be issues or concerns about rudeness or the way that a person has been communicated with by a health practitioner. We believe that those could continue to be dealt with through the OHO. That mirrors the arrangement we have in place in most other jurisdictions.

Mr CRAMP: You have addressed a point of mine. The previous witness gave an example that a doctor raising their voice to a patient would be vexatious, in his words. To the complainant that would not be vexatious. All matters are relative to the person making the complaint. It would be of grave concern if we took away that right of the consumer. Would you agree with that?

Mr Fletcher: I agree with that. We believe that every complaint should be looked at on its individual merits. Under the arrangement we are proposing, the OHO would deal with a percentage of those complaints that relate to those sorts of issues.

Mr CRAMP: I note that you have also referred to a potential conflict of interest, being the oversight body and also dealing with matters. Do you feel that by taking away that role for the more serious matters and making them a low-level resolution there is any conflict of interest there? In AHPRA's view would that remove absolutely any conflict of interest?

Mr Fletcher: I think we could say we welcome the requirement to be accountable in Queensland. We believe that the ombudsman could more effectively discharge his accountability responsibilities in relation to the oversight of our performance if we dealt with the matters and then he had a clear jurisdiction to report on how we performed in doing that.

Mr HARPER: Thank you, Mr Fletcher and ladies, for your submission and for being here today. In your submission you recommend the establishment of a new joint consideration process between the OHO and AHPRA. How would this work in practice; for example, how would disagreements about how a complaint should be dealt with be resolved?

Mr Fletcher: The way this would work—we have examples of this that occur in most other jurisdictions—is that at its simplest it would involve probably a weekly meeting between the office of the ombudsman and the office of AHPRA to review any matters that have come in during the past week. Under our proposed model they would continue to all come through the front door of the OHO and there would then be a discussion about which body is appropriate to deal with them. We have done a lot of work around Australia to agree a framework to guide the decision-making about what matters should appropriately go to which entity. Our view would be that if there was a disagreement the most serious view should prevail, so if there was a view that it was something that in this case we should take, we would take it.

Mr HARPER: It is good to hear you have some increasing collaboration. I think it was in your opening statement there to move through these investigations. Also in your submission you state that performance processes and systems have improved considerably.

Mr Fletcher: That is correct.

Mr HARPER: Can you please expand on that a little further to support that statement?

Mr Fletcher: In relation to notifications, the key areas that we have done a lot of work on are, firstly, to look at the timeliness of our processes, because one of the things that is very important, as the committee has been discussing around procedural fairness, is a process that is timely. We have done a lot of work to make sure that our assessment processes are occurring within 60 days, and we are now achieving consistently 98 per cent of our assessments being completed within 60 days from the point that we receive the matter. Obviously that is important, because if it is a matter that does not need regulatory action then we can get the matter out of the system quickly. If it does need further investigation, we can then move that investigation forward.

The second area we have had a major focus in is around the timeliness of our investigations and trying to reduce the time frames of investigations to make sure that, to the greatest extent possible, we are completing as many of those within a six- to 12-month time frame.

The third area that we have been monitoring very closely is our overall closure rate to open rate. As we have had more than a doubling of the notifications that we have received from the office of the ombudsman over the past year, we have been keen to make sure that we are appropriately closing matters in a timely way so that we are not building up a backlog.

Mr McARDLE: Thank you very kindly for being here today and for your submissions, both written and oral. We had the Davies inquiry in 2005 into the Bundaberg hospital situation. In 2005 we were forced to review as well the outlined issues regarding complaints, and of course there was the report in 2013 by Chesterman that led to the 2014 bill on 1 July, the year the OHO came into existence. We are now in 2016 and it seems that we are going back over the last 11 years yet again. Are you saying that your proposal would solve the problems that Davies identified and that Forster identified back in 2005, or are we going to be here in two years time looking at another model yet again?

Mr Fletcher: We agree that the idea of throwing everything up in the air and starting again is not the right thing to do. That is why our submission says that we should build on the strengths of the current model and we should address those areas that we think are not working as well as they should be.

Mr McARDLE: As I understand it, Mr Fletcher, you are saying that we should bring in AHPRA in relation to complaints concerning medical practitioners and the Medical Board as well, which are two new bodies which would fit into the current regime—not unlike we had before Chesterman's report.

Mr Fletcher: If we take medicine as an example—in fact we regulate across 14 health professions—the board currently works, as does AHPRA, as part of the complaints management system in Queensland. What we are arguing is that, to reduce the duplication, the delay, the cost and the cumbersome nature of the system that has now been developed, it would be much more sensible to maintain an arrangement where everything comes through the front door of the ombudsman, we have a sensible mechanism to jointly look at everything that is coming in, and those matters that relate to conduct, health or performance of practitioners should come to the boards and AHPRA to deal with. It is a more streamlined approach.

Mr McARDLE: It is not unlike what we had before, is it?

Mr Fletcher: There is a difference. As I said, there was not a single front door in relation to complaints coming in before.

Mr McARDLE: The complaint is dealt with by the same bodies as it was before.

Mr Fletcher: There was not a performance oversight. As you well know, part of the issue when these changes were made was to increase the local accountability of the work of the scheme in Queensland. We believe that what we are proposing would strengthen that local accountability mechanism by giving the ombudsman a very clear role in relation to oversight about performance.

Mr McARDLE: Am I right in saying that AHPRA would have a much more elevated role under your regime in relation to complaints against those practitioners under which you and the boards have jurisdiction?

Mr Fletcher: We would have the role, as we do under the national law in many jurisdictions—

Mr McARDLE: But not Queensland.

Mr Fletcher:—to deal with those matters. At the end of the day, if we are talking about matters that could lead to cancellation of registration or raise questions of serious misconduct or professional misconduct, the law says we must refer those to the tribunal, so those matters would continue to go through to QCAT as they do now.

Mr McARDLE: You heard me pose the question to the AMAQ president. There would not be a body—registration body, oversight body or jurisdictional body—in the medical field in this state or in Australia that has not been subject to criticism; would you agree with that?

Mr Fletcher: I would agree there is great scrutiny of what regulatory bodies do.

Mr McARDLE: AHPRA is no exception to that. There was the proposed Senate inquiry by Nick Xenophon into AHPRA that fell, I suspect, when the election was called. There was the review by the college of surgeons into bullying and harassment as well. Has that report been issued yet, do you know?

Mr Fletcher: Yes, it has.

Mr McARDLE: When we are talking about one body saying to another body, 'We are going to criticise you because of what you have done or what you have not done,' there would not be a body in that position that would not face severe criticism themselves based upon what they have or have not done; is that right?

Mr Fletcher: I think the point we are really trying to make is that we are absolutely committed to playing our part fully in making sure that the system of complaints management in Queensland serves the community of Queensland in the best way possible. We are not proposing to throw out all of the changes that have been put in place. We are proposing to build on what we think are the strengths of that model but address what we believe are shortcomings. In our submission and in our comments we have tried to set that out with data and with case studies to illustrate the concerns that we have.

Mr McARDLE: You made the comment that the OHO is not delivering an effective model. Timeliness—and I cannot recall the second word that you said.

Mr Fletcher: Appropriate decisions.

Mr McARDLE: My apologies. Therefore, you are criticising the OHO. What I am trying to establish here is that you are putting yourself forward as the appropriate body to oversight—my word, not yours—in certain circumstances. If that is the case, I am saying to you that AHPRA of recent times has been subject to severe criticism, both within the media and within parliament, as I understand it. There have been reports prepared with regard to bullying and harassment, so an equal playing field would be to say that both bodies have been the subject of criticism by persons in other organisations, just to make it clear that AHPRA is not seen as the perfect specimen in the world of the public.

Mr Fletcher: I would not say for a moment that we are perfect, and I would not say for a moment that there are not areas where we can also make improvements. What I am saying is that if I look at the people that we have in terms of boards and staff, if I look at our performance in terms of data about timeliness and proportionality of decision-making, and if I look at the underpinning of the policies and procedures which are the benefit of being part of a national scheme, we have a strong foundation and we are getting better all of the time. It is from that basis that we are making suggestions about areas of the current model that could be built upon and areas that we think need change because we do not believe they are working as well as they need to.

Mr McARDLE: The perception that the public will have, I suspect, is that it is—to use an old phrase—Caesar judging Caesar, which was heavily criticised by the public in years gone by in the Davies, Forster and Chesterman inquiries. Why should that be allowed to be re-presented in the minds of the public when it has only been two years since the OHO came into being?

Mr Fletcher: That is why we are not suggesting that the whole model should be thrown out the window. We say that we think there are elements of what has been put in place that are working and should be built upon, but there are elements that we think also need to change. It is not a return to what was there; it is an evolution of what has been put in place into what we believe will be a set of arrangements that serve the Queensland community better.

Mr McARDLE: I think we are going to ask you to come back at a later date, so we may continue on with the conversation. Thank you very much indeed.

Mr KELLY: Thank you for your submission and coming along today. We seem to be on a bit of a merry-go-round. We have had claims and counterclaims from both the OHO and AHPRA, and last year we went through some of those and asked you both to go away and deal with those issues to the best of your ability. In the covering letter to your submission today you have stated that there are limits to the improvements that can now be made administratively. Do you believe that you have reached the point where you cannot improve things administratively any more in terms of achieving efficiency or improvements in the current system of a co-regulatory model?

Mr Fletcher: We think that we, along with the OHO, have worked hard to build a very constructive day-to-day working relationship, but we believe the issues that we have identified in our submission are not issues that are going to be solved administratively and do require legislative amendment.

Mr KELLY: There seems to be a lot of 'he said, she said' or 'she said, he said'. I will give you an example. Paragraph (f) on page 6 of your submission states –

Data continues to be misaligned with the national dataset and approach …

There is clearly a difference between what happens nationally and what happens in Queensland. Then if I go to the OHO submission—I do not have a page number, I am sorry, so I will just read the quote—it states—

The Health Ombudsman continues to encourage AHPRA to embrace transparency and accountability on a national basis and to publish national versions of all the Queensland-based datasets.

It seems to me that both organisations are saying their datasets are better than the other's datasets and each of these should move towards one another. How do we determine the truth of this matter?

Mr Fletcher: The point that we are trying to make is that we have nationally agreed data for every other jurisdiction except Queensland. The extent to which we are able to report nationally on the performance of regulation in Australia is obviously constrained if we do not have nationally consistent data. That has been a concern for us. It is as simple as how professions are described. It is also about how notifications are counted. They are quite basic things.

The wider issue for us is that we are very keen to use data about regulation to improve regulation for the future. We are interested in how we become a risk based regulator. Part of being a risk based regulator is being able to look at patterns and profiles in the data about why people are subject to complaint to identify hotspots or issues that may lend themselves to interventions. Again, to the extent that there are differences in the way that data is classified in Queensland, it creates problems in terms of Queensland data being part of that national work.

Mr KELLY: Do any of you have a view on why the number of complaints in Queensland has increased?

Mr Fletcher: Just to be clear, what we have said in our submission is that the number of complaints that have been referred from the ombudsman to us has more than doubled over the past year. I think our understanding is that there has been an overall increase in the number of complaints

the ombudsman has received as well. I think we would probably be speculating as to why that is the case. It is interesting for us—and one of the things that we can look at with national data is differences across jurisdictions. We have 25 per cent of the registrant base in Victoria. There are 650,000 registered health practitioners. Nineteen per cent of them are in Queensland. There are more complaints in Queensland than there are in Victoria. That may indicate there is an under-reporting problem in Victoria. It may indicate that there is greater awareness of reporting obligations in Queensland. We do not really know. They are important questions to look at and to try to understand. I hark back to my point about national data in helping us to be able to unpick some of those issues.

Mr KELLY: It seems to me that you are wanting almost a reversal of the current system, which is that the Health Ombudsman must retain all serious matters and the Health Ombudsman has a discretion in relation to non-serious matters. It seems to me that what you are proposing is that that reverses and AHPRA automatically deals with all serious matters and the Health Ombudsman deals with matters that can be resolved locally or through conciliation. Why do you think that system is superior to the one we currently have?

Mr Fletcher: One of our concerns about the current arrangements is that there appears to be a lighter touch regulation approach in place in Queensland and hence the point we make about measures such as tribunal matters and immediate action. What we want is proportionate regulation. We believe that, through the arrangements that we have in place through boards that have experienced practitioner members and experienced community members appointed in Queensland by the Queensland health minister, that creates the right framework for making sure that the regulatory decision-making is proportionate to the risk that is being addressed. Did you want to comment from a Medical Board point of view?

Dr O'Dwyer: Certainly from the board's perspective, the concerns the boards are raising are in relation to matters that come across on referral from the ombudsman where we then believe immediate action is necessary because we have a reasonable belief that there is a serious risk to the public that necessitates action. They are some of the concerns that we have raised in respect of that. That is why we believe a single track through to AHPRA in terms of health, conduct and performance is appropriate.

Mr JANETZKI: Building on the member for Greenslopes' question about complaints and complaints growing generally, are you concerned at all about matters of serious offences significantly dropping in referrals to QCAT at a time when we are seeing a large increase in complaints?

Mr Fletcher: It would be fair to say that, given that the ombudsman has currently an obligation to retain the most serious matters and there seem to be so few matters being referred to the tribunal, it does raise the question for us about the proportionality of the regulatory response, yes.

Mr JANETZKI: Would that be under-resourcing or perhaps that lack of medical experience or broadness that the AMAQ was submitting earlier?

Mr Fletcher: Quite possibly. As Dr O'Dwyer said, the experience of the board at times has been that matters are referred over that the board actually views as being quite serious, but that has not been the view of the ombudsman on their assessment. The question for us is about the lack of clarity about what the ombudsman's threshold is for judging a matter serious. As I say, that appears to then be turning into the fact that there is a far smaller number of matters that are resulting in immediate action, which is the action we take where there is an immediate concern for public safety and, indeed, of tribunal referrals, which is at the serious end around professional misconduct.

CHAIR: Nationally consistent data is a concern to me. That has come through in your submission and you have been raising that consistently. What do the co-regulatory models in other states do? Your comments seem to imply that they are using the same measures to ensure nationally consistent data is available. Could you speak to that, please?

Mr Fletcher: There is only one other co-regulatory regime, which is in New South Wales. We have an agreed protocol in place with them which means that we are able to report. For example, in our annual report—this is New South Wales—we are able to report fully and consistently on the data around complaint matters that they are dealing with. The only difference is that there are a few differences in the legislation in New South Wales, for example, around some of the outcomes around complaints. We obviously report that separately. There is consistent taxonomy and definitions, for example, around how we define who a general practitioner is and who a specialist practitioner is in medicine.

CHAIR: What reasons have been given as to why we cannot achieve that similar harmonisation between the two regulators here in Queensland?

Mr Fletcher: From our point of view, for all the reasons that we have been saying—quite frankly, it is almost self-evident that it would be useful to have the data aligned in Queensland. I think we have made some progress there. For example, one of the other issues there has been for us is the way the notifications are counted. We count at the level of the notification. The ombudsman counts at the level of the issue. That already creates problems if you are just trying to get a straight count of how many matters are actually being dealt with. From our point of view, we think they are sensible things that would mean that we would have much more accurate and complete national data for comparative and analytic purposes.

CHAIR: That is what I am trying to get to the heart of, though. You have consistently been raising it as an issue and saying that you have been bringing it to the table. What has been the reason given that we are still potentially left with the same issue now?

Mr Fletcher: I think you are probably going to have to ask the ombudsman.

CHAIR: I will, but I am interested from your point of view.

Mr Fletcher: From our point of view, to date on a number of these areas we have not yet been able to get the ombudsman's agreement to align some of these definitions with what is being used nationally.

CHAIR: What impact does that then have on the ability of the system overall to protect the public, if any, and what nationally consistent data trends value could we as a state derive from that information if we did have a system like New South Wales where we had some consistency?

Mr Fletcher: It means, for example, when you look at our annual report for 2015-16, which is tabled in every parliament in Australia, the Queensland data will only refer to those matters that have actually come over to us from the ombudsman. It will not capture any of the data about matters that the ombudsman has retained. Basically, part of the whole point of the national scheme was to have a single national view of the overall patterns and trends and nature of complaints. That is not possible because of this.

I think the other area that is of concern for us is the extent to which we then want to use this national data and have research partnerships and the like to identify patterns of risk. For example, we are finding very interesting data that suggests that there are patterns of risk around context of practice, age of practitioner, nature of speciality, number of complaints they have received previously. Obviously the more that we can have comparable complete Queensland data around those sorts of issues the more useful and meaningful that research is for both what we do in Queensland and what we might learn nationally.

CHAIR: If I understand what you are saying correctly, essentially Queensland has incomplete data because of our current situation?

Mr Fletcher: It has different data and we do not have any longer the totality of data about complaints that are being raised about registered health practitioners. That would have been the case prior to the establishment of the ombudsman.

CHAIR: There are two other matters I wanted to raise quickly but I may only get to do one because I am aware we are over time and we need to allow the OHO his time. The first is to do with—my words—the lack of transparency of complaints coming through pertaining to health professionals and registered practitioners. If I am understanding your submission correctly, essentially now you do not have the transparency of access to information about some complaints which are not referred to you about practitioners that would allow a more, would it be fair to say, informed view about trends or issues that might be coming through? Would you have it in all other states?

Mr Fletcher: We would, yes. One of the things we have learned from our data is that, if you are a practitioner who has multiple complaints—and each of them may only be minor complaints—the fact that you have multiple complaints may in itself raise a question about risk. At the moment in other states and territories we would know about those minor complaints which we might have assessed and decided on their own not to do anything about. Under the national law we can look at the pattern of complaints over time. In Queensland we do not have visibility around that sort of contextual information. It may well be that we miss a connection because we do not have that information any longer accessible in the way that we do in other parts of Australia.

CHAIR: Given your role not just in Queensland but at the national level, has it been the experience of AHPRA that sometimes those complaints contextually may not be serious in themselves but that can give rise to or raise awareness that there may be an elevation in inappropriate behaviour? Has that been the experience of AHPRA in regard to some practitioners or is that not correct?

Mr Fletcher: Our experience is that if you are a practitioner who has multiple complaints, even though each of them on their own may be not that serious, the fact that you have multiple complaints probably indicates that there is an issue that needs to be looked at more deeply. As part of our risk assessment and triage process, we would routinely look at the history of complaints to make that risk judgement about whether a matter should actually be investigated more closely.

CHAIR: You have raised in your submission about threshold decisions that are made at the triage stage. What transparency do you have about how those decisions are made? It seems that you are saying you do not. Therefore, I imagine you have raised the desire for further transparency with the OHO—a matrix of how decisions are made; I do not know. Could you give a brief understanding to the committee about that?

Ms Stenzel: In the consult stage, where the Health Ombudsman is proposing to refer a matter to AHPRA and the boards to deal with, there is a decision that is captured in relation to whether it would constitute professional misconduct or grounds for cancellation or suspension. That is the primary decision that is being made on the decision to refer. We receive that detail. We do not receive detail in all instances where there is a decision to take no further action by the Health Ombudsman. We do not know what constitutes his decision-making in that area, nor the decision to keep and investigate a matter.

Mr Fletcher: I think in short our experience in some cases has been that there have been matters that have been referred by the ombudsman to us that he has judged not to be serious whereas when the board looks at them there is a concern. Equally, there are matters where there has been a concern raised by the ombudsman but when the board has looked at it there has not been a sense, with the clinical input, that there is actually a substantive issue. Do you want to add to that?

Dr O'Dwyer: Yes, that is correct. That is the main experience of all of the boards that are represented as part of the submission today.

CHAIR: To pick up from the deputy chair's earlier comments, I think it is a fair assessment to make that health complaints are so important that there need to be these sorts of reviews and that there will be complaints of any model, as there now is about the OHO and equally with all the other bodies. Is it the view of AHPRA that we have moved forward, backwards or stayed largely the same in regard to concerns about the overall system?

Mr Fletcher: We believe that AHPRA and the national boards have made significant improvements in people, processes and performance since the reviews that occurred a few years ago that gave rise to the changes. We are concerned, however, as we have said in our submission, that we do not believe that the current way the ombudsman model is established in Queensland is achieving the objectives of parliament in establishing the new complaints management system. Again, I reflect on what we said around our concerns about the proportionality and apparent light-touch nature of regulation, the time frames that are not being met in relation to the published data, the duplication and waste, the cost to registrants and, ultimately, I think, the unnecessary distress to practitioners and complainants about the sort of loops and delays in the system as it currently operates.

CHAIR: Thank you very much. I know we all have more questions. Again, as I said to the AMAQ, we will invite you back to a further hearing. As the deputy chair did, I thank you for your submission and for coming here today.

ATKINSON-MacEWEN, Mr Leon, Health Ombudsman, Office of the Health Ombudsman

CHAIR: I take this opportunity to thank the OHO for the extensive submission they made to the committee's inquiry. Welcome, Mr Atkinson-MacEwen. Would you like to make a brief opening statement of up to five minutes?

Mr Atkinson-MacEwen: Yes, I will. I realise that time is short, so I will try to not gabble my way through. Thank you very much for the opportunity to address the committee and to answer any questions you have in relation to my performance and the performance of AHPRA and the boards. I want to do three things this morning: draw your attention to a couple of matters in my submission; provide you with some additional information that might illuminate some of the submissions provided to you by other stakeholders; and, obviously, answer your questions in as fulsome a manner as I possibly can.

Turning to my submission, you will note that I provided two years of performance data. Obviously, that data is published monthly, quarterly and annually on the OHO website. There are a couple of points to note in that data. First of all, there has been a 28 per cent increase year on year, from 2014-15 to 2015-16, in the number of complaints coming to the office—that is, complaints and notifications coming to the office. In my view, and certainly from the feedback we get from complainants and notifiers, this is a very strong indicator of confidence by the public and practitioners in the health complaints management system. They feel confident that they can put a complaint to us to be dealt with fairly and independently. From February to June this year, we have had an average of 513 complaints accepted each month. We have had 502 in July, so we are being hit with roughly 500 complaints every month. When you look at our performance in that period, our performance continues to improve, even though we are seeing the highest number of complaints ever in Queensland or any other jurisdiction.

I have included in my submission a range of potential amendments to the Health Ombudsman Act which, if enacted, would do a number of things. They would correct some deficiencies in the act to repair inefficient work-arounds; provide some clarity around time frames and legislative requirements; provide some additional flexibility in dealing with complaints to ensure that all the relevant parties are included; and remove uncertainty and barriers to information sharing to ensure that the public are protected and that regulatory processes operate efficiently. I have also mentioned that there is a potential to adopt the model used by other professional regulatory bodies in relation to those serious matters, as you know, that I must deal with, but at the lower end of seriousness that might increase the efficiencies in dealing with those as well.

I would like to talk briefly about some points in my submission. In terms of the use of independent clinical experts, I am the first to admit that it is critical for the independence and fairness of the regulatory system that a practitioner's performance, in particular, is assessed by an appropriately qualified clinical expert. This ensures judgements about a practitioner's clinical performance are robust, defensible and transparent. It is an issue that I will pick up, given some of the submissions, a little later on.

One of the other things that I want to talk about is the OHO approach to the assessment and investigation of matters. In deciding to assess a matter or investigate a matter, our approach is to seek a range of information that identifies the issues outlined by the complainant or the notifier. Given that we are dealing with matters that, on the face of it, are potentially serious, a thorough process is required, particularly in circumstances where registered practitioners or health service providers have a previous history of complaint. In many cases, significant additional information and issues that were not evident with the initial complaint can be and are identified. That is another issue that I will pick up, given some of the criticisms from submitters.

The issue of funding is critical. You will see from my submission that funding has been an issue since the start of the OHO. As I flagged in my submission, the minister has commissioned an independent consultant to examine the costing model that we have developed and to compare it to the costing model that AHPRA contends should be used. As I understand it, the advice about the two models is yet to go to the minister, but from the draft that I have been provided with there are a couple of points worth noting from the consultant's observations of the two models.

AHPRA's proposed funding approach does not appear to be consistent with the requirements of the national law and does not reflect the costs of the OHO performing its functions; AHPRA's approach relied on a sample size that was small, cases that were not randomly selected, a subjective assessment of seriousness and complexity, limited transparency regarding the average cost methodology used and were reflective of AHPRA's costs at a single point in time; and AHPRA's

approach would exclude certain activities performed by the OHO in undertaking its functions on the basis that AHPRA did not undertake those activities in performing its functions. These costs include the direct costs of clinical advice and travel costs. It is interesting to note, according to the consultant, that AHPRA advised that travel costs were a minor cost associated with AHPRA's cost for the complaint management function. That is something else I will come back to.

I would like to talk about some of the submissions that you have received from other stakeholders. In reading those submissions it is pretty clear that stakeholders—some of them at least—would like to return to what I will call 'the good old days' when practitioners regulated practitioners, when there was no oversight and no transparency in the system and where the health and safety of the public were poorly protected.

Some of the submissions have raised the issue of timely and appropriate regulatory action on serious matters, and you have just heard from AHPRA on that. You will recall that I provided the committee with information in June about the unsupported assertions made by AHPRA and the Queensland Board of the Medical Board of Australia about the level of immediate actions in Queensland. As I noted in my correspondence, the number of immediate registration actions in Queensland per registrant since the OHO began is significantly higher than, for example, in Victoria, which Mr Fletcher used as a model for regulatory soundness.

Since the OHO began, this state has had a more robust, impartial and effective regulatory system in place to protect Queenslanders and prevent the kind of deficiencies in regulatory responses that Victorians have seen, particularly, for example, the lack of an effective response by the Victorian Board of the Medical Board of Australia to the practitioner related issues that were uncovered at the Djerriwarrh Health Services at Bacchus Marsh. There has not been a similar situation in Queensland, yet in other states and territories those regulatory failures continue to occur.

Given the poor performance of boards evidenced in the Chesterman, Forster and Hunter reports and the continuing inability of boards outside of Queensland to deal with serious matters appropriately, it is difficult to see how AHPRA could assert that we are better to let AHPRA and the boards deal with serious matters in Queensland in the future.

CHAIR: Mr Atkinson-MacEwen, can I just get feedback on how much longer you have? I have given latitude of an extra couple of minutes, because I know how important your evidence is. If you have more that you wanted to—

Mr Atkinson-MacEwen: I am sorry; I understood I had 10 minutes.

CHAIR: No, I am sorry; it was five minutes. You are welcome to table your statement, if you want to.

Mr Atkinson-MacEwen: Yes, I think I might table it.

CHAIR: We want to be able to ask you questions as well.

Mr Atkinson-MacEwen: Certainly. I have some responses in relation to the issues of timeliness, particularly in relation to the quality of the work done. I can certainly rebut some of the statements made about clinical advice.

CHAIR: I suspect much of that will come out in response to questions.

Mr Atkinson-MacEwen: Yes, and vexatious complainants et cetera. If I could, I would like to say in conclusion that the OHO is just two years old. You will recall that last year Mr Fletcher talked about AHPRA and it was still very early days after five years. I can reassure you that after two years, unlike AHPRA, we are well on the way to organisational maturity and our statistics, improving as they are, particularly given the large number of complaints we are dealing with, are good evidence of that. I will table my submission and let you ask me as many questions as you would like.

CHAIR: Thank you very much. I invite the deputy chair to open questions.

Mr McARDLE: Mr Atkinson-MacEwen, thank you for your submission and your oral testimony here today. You heard me run through a time line from 2005 to 2016—that is, 11 years. You also heard me comment that I suspect in two years time we will be back here again. To me, this is a turf war over who controls what. What the people of Queensland want is a robust system that provides answers to them, that provides them with a medical service across the specialties and subspecialties, and that protects them from doctors and others who are and should not be treating patients. There has been a significant increase, as you said, in the number of referrals to your body. That has been put down to one suggestion that it relates to underreporting in other jurisdictions. I find that a rather odd comment. Would you agree with me that the fact of the number of reports coming through to you indicates the opposite—that there is greater confidence in what is now in place in Queensland?

Mr Atkinson-MacEwen: I would certainly agree that there is greater confidence in what is happening in Queensland. We hear that from complainants and we hear that from notifiers. In fact, I hear it from practitioners who are the subject of notifications who ask if I could deal with it rather than sending it across to AHPRA. When my staff explain to them that it is a less serious matter, that it does not have to be dealt with by AHPRA and the board, they still say, 'No, we would prefer that you dealt with it.' I think there is a greater level of confidence.

In relation to what goes on in other jurisdictions, having been the health complaints commissioner in Tasmania and having very strong relationships with my colleagues in other jurisdictions, I have to say that the two-path approach to making complaints in other jurisdictions—that is, a complaint that might go to a health complaints entity in the state or a notification about a doctor that might go to AHPRA and the relevant board—is a barrier to providing access to the complaints system. The other barrier, of course, is that it is extraordinarily difficult—and I would ask you to look at the AHPRA website because I do regularly—to find out how to make a complaint in other jurisdictions about a doctor, a nurse or another kind of registered practitioner.

Mr McARDLE: One of the criticisms has been a lack of communication between the bodies: yourself, the AMAQ, AHPRA and the medical boards as well. Communication is the way to solve most problems. Do you have a comment about that? The AMAQ made it quite clear that 12 months ago they issued a paper that then pulled down the shutters, shall we say, and also AHPRA raised the point about the information and the data. You touch upon that in your submission. Can you comment about the communication?

Mr Atkinson-MacEwen: Certainly. Up until quite recently I had biannual meetings with the head of the AMAQ. I had my first meeting with Dr Zappala last year. I have to say that at that meeting none of the issues that are in the AMAQ's paper were raised with me. More importantly—I will be frank—Dr Zappala was more interested in taking mobile telephone calls than actually sitting in the meeting. I was left with his research director to deal with issues.

CHAIR: I would advise that we do not tend to make personal comment about individuals who are not in the room or reflect on them, thank you.

Mr Atkinson-MacEwen: Sure. In terms of the communication, my staff have attempted to re-engage with the AMAQ. It was not a year ago that they published that; it was probably earlier this year. Since that time the AMAQ has not been interested in a meeting with me.

Mr McARDLE: The question I then have is on the data. AHPRA raised the question of the data. Can you comment upon that?

Mr Atkinson-MacEwen: Certainly. We provide AHPRA with a comprehensive amount of data that comes out of our system. We do that on a weekly basis. We do a range of updates regularly on that. They have access to as much data from us as any other jurisdiction does, and I find it difficult—and we continue to find it difficult—to understand why AHPRA cannot take the data we provide it. Yes, they are quite right: we do look at issues as well as notifications, but we do not hide the number of notifications or complaints. That data is there, but it is also fleshed out and expanded with all of the issues that we see.

When Mr Fletcher and AHPRA have raised this with me and said, 'New South Wales does this; why can't you?,' I have gone back to New South Wales and said, 'What data do you provide, because this is what we provide?' They said, 'You are doing better than we are.' I am at a loss to see why AHPRA is not able to take all of the data we give them and use it appropriately. I accept that for those matters that I retain, which are serious matters that I must retain, that data is provided, like everything else, in its rawest form. We do not—and I am not obliged to—update AHPRA every month, two months or three months about how a matter is going. If they have a concern about a practitioner that I have retained which they know about, they are more than perfectly able—and they do—to seek an update or further information from me about that process.

The issue of data is an interesting one, because at the end of the day I am struggling to find any publication by AHPRA that actually parses national data with or without Queensland data in it for the last two years that is of any research or analytical value. It is a bit disingenuous, I think, for statements to be made about my data not being provided because it is somehow holding up national analysis when there is very little national analysis that has been provided.

Mr McARDLE: Would you agree with me that the three bodies who are here today, including yourself, must work together?

Mr Atkinson-MacEwen: AMAQ is an interesting one. That is, quite rightly, a body that represents the interests of medical practitioners. My role is to impartially and fairly deal with complaints that come to me. Whilst I am happy to have meetings with stakeholders like the AMAQ,

as I have done in the past, it is not necessarily my role to work with them in relation to these issues. That could well be seen as being partial towards doctors, for example, rather than being impartial in the way that we deal with complaints.

I noted from Dr Zappala's testimony he talked about the GP that he spoke to last night in relation to how they had been dealt with. I struggle to understand that, simply because it was not a serious matter and not a matter that I would retain. I cannot admonish. If that practitioner was admonished, that admonition would have come from the board. That was a matter that would have been dealt with by the board, not by me.

Mr McARDLE: I must admit that I tend to disregard those sorts of examples because they are always a subjective assessment of a situation. Dr Zappala made the comment that the OHO should get rid of those matters that are frivolous. I will not use the word 'vexatious'; that is quite a different category entirely. I put to him that that is a subjective statement because the other side of the coin is the view of the patient. I think AHPRA made the comment that one complaint alone might be frivolous; five complaints against the same doctor start to build up a case over time. Would you agree with me that we can look at the role of a practitioner, but your role is equally to ensure the constituent gets a fair hearing, however you define that term under the terms of the act?

Mr Atkinson-MacEwen: Absolutely. When you receive a complaint, it is not necessarily, if at all, apparent from it that it could be frivolous, vexatious or not made in good faith. Certainly there are some complaints which we do not accept because they do not meet the definition of a health service, but, in terms of whether something is by definition frivolous, vexatious or not made in good faith, unless the complaint is on its face totally incredible, if it appears that it could occur have occurred—the dentist yelled at me; the podiatrist was rude to me—that is worthy of at least some further not investigation but assessment. Let us get some information, which is what we do. We seek fundamentally, if there is a health record involved, the health record to see what might be behind the complaint. We seek a submission from the practitioner. All we are doing is seeking information, and we make that very clear in all of our correspondence. It is about gathering information to determine whether or not there is any substance to the complaint. If there is substance to the complaint, it might be referred to AHPRA if it is to do with the health conduct and performance of a practitioner. It might be put into local resolution because it is an issue that could be resolved that way, but if there is no substance to the complaint once we have received the information the matter is ended. No further action is taken, and the complainant and the provider are advised not only that we are taking no further action but also that these are the reasons we are taking no further action. It is a very transparent system.

Mr McARDLE: The example that is forever enshrined within the health system in Queensland is the Bundaberg Base Hospital and the report by the nurse whose name I cannot recall but whose face I can see. It could quite well have been that that would have been dismissed at the time except for an MP standing here in the parliament. My point is: a simple complaint can shield or hide significant issues in a health system that may need to be looked at.

Mr Atkinson-MacEwen: Absolutely.

Mr McARDLE: The allegation could be made that if you do not do the proper assessment something that is critical is missed entirely. Would you agree with that?

Mr Atkinson-MacEwen: Absolutely. In fact, with many of the matters that we take on that appear relatively straightforward in terms of conduct or performance, when we gather additional information, when we speak to witnesses, when we leave Brisbane—as my investigators do—and go to the locations where these matters are raised and gather information, we often discover that there are many more issues involved with that practitioner than were immediately apparent or even known to the initial complainant.

Mr McARDLE: Thank you very much.

Mr JANETZKI: I apologise if the member for Caloundra went there, but my question is about the QCAT referrals that I asked AHPRA about before. You are seeing an increase in complaints. What is your process for elevating those serious matters to QCAT?

Mr Atkinson-MacEwen: There are two paths we need to be very clear about. Firstly, is it a serious matter that I must retain under the legislation? Is it a serious matter that gives rise to serious risk where immediate action is taken? In the case of immediate action, immediate action is taken to protect the health and safety of the public. The practitioner has the right to appeal that decision to QCAT, but once I take an immediate action decision the next decision is to investigate the

circumstances around the complaint in the first place. Either way, the legislation says that I must produce an investigation report that is then considered by the director of proceedings, who makes an independent decision as to whether or not the matter is run in to QCAT.

We have run a number of matters now in to QCAT, and the feedback from the tribunal has been extraordinarily positive in that it is the first time in this jurisdiction that practitioners on the other side—that is, the practitioner involved in the investigation—and the tribunal have received a brief of evidence that clearly outlines every issue that we intend to prosecute in the tribunal and clearly outlines every document, witness statement et cetera that we are relying on to demonstrate the proof of that particular assertion. From our point of view, while required by the legislation, it also is probably best practice in terms of how things are run. I say best practice because it is very similar to what happens in New South Wales.

Mr JANETZKI: A lack of resources is not precluding more matters being referred to QCAT?

Mr Atkinson-MacEwen: No. We have a legislative requirement to produce a quality product, and we do.

Mr JANETZKI: A range of submissions have talked about a lack of timely adjudication. I accept that some of those may be legacy issues that you inherited. Is it simply, again, a lack of funding and resources for you to address those longer term issues or are there other complicating factors?

Mr Atkinson-MacEwen: There are a couple of things. Certainly funding has been an issue. The way in which AHPRA has pushed back on the funding that should be transferred to my office has meant a funding uncertainty all the way through. When you have a significant increase month on month in complaints, you are essentially playing catch-up if you have a lack of certainty around funding.

To put funding to one side, the issues for us are about doing a quality job. It is very clear that the legislation and the reports that preceded the Health Ombudsman Act make it very clear that quality investigations are required. That takes time. That takes resources. It means that we use all of the powers available to us to obtain statements and to obtain information from people, but it also requires, quite frankly, as I said, having to leave Brisbane and fly to locations and do a whole lot of work in those locations to bring matters back for appropriate conclusion.

We also have a significant proportion of matters because fundamentally ours is the conduct and performance base, and it is interesting to note that the Queensland Board of the Medical Board of Australia have raised issues around immediate actions that I have not taken. They have been immediate actions that I cannot take because they are in the health space. I do not have powers in the health space. When I have a matter that is to do with the health of a practitioner, I immediately refer it to AHPRA and the board. If the board takes immediate action, that is more than appropriate because I cannot.

To get back to the issue, we have a number of matters—around 25 per cent at the moment—that are in some sort of criminal proceeding either being investigated by the police or going through the court system. Those matters are matters that I cannot pick up until those processes have ended. There is a significant amount of work that has to sit—and it is not a criticism of the courts or the police—while more superior processes work their way through.

Mr JANETZKI: On that, in your submission you also make a number of suggestions to amend the act including but not limited to a time frame change from 30 days to 30 business days. In the circumstances you have just outlined, is there merit in making those time frames when so much of your role is subject to the actions of others?

Mr Atkinson-MacEwen: We have also suggested some stop-the-clock moments, but at the end of the day we are not trying to shy away from time frames. We are very conscious of the time frames that we require other parties to provide information under. We can only give them 14 days. The act does not allow for an extension. I cannot say, 'You can have 25 days.' The act says a maximum of 14. There is a reasonable excuse provision, but at the end of the day what we are seeking is some clarity around business days versus calendar days. If you have ever had to deal with the Acts Interpretation Act, a Sunday preceding a public holiday can be counted in a variety of ways. We are trying to do, as I say, an honest job by reporting. If we are a day over seven calendar days, we have failed; we will report that. If we are two days over, we have failed; we will report that.

Mr KELLY: I am interested in your own-motion investigations and your systemic investigations which I think is a feature that is somewhat distinguishing. I note in your submission under the own-motion investigations you list a whole range of investigations that I assume have been initiated. How do you think your organisation is performing in terms of fulfilling these two functions: the systemic investigations and the own-motion investigations?

Mr Atkinson-MacEwen: The systemic investigations are ones where we try to analyse our complaint data to identify issues that sit across more than one health service. They tend to be issues that are linked back to, say, the hospital and health service system rather than necessarily other services, although we have certainly seen issues with some of the unregistered practitioners where I have gone out and made statements about dealing with those.

In the systemic space, we are very much focused on adding value—that is, identifying what has already been done and not duplicating it, but rather saying, for example, 'There was a raft of recommendations made in 2013. We are not going to reinvestigate those, but what we are going to do is look at how those recommendations have been implemented and see whether or not the implementation was appropriate and how much more is there to do and whether something can be done better.' That has always been the approach we have taken.

Own-motion investigations are slightly different. As I pointed out in the submission in relation to some of the amendments to the act, when I receive information from police, for example, about criminal charges laid against anybody, a registered or unregistered practitioner, unfortunately I do not have the ability to look into those charges without putting something into an own-motion investigation. That is a feature of the way the act currently works. I do not have any way of enlivening powers to collect further information, except by way of own-motion investigation. There is a bit of distortion in that space at the moment because of the requirement to lawfully obtain information and therefore do it via own-motion investigation. We have conducted own-motion investigations. The one that is likely to be published in the next couple of months is the one into the regulation of schedule 8 medicines in Queensland.

It has been a very productive process to date because it has meant a lot of engagement with particularly the Department of Health and hospital and health services. There has been a lot of pick-up of the recommendations as they have developed. We have seen some significant changes that, in a sense, are ahead of the crest of the wave. As we come in and say, 'This is what we have found,' we will be able to say, 'And this is what has changed as a result.' We see those as being particularly important.

Mr KELLY: You mentioned the number of immediate registration actions in Queensland—75 versus those in Victoria. AHPRA has raised concerns about the number of matters that have been referred to QCAT and has done a comparison between their processes and yours. What are the conclusions we are to draw from this? Your organisation is saying, 'Another jurisdiction is not doing this in this way on this particular issue,' and then they are saying, 'You are not doing something in relation to the QCAT matters.' What are the conclusions that we can draw as a committee?

Mr Atkinson-MacEwen: First of all, it would be instructive to look at the number of immediate actions in all jurisdictions in Australia. I think you will find that, when statements are made about harmonisation of policies and procedures and a common approach, that is not evident in the statistics. Western Australia, which obviously has a very small number of registrants per head of population, has significantly higher rates of immediate action than Victoria, Queensland and other states.

It is hard to see how there is a common approach, for example, by the Medical Board nationally when you see statistics that are reported by AHPRA but there is no analysis and no understanding, from what I can see, of why that might be occurring and what might be underlying it. When I, as I have been, have been criticised by the Medical Board for the level of immediate actions, I keep going back to the fact that I have a legislative requirement. The act says that if I form a reasonable belief of serious risk to the health and safety of the public and it is necessary to act, I can act. 'Reasonable belief', 'serious risk' and 'necessity to act' are all phrases that courts and tribunals have parsed for us for many years.

I go straight back to the court and tribunal decisions and say, 'That is the policy I must follow. Those are the reasons. These are the parameters around serious risk. These are the parameters around reasonable belief that I must follow,' and I follow them. No-one has done the analysis on why, for example, medical boards across the country seem to have very different rates of immediate action.

Mr KELLY: So there is no academic analysis or independent analysis of—

Mr Atkinson-MacEwen: Not that I have seen at all.

Mr KELLY: I am not here to criticise; I am here to assess and analyse performance. I think effectively that is what we are doing here. There is no independent academic assessment of various jurisdictions and how they perform?

Mr Atkinson-MacEwen: Not that I have seen.

Mr CRAMP: Obviously there is a gaping difference of opinion between yourselves and the previous witnesses. You made a comment about doctors and the public feeling confident in the OHO role. I heard from previous witnesses that perhaps that may not be the case with some of their members. Is there any substantive evidence, especially with regard to the medical profession, that you can produce that would show confidence in the OHO's role, or at the moment are we just dealing with a difference of opinion between the different bodies and yourself? I am happy for you to table evidence if there is some.

Mr Atkinson-MacEwen: We have had practitioners say to us, 'I would prefer you did not refer this matter to AHPRA and the boards and that you retain it.' We would say to them, 'It is not a serious matter. It has to go to AHPRA and the boards because it is not serious.' We are trying to, in a sense, downplay any concerns they may have. They consider that they would prefer to have it dealt with by my staff because, according to them, they think it is a fairer system. At the end of the day, complaints keep coming in hand over fist. When we talk to complainants we often find that they are more confident now to make a complaint because they know it will go somewhere.

In relation to those practitioners who feel, as Dr Zappala said, beleaguered by the system, I say that it is not a punitive system; it is a protective system. The matters that Dr Zappala characterised as trivial and vexatious—we can have a different view about whether or not they are—are all low-level matters which fundamentally would be, on the current system, referred across to AHPRA and the relevant board to deal with. I sat there wondering why the criticism was being aimed at the Office of the Health Ombudsman when a substantial proportion of matters that come in the front door get referred across to AHPRA to be dealt with.

CHAIR: I know that we are over time. We will absolutely invite you to come again to answer more questions. My question is to do with—and it comes from my view of the situation; I am not a medical practitioner like some of my colleagues here—the public interest and what obviously would encourage confidence in the system from the many constituents who come into our offices with concerns about the health system and those issues. One of those is timeliness. Earlier you mentioned quality.

I note from the data you have kindly provided and publicly reported on that just under 50 per cent—and I am just referring to 2015-16—of investigations take 12 or more months. When I look at the outcomes of closed investigations, approximately 80 per cent of those closed investigations either had no action or were referred to AHPRA. That is a significant component. I would think that people in the community—and the comment has been made about it taking 12 or more months when the majority of complaints actually have no action taken or are referred—would find that a concern. Would you acknowledge that?

Mr Atkinson-MacEwen: It might provide some perception thereof, but when you look at the reasons matters are investigated, on the face of it there are serious allegations made around conduct or performance. If we find, at the end of an investigation, that those matters are not serious and do not need to be run to the tribunal because it does not inform an issue where you might see the tribunal suspend or cancel a registration for a practitioner, all that information is provided across to AHPRA—as we provide all of the material in everything we refer to AHPRA—and that is provided to the relevant board for the board to say, 'It is not a serious matter; it is actually a matter of unprofessional conduct that we can now deal with.' Unless and until matters are thoroughly investigated, you cannot determine where they should go.

In relation to matters where there is no further action taken, that is often the case because the practitioner surrenders their registration. When a practitioner surrenders their registration and says, 'I am no longer going to be practising,' unless there is a particular deterrent reason to run a matter to the tribunal—and tribunals have made comments in the past and recently about the need from time to time to deter behaviours—no further action is the most appropriate process because the public is now protected and in future the practitioner is not going to be doing whatever they have been doing.

CHAIR: How representative would that situation be of the almost 45 per cent of closed investigations which do suggest no further action?

Mr Atkinson-MacEwen: I would have to take that on notice. I cannot give that figure off the top of my head.

CHAIR: I certainly have questions around the use of clinical input—not use of independent clinical experts—into the process which I will ask at a future hearing. Time does not permit that now. I have questions around transparency of triaging and how that is occurring and consistency in terms of that. Obviously these are serious concerns that are being raised in submissions and that is why we do these sorts of things.

Mr Atkinson-MacEwen: I am happy to answer those questions.

CHAIR: Many of these issues—and obviously I was not around in this role—were around prior to legislation that was introduced in 2013. I would think that concerns about the complaints system aired then are no less valid today if there are concerns about quality or timeliness. Would you acknowledge that there are issues with consistency around procedures or processes within the ombudsman's office, or would you say it is just a resourcing issue?

Mr Atkinson-MacEwen: Resourcing is certainly an issue, but in terms of transparency and consistency of decision-making, for example—and you will note one of the submissions you received was from the office of the Queensland Ombudsman, to whom people are entitled to take their complaints about my administrative processes—we have an extraordinary number of opportunities for people to seek reviews of decisions and to seek process reviews from the Queensland Ombudsman as well. We provide people with an opportunity at every level of decision-making with their complaint to seek a review—internally or externally; it is their choice—and to have those issues explored. We think we are far more transparent and open to review and to having our processes identified as transparently as possible than any other jurisdiction in the country, with the probable exception of New South Wales, which operates a very similar system to the one we do.

CHAIR: Mr Atkinson-MacEwen, thank you very much for your time today. As time has expired I will draw this briefing to a close. The secretariat will be in touch should we request any further information in the meantime. We look forward to inviting you back to brief us again. Would you please table your opening statement?

Mr Atkinson-MacEwen: I am happy to.

CHAIR: I take that as tabled and declare the briefing closed.

Committee adjourned at 12.28 pm