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

Members present:

Ms L Linard MP (Chair)
Mr MF McArdle MP (Deputy Chair)
Mr SE Cramp MP
Ms LE Donaldson MP
Mr AD Harper MP
Dr MA Robinson MP

Staff present:

Mr K Holden (Committee Secretary)
Ms L Pretty (Assistant Committee Secretary)

PUBLIC HEARING—HEALTH PRACTITIONER REGULATION NATIONAL LAW AND OTHER LEGISLATION AMENDMENT BILL 2017

TRANSCRIPT OF PROCEEDINGS

MONDAY, 17 JULY 2017

Brisbane

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Committee met at 10.01 am

LENTAKIS, Inspector Nick, Senior Clinical Educator, Queensland Ambulance Service

PEVERILL, Mr Dermot, Industrial Officer, United Voice

CHAIR: Good morning. I now declare this public hearing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee open. I would like to acknowledge the traditional owners of the land on which we meet and pay my respect to elders past, present and emerging. My name is Leanne Linard. I am the chair of the committee and the member for Nudgee. Other members of the committee are Mr Mark McArdle, deputy chair and member for Caloundra; Ms Leanne Donaldson, member for Bundaberg; Mr Sid Cramp, member for Gaven; Mr Aaron Harper, member for Thuringowa; and Dr Mark Robinson, member for Cleveland. Today's hearing is part of the committee's examination of the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2017. The bill was introduced by the Hon. Cameron Dick, the Minister for Health and Minister for Ambulance Services, on 13 June 2017. The committee is required to report on the bill by 11 August 2017.

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 which takes a non-partisan approach to inquiries. This hearing 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. Witnesses have 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 hearing will also be broadcast live on the parliament's website.

I welcome our first witnesses—Dermot Peverill from United Voice and Nick Lentakis from the Queensland Ambulance Service. I apologise that we are running late this morning. I know we started 15 minutes late, so thank you very much for being here and for also being so patient. Thank you for your submission. You have the opportunity to make a brief opening statement. As the committee has read your submission there is no need to reiterate the content of that, but you are welcome to make a brief opening statement before we ask questions.

Mr Peverill: Thank you for the invitation to address you this morning. United Voice, together with Mr Nick Lentakis, appreciates the opportunity to come before the committee to assist the committee in any way we can. This is a bill that United Voice and our members clearly support. It is a bill which delivers significant reforms to our members—paramedics—employed in Queensland. Its significance is best demonstrated by the national regulation registration of paramedics under the National Registration and Accreditation Scheme for health professionals.

The bill before the committee, the passage of which we commend to this committee, delivers to Queensland a number of significant factors which will give public confidence to paramedicine in Queensland. The protected title of paramedic itself is something which for health practitioners in Queensland is fundamental to ensuring that there is public confidence in the delivery of prehospital medical services. That protected title then gives the public some surety as well around the qualifications that paramedics in Queensland will bring to their position delivering prehospital care. There is no doubt this committee can now appreciate the complexity that paramedics now have to be equipped with to assist people in often do-or-die circumstances. They come to people's aid morning and night and we believe that the qualifications that a paramedicine employee in Queensland needs to bring is so complex that national registration is mandatory. We commend the passage of the bill not only for its public protection but also because it gives our members recognition for the work they do every day.

The bill also delivers national standards which will be determined by a national board. We hope there is some transparency around the board. It is a tranche of the amendments which are yet to be set in place, but obviously a national board will give some transparency across jurisdictions in that it will be a board that has jurisdiction across a number of states. Nick Lentakis is with me here this

morning to assist the committee in any way we can. I am happy to furnish any information the committee may request of us, but other than that we support the passage of the bill. United Voice thinks this is a proud day for United Voice members. We have represented the industrial interests of ambulance members across the state for some period of time now. This is something our members are telling us will deliver them some certainty and outcomes which will not only give them confidence in performing their job coming to our assistance every day but also give the Queensland public some certainty as well. Thanks, Madam Chair.

CHAIR: I invite the member for Thuringowa to open it up for questions.

Mr HARPER: Thank you very much. Good morning, gentlemen, and thank you very much for being here today. It is no secret that, from working in the Ambulance Service for a number of years, this is something that I have observed in my time. I am glad that, in terms of paramedic registration, Queensland is leading the way. What percentage of the paramedics in the Queensland Ambulance Service do you cover?

Mr Peverill: I thank the member for the question. Currently, United Voice represents approximately 70 per cent of the paramedics across Queensland. Queensland is obviously a large state. We cover members in regional centres—one- and two-man stations—right down to the large metros here, the LASNs, Metro North and Metro South.

Mr HARPER: How much consultation on paramedic registration has United Voice undertaken with your members who are employed as paramedics?

Mr Peverill: I would like to answer that in two parts and then give Mr Lentakis an opportunity. I will answer the first part of that question. United Voice is a proud union. We represent our members vigorously. This has been an issue that has come before a number of states and a number of jurisdictions over the years. As a key stakeholder, we have been consulting for a number of years now. Our paramedics have been telling us clearly that they want professional recognition. These guys work hard every day—much like our nurses in the public sector and other medical professions. United Voice has the clear message that it is something that our members have been seeking. Mr Lentakis plays a very senior role in United Voice. He is, obviously, in a dual capacity here today to some degree. I will give him the opportunity to answer that question too, if I could.

Insp. Lentakis: Thanks for the opportunity. The QAS has a national registration advisory steering committee, which was implemented as the bill progressed. I am a member of that committee, along with two other delegates and a senior organiser, Debbie Gillott. We were a bit hamstrung in the beginning with getting information out, because we had to wait to see how this was progressing, but now the advisory steering committee has started with at least two pages in our *Insight* magazine, which goes out to all staff, as well as frequent commissioner bulletins, as well as frequent United Voice communiques going out to the staff and our delegates on the ground talking with the guys and answering any concerns that they may have in relation to national registration across-the-board. There were some concerns, which I believe have been adequately addressed in the bill. I think, in the majority of cases, that has put those to bed.

Mr HARPER: That is a good segue into my next question. What considerations are important to your members in the transition period, particularly for those members who have been around for some time?

Insp. Lentakis: Exactly. They are probably the members who felt the most concerned about the registration, in particular with the qualifications around the registration—what was going to be the standard qualification required. I think the grandparenting law addresses that quite well. In particular, for those officers who have only a diploma and who have not progressed through to the bachelor's degree, because it was not required when they came through the service—I am talking 15, 20-year-plus veterans—the grandparenting law, particularly in the third point, addresses that in relation to at least five of the last 10 years of clinical practice. They would recognise them for registration. I think that has put that to bed pretty well.

The other issue would have been the registration fees, because that is something that we were not used to having to pay. Of course, indemnity is the other thing. As we know, we are covered by the Queensland government indemnity and we are covered by the QAS indemnity in relation to anything that is within our guidelines, but personal professional indemnity is something that questions are being asked about and then the registration fee. Those we cannot answer at the moment, but the main concern was probably the grandparenting law. The qualifications and the grandparenting, I believe, address that. I seem to have settled down a lot of the people who asked me about it. They seem pretty comfortable about it.

Mr HARPER: Nick, in your role as a clinical educator you have been around for some time. I have been out of the system for a little while now. Previously I was an intensive care paramedic. That is now called a critical care paramedic. Can you inform us of those skill sets that you take into the prehospital arena?

Insp. Lentakis: They have grown exponentially in the last decade. There has also been a boom in prehospital care, which is great for our community. We have been saying this for a while. With intensive care paramedics, we virtually bring the emergency department to the house. At an advanced care paramedic level, which is probably what you would call the baseline level—the majority of paramedics have that level—they can now do thrombolysis if they need to in remote areas. They can do referral to the catheter labs for cardiac artery blockages. We can now sedate patients without having to consult first, in particular, with mental health cases where we have extremely violent psychotic patients, whereas in the past we basically had to run. Now, with police assistance, we can medicate them—what we call medical restraining rather than physical restraining. Over the years, research has indicated that the physical restraint can be detrimental to the patient and has inadvertently—not intentionally—caused a number of deaths. With a critical care paramedic, we are doing ultrasounds in the field. We are opening up chests if required. We are providing blood transfusions now in the field for those big trauma patients. That is in the high acuity response unit, which is another level above critical care paramedic.

To give you an idea, when I started 28 years ago now—and I am not sure if you have heard this before—we used to get in trouble for taking blood pressure. If we walked into a hospital with a stethoscope around our neck, we would get into trouble. Nowadays, with the drugs we carry, the simplest one would be for an asthmatic. When I started, an asthmatic who was what we would call peri-arrest—about to go into cardiac arrest—would have died by the time we got to the hospital, because we did not have anything except Ventolin to nebulise. Nowadays, we can turn that around in a minute with adrenalin, hydrocortisone et cetera. It has jumped in leaps and bounds. I would like to think that the mortality rate has been reduced with the interventions that paramedics can now do in the field, rather than waiting to get to hospital.

Mr HARPER: Thank you very much. I was just establishing that it is a lot more complex now. Certainly, it is deserved of paramedic registration nationally.

Insp. Lentakis: Absolutely. This recognises the level that paramedics have reached compared to 28 years ago.

Mr HARPER: Thank you very much, gentlemen.

Mr CRAMP: I thank you both for coming along today. I have asked similar questions in a previous hearing. With regard to the protected title of 'paramedic', what is the view of United Voice in regard to private companies and paramedics working in a private capacity outside of the service and outside of any generic industrial agreement using that term ' paramedic' and being able to reach that qualification?

Mr Peverill: I thank the member for the question. We think it is consistent with our submission that, whether the protected title is in the state system—that is a state-run organisation, much like many of the other state-run organisations across the country—the QAS is no different. Being a public sector, the public should have confidence in the delivery of prehospital medical care. It is our position—and I believe this is consistent with the view of our members—that that should apply across to private practice as well. The Queensland public should not expect any less care from a role which has, as Mr Lentakis has taken us through this morning, such significant outcomes.

In summary, United Voice sees this bill as a way of ensuring that paramedics across the state are registered under a protected title that gives not only paramedics confidence but the public confidence, as well.

Mr CRAMP: My question was pertaining to the exclusivity of the title. Insp. Lentakis, this is open to you, too. Should it be just an Ambulance Service state-held title or should this be accessible for all persons who reach that qualification? I read that it is a degree-based qualification, which obviously I am aware of from my history in the service. Should it be accessible to all persons meeting those qualifications who do not work for the Queensland Ambulance Service, but perhaps work in a private capacity?

Insp. Lentakis: From my reading of the bill and the build-up to the bill being written, my understanding is that as long as they meet the standard qualification required they could use the title of paramedic. That is my understanding. Is that correct? Whether it is private or a recognised

Ambulance Service, my understanding is that. I think you will find in the nursing profession that you have nurses who are registered but not practising. I would think that as long as they meet the qualification required to attain registration, they should be able to become registered, yes.

Mr CRAMP: I may have missed this, but you spoke about the grandfather clause. My interest is also lying with bridging courses, which we see as paramedics move through, when we have advancements in minimum qualifications. I take it that the service will be seeking to assist some of the more experienced paramedics. I guess everyone in the service is degree based these days; is that correct? Do we still have persons out there—

Insp. Lentakis: There are still officers out there, probably of my vintage, who do not have a—

Mr CRAMP: Like the member for Thuringowa, perhaps?

Mr HARPER: I like the grandfather clause.

Insp. Lentakis: I do have a degree, but they are getting to the age of thinking about retirement, so the 50- to 55-year age group in our service still only have the a diploma.

Mr CRAMP: Obviously, there is care and concern for the experience and the wealth of knowledge that they have. They are still valuable to the service. I take it that the service will work closely to make sure that those personnel are qualified and appropriately put over to registration?

Insp. Lentakis: I think the grandparenting law covers them if they do not go to a degree. That is my understanding.

Mr CRAMP: This is what I am trying to get my head around.

Insp. Lentakis: I think the grandparenting law covers that. I am not an expert on legislation, but the way that I read it that covers that area, as long as they are still practicing.

Mr CRAMP: The intent of the service will be to do everything that you can to ensure that those personnel are not discriminated against—

Insp. Lentakis: And pushed out?

Mr CRAMP: Exactly.

Insp. Lentakis: As a clinician, a senior clinical educator and a union delegate, I give you my word that I would fight anything like that. You do not throw experience like that away, because what they do not have on a piece of paper they have certainly seen. As we know, experience is the best teacher.

Mr McARDLE: Gentlemen, in your opening comment you raised the point of the transparency of the Paramedicine Board. Can you give me an indication of what you would see as an appropriate process for the appointment of members to the board? What would you see as being the best way to go about that?

Mr Peverill: Our submission simply is taking a position that, when it comes to the registration and appointees to the board, that appointment should be merit based. Where it is merit based, we say it should also be representative. We would envisage that the board would not be just, to use a term, people who are office bound. It should call upon people in the field and people who are true clinicians. United Voice represents a significant group of members who are well trained and well versed to be able to fill those positions. We say that merit based is the only way to really deliver a truly transparent board.

Mr McARDLE: Would you consider wide consultation with the union as being part of that process?

Mr Peverill: That is correct.

Mr McARDLE: The registration of members, as well?

Mr Peverill: That is correct. We are a key stakeholder and other key stakeholders have been before the committee. We note the QAS has been before the committee and we know there are others to follow. We think that United Voice would be a key stakeholder and would warrant genuine consultation.

CHAIR: Thank you very much for attending this hearing today and for your submission.

KHEDR, Dr Yara, Consultant Psychiatrist, Toowoomba Hospital; Senior Lecturer, University of Queensland; Royal Australian and New Zealand College of Psychiatrists, via teleconference

CHAIR: Dr Khedr, thank you very much for joining us. I am Leanne Linard, chair of the committee and member for Nudgee. Thank you for your submission to the committee. I will give you the opportunity to make a brief opening statement. The committee has certainly read the submission provided, so there is no need to reiterate that, but would you like to make a brief opening statement and then we will open for questions.

Dr Khedr: My name is Yara Khedr. I am a child psychiatrist working at the Toowoomba Hospital in Queensland. I am also the trained psychiatrist representative in the Queensland branch of RANZCP. I guess the main concern that RANZCP was raising through its submission was the process regarding the health practitioners working both in Queensland and New South Wales, the concern about their different alignments and how this will go with the New South Wales legislation. Otherwise, there are no other concerns, as is outlined in the submission.

CHAIR: I invite my colleague, the member for Bundaberg, Ms Leanne Donaldson, to open with the first question.

Ms DONALDSON: Dr Khedr, page 1 of your submission highlights the college's support of clause 20, which proposes that the National Board could ask for information about a practitioner's practice arrangements, including anywhere where they are either an employee or a contractor. The clause proposes to require a practitioner to give information about another practitioner that they may have had no dealings with other than sharing the cost of a premises. Does the college consider this part of clause 20 to be reasonable?

Dr Khedr: I am sorry, but which part exactly are you referring to on page 1?

Ms DONALDSON: I am referring to the support for clause 20, at page 1. The college is supportive of clause 20, which proposes to allow the National Board to ask for information about a practitioner's practice arrangements, including anywhere they are an employee or a contractor. The clause proposes to require a practitioner to give information about another practitioner with whom they have no dealings, other than perhaps sharing the cost of a premises. Does the college consider this part of clause 20 to be reasonable?

Dr Khedr: I am struggling to find that part about another practitioner. Is it in the submission? I can see in the submission it says—

… no objections to clause 20 which enables the National Board to ask for a broader range of information about a registered health practitioner's practice arrangements for example, where the practitioner is an employee, contractor, volunteer, or partner in a partnership.

Ms DONALDSON: Yes.

Dr Khedr: It comments on the practice information, which enables the user to extract information to inform all places. I cannot see the part that talks about informing about other practitioners. I cannot see that in the submission.

Ms DONALDSON: There is another element to clause 20 that goes to that part of the question. In terms of the college's support for clause 20 in its entirety, that would then be part of clause 20?

Dr Khedr: It would be part of it. I am happy to come back to you, because I cannot find anything about it in the submission and in the discussion with the policy department. I am happy to come back to you about that.

Ms DONALDSON: That would be great, thank you.

Mr McARDLE: Dr Khedr, I am the deputy chair of the committee. The chair has stepped out for a couple of moments. Do you have any concerns in relation to AHPRA and their process of investigation? It has been subject to a couple of inquiries by the Senate, with the last report coming out late last year. This bill tends to widen that power or the powers they have. Do you have any comments to make about AHPRA and how they deal with complaints time wise?

Dr Khedr: I believe, when I went through the new bill and the submission, I guess the college is happy with the change that is happening in the process at this stage, especially when it comes to the immediate action. I guess there will be a time limit, as well, that will be added to it to provide the update. This might help. I am not very much aware of the previous issues with AHPRA that go to the time process. I cannot comment on it, because I am not aware of it. The other amendments that are happening are definitely welcomed at this stage.

Mr McARDLE: Dr Khedr, that is our last question. On behalf of the committee, I thank you for your time today and also for the submission that you made to the committee. Have a good day.

Dr Khedr: Thank you very much.

PYRA, Ms Kalina, Solicitor, Hall Payne Lawyers

SHEPHERD, Mr Jamie, Professional Officer, Queensland Nurses and Midwives' Union

CHAIR: I welcome our next witnesses: Mr Shepherd from the Queensland Nurses and Midwives' Union and Ms Kalina Pyra from Hal Payne Lawyers. Thank you for joining us this morning. Can I offer you the opportunity to make a brief opening statement? As I have mentioned before, we have read your submission, but if there is anything additional or brief you would like to say we would welcome you to do so before we move to questions.

Mr Shepherd: The Queensland Nurses and Midwives' Union thanks the committee for providing it with the opportunity to comment on this bill. The QNMU believes the implementation of the national registration and accreditation scheme has had a significant impact on providing protection for the public and fairness in regulating the health professions. We support the recognition of nursing and midwifery as two separate professions that continue to be regulated by the NMBA. However, there are specific amendments this bill proposes that we believe are unnecessary and may impact adversely on nurses and midwives. We have made a detailed submission that outlines those concerns.

We recognise the need for legislation to protect consumers from the adverse consequences that may arise through the action or inaction of a health practitioner. We also ask the committee to consider the stressful environment in which many nurses and midwives carry out their roles. Theirs is a highly regulated profession under constant scrutiny by patients, families, friends, other health practitioners and their employers. Despite this, nurses and midwives choose this role because they care about the welfare of others. We ask the committee to balance their interests with those of the public by accepting the considered and reasonable amendments we seek in our submission.

CHAIR: Thank you very much. For the benefit of the committee, could you explain from your point of view what the key benefit is under the bill with regard to separation of nurses and midwives?

Mr Shepherd: They will still be regulated under the same board, the NMBA. Increasingly over the last few years there has been recognition of quite clear distinctions between the two professions. Whilst there was a time when a midwife could not be registered as a midwife unless they were a nurse first, there are now direct entry midwifery qualifications and we are seeing an increasing number of midwives who are registered as midwives and not registered as nurses.

The other point to make is that, since the inception of the National Law, the Nursing and Midwifery Board of Australia have had separate codes of professional conduct and practice standards. There is a suite of documents that they provide as the codes and guidelines made pursuant to the National Law. The board also sees quite a clear distinction between the two professions.

CHAIR: I am interested in clause 5 of the bill—the replacement of section 31 and the ministerial council's capacity to change the structure of national boards. Could you extrapolate a little more on your key concerns in that regard?

Mr Shepherd: I will call on my colleague, Kalina, to answer that question.

Ms Pyra: In relation to that, I think it is important that the boards have some certainty. I think the AMA also made quite a cogent submission in relation to what had happened to the Medical Board. If the change is made under legislation it allows for proper consultation with the various stakeholders rather than under regulation which might be seen as just an ability to remove a board or the chairperson without proper consultation with the stakeholders. There did not appear to be any real need for change in those circumstances.

CHAIR: My recollection of the explanatory notes, without leafing through them, and the information provided in that regard was that there was discussion, which I am sure you would be privy to, around whether this change should be made, whether there should be some consolidation of the nine boards that deal with some 12 per cent of matters—and, obviously, those that you represent, Mr Shepherd, are represented in the 90 per cent of issues and matters dealt with—but they chose not to, however sought this flexibility and made the comment that there would be consultation should that power be sought to be used in the future. Did you feel that that is not a high enough threshold though should it be contained in regulation rather than the act?

Ms Pyra: Our view was that it should be contained in the act rather than in a regulation. Of course, consultation is always greatly appreciated and very important in these sorts of matters, but we thought that our suggestion not to change still gave better protections in that regard.

Mr McARDLE: Thank you kindly for coming in and for your great submission. It is very detailed. I agree with you regarding the regulation and the act. There is more certainty in the act and therefore it gives a greater capacity to understand what is taking place in relation to the board membership and the like. You make comment about the appointment of a state manager in relation to complaints and that body or person having the right to knock out a vexatious complaint or a complaint that does not have merit. You made comment on page 9 of your submission that there are complaints that are made without merit. What is your background to making that comment? You have a very large membership base. Are you going on your own background or QNMU knowledge?

Ms Pyra: Yes. There are some matters, but it is not a large number of complaints. There are certainly some we have seen. For example, where a complaint is made by another health practitioner against one of our members and it is seen as retribution for a complaint our member has made against them. We have seen some matters out of the prison system where the prisoner's stated aim, as witnessed, has been to get back at our nursing members and to have their registration removed.

There are some matters, a small number, but important ones to our members, where it is fairly clear when you look at the evidence that the claim is vexatious or misconceived. They rely on a misunderstanding, for example, of the medical care provided. As I said, it is a very small number. It is not a significant number, but these claims cause an immense amount of stress to the members.

In these cases, the decision has to be made by the Nursing and Midwifery Board to declare a claim vexatious or misconceived. In a case where it is extremely clear the view was that it would be appropriate for the state manager to make that sort of decision to remove it from the necessity to go to Nursing and Midwifery Board that would also free up the Nursing and Midwifery Board in those small but still a fair number of complaints. In addition, it would likely speed up the process as well, which is another important matter in these sorts of claims where there is really no basis to them.

Mr McARDLE: Although we use the phrase 'no basis for the claim' how do you get to that point without having a full inquiry and coming to that determination. It may well be that on the papers it looks very clear cut, but I think we all know that sometimes those matters do hide a major issue going forward. How does the state manager come to a conclusion without a proper inquiry into the complaint that mirrors what happens at a higher level?

Ms Pyra: There are a couple of ways the claims are dealt with. First, claims can be dealt with in the assessment phase. That is a 60-day process where all the evidence can be accumulated and a decision can be made by the Nursing and Midwifery Board at that point. That is a speedier process. However, if the assessment officer and the Nursing and Midwifery Board decide that there is more information required they can determine that it go to investigation. There are two processes. Certainly if AHPRA believe and if the notifications officers believe that there is more information required the matter will press to investigation. That will seek further information regarding the matter. That is a full investigation of the case.

In these sorts of matters we are talking about there is really good evidence, including documentary evidence. It is not simply a he said she said or a she said she said sort of case. It is one where there is documentation which can support the view. What we are saying is that it should be in a case that is very clear cut. The ones we are talking about are those sorts of cases—that is, where there is documentation, evidence and statements that can support the view that the claim is either misconceived or simply vexatious.

Mr McARDLE: Just to flesh out a little further what you are talking about, what proportion of matters would you say would fall into that category?

Ms Pyra: It would be a very small proportion. It would be less than one per cent, I would think.

Mr McARDLE: That would account for how many, do you think? I talking about your own body.

Ms Pyra: It may be 20 cases a year or perhaps fewer, I would suggest. It could be up to 20, but I would think fewer than that.

Mr McARDLE: Could you take that matter on notice and come back with the percentage and the number of cases that you say would fall into the category that you could eliminate very quickly?

Ms Pyra: Most certainly, we could have a look at that.

Mr Shepherd: Prior to my joining the Queensland Nurses and Midwives' Union my employment experience included working as a senior health and performance officer and investigator with AHPRA in Brisbane. I can say that there were a handful of matters that landed on my desk that in my view as an investigator and senior health and performance officer and also in the view of my senior supervisors would not be necessary to go to the board because of the details that were

provided and the nature of the complaint and subject matter of the complaint. There were those that, in my view, were vexatious and sought retribution. There were others that should have been managed at the manager level of the employer. We found it somewhat frustrating that there was no delegation afforded to the state manager of notifications to be able to make that decision on behalf of the board. Again, it was a very small number. It would have been no more than a handful in perhaps 200 matters that I dealt with.

Mr McARDLE: At page 15 of your submission you talk about the national register and the issue of domestic violence and addresses being provided on the register. That is a matter that I can certainly concur with—that is, to allow contact via a register that then produces a domestic violence scenario is the very worst outcome. Are there other areas of information that may well be excluded or should be considered for exclusion?

Mr Shepherd: I think the principal place of practice is the main one. If a person does not have a principal place of practice they are expected to put their principal place of residence. That is the major concern for some of our members, especially those, as you recognise, who have been subjected to domestic violence issues.

There is the capacity at the moment for a registrant to apply to the board to have those details removed from the register, but the time lapse could be problematic. It could be a month or six weeks before that matter gets to the board. As you know, domestic violence issues can often be quite impulsive. It could occur before the board met and agreed to remove those details from the register. If that decision could be made by a delegated officer at AHPRA it would be a much quicker process.

As a professional officer with the QNMU we meet every three months as the national body, the ANMF, the Australian Nursing and Midwifery Federation. All the professional officers around the country meet. I was advised of an issue in South Australia involving a nurse who had been subject to domestic violence from her partner. Her partner found the principal place of practice where she had moved to on the register—a different area of South Australia. He realised that there was only one major hospital. He spent days stalking the exits of that hospital waiting for his former partner to exit.

Mr HARPER: Thank you both for being here this morning and for your detailed submission. I am interested in your recommendation 5, which states—

The QNMU does not support the replacement of section 180 and recommends there should be no change to the current provision.

Can you expand on that? Your first paragraph says that you have—

… serious concerns around the health practitioner's privacy if the reasons for the decision are also included in the notice given to the notifier as subsection 180 ...

Can you expand on that and break it down?

Ms Pyra: There are a number of matters. When we as a firm respond to a complaint we provide a lot of detail in relation to the complaint in our response. We include the background to it which can include personal background, what is happening in the practitioner's life, family, domestic violence, health matters and psychiatric issues in health cases where there are psychiatric issues. We are documenting a great deal of very private and personal information as background to the complaint, because our view is that often you cannot see a complaint in isolation. There is often background information—bullying in the workplace or significant issues surrounding systemic issues in the workplace.

Some of those matters are not matters that the practitioner would necessarily want the notifier to know about. We find in complaints regarding nurses that most of the complaints are made by other health practitioners or by their employer. A smaller number tend to be made by patients. Our concern is that to provide details of those really intimate matters regarding a person's life—including what has happened in their past leading up to the event, sometimes deeply personal aspects that can inform a decision made by the nursing and midwifery board—we think has the potential to lead to a little less frankness in the response. Absolutely it is very important for the notifier to be advised of reasons why, but our view is that some of the more detailed reasons, particularly the very personal information contained, is not necessary to be provided to the notifier in those circumstances.

Mr HARPER: On page 8 of your submission you mention registration, which is covered by clause 9 of the bill which amends section 56. You note that 'a period of up to 90 days is not acceptable for a commencement date of registration'. What are the current arrangements? How long does it take to gain registration? I am wondering why you are opposing that particular point.

Mr Shepherd: When students apply for registration they are advised by the board or by AHPRA to make an application about four to six weeks prior to their graduation because it can take that long. At various times of the year they can get a huge influx of student applications, and it can take the officers quite some time to get through those applications in December and in July each year. We think it is a reasonable time. Four to six weeks should be adequate. Anywhere between 30 and 45 days would be sufficient to be able to determine the merits of an application and whether they meet the registration standards. We are keeping in mind that the reason for registration is to gain employment. The smaller the gap between your application for registration and gaining employment the better. We have dealt with members who have been offered positions as registered nurses on a graduate transition program and they have missed out on getting into that program because of delays in getting their registration.

Mr HARPER: Thank you very much.

CHAIR: There being no further questions, I thank you for your attendance today and for your detailed submission. The committee appreciates it.

BOWEN, Mr Timothy, Senior Solicitor, Advocacy, Claims and Education, MIGA

HAYSOM, Ms Georgie, Head of Advocacy, Avant

CHAIR: I am Leanne Linard, the chair of the committee. Thank you for joining us. I offer you both the opportunity to make a brief opening statement. We have received your submissions and read them. If there is anything additional that you would like to open with, I invite you to do so and then we will ask some questions. I invite you to start, Ms Haysom.

Ms Haysom: Thank you for the invitation to appear today for the hearing. We welcome many of the proposed amendments to the national law and the Health Ombudsman Act that seek to improve the operation of the complaints process. For example, there are mechanisms to improve communication with notifiers, amendments relating to review periods and the power for co-regulatory jurisdictions to change conditions imposed in another jurisdiction. They are welcome amendments. The power for a board to take no further action where the practitioner has taken appropriate steps to remedy the issue that is the subject of the notification is a particularly welcomed amendment, and it is consistent with the protective role of the boards and AHPRA.

We do have some continuing concerns about some of the proposed amendments and these are outlined in our submission. Avant supports a national scheme and a nationally consistent regulatory framework so that the public and the profession can be confident that there is consistency in their experience and in outcomes wherever they are in Australia, but there needs to be the right balance. The role of AHPRA and the board is protect the public and not to punish practitioners. Doctors feel under increasing pressure and, as we have said many times in inquiries such as this one, it is important to ensure that the regulatory process is timely, fair and transparent, and does not cause harm to the practitioners being regulated.

Mr Bowen: I thank the committee for having me here to represent my organisation, MIGA, today. I will make a brief comment and it is really a theme that has emerged from some of the comments made in the submissions. We appreciate that the bill as proposed has focused on issues of protection of the public and disclosure, and they are of course very important ones. One theme that probably has not come through as much and we are hoping will be focused on in the next tranche of changes but we think would be an important one to bear in mind now is the issue of educating the profession over punishing the profession.

I understand the committee is aware of the recent Senate inquiry and its findings. There were some interesting comments made in that inquiry arising out of some submissions we made about the need for regulators to look more at what needs to be improved and how it can be improved over imposing things such as cautions without engaging further. The Senate did comment that there is a need not to sanction every mistake and that education and mentoring can be used to manage risk. We think those are important things. We think an approach like that would address some of the concerns raised so far about the bill, but we appreciate that it might be the next round that we get a chance to look at that more closely.

CHAIR: Thank you both for your brief opening statements. Ms Haysom, in your submission to the committee in regard to the amendment to section 156, which is grounds for taking immediate action, can you extrapolate on any concerns experienced in this regard?

Ms Haysom: Yes. We acknowledge the reasons for broadening the immediate action powers, but we have found that in New South Wales that power to take action in the public interest is increasingly used more as a routine than as an exception. Because it is open to interpretation, as outlined in the explanatory memorandum, it gets more broadly interpreted than we would say is appropriate. We find that there is an increase in the use of that power when we would say that it is not required because of the notion of risk to the public. That is why we say that, although we acknowledge that the board does base its decisions on a risk based regulatory approach, that is not enshrined in the legislation and we would be asking for that because we believe that that could be interpreted more broadly than intended.

CHAIR: Ms Haysom, you have commented that the explanatory notes outline that a risk based approach would be taken but also that such matters would be subject to a show cause process. You also do not feel that that provides enough safety from the public interest test being applied too broadly.

Ms Haysom: It does provide some reassurance but I guess the point—and it was one that was raised by the nurses in the previous submission—is that the impact of these processes on practitioners are significant and to go through a show cause process is a significant issue. Whilst that is a protective mechanism, it is not sufficient, we would say, given the broad nature of the potential interpretation of that provision.

Mr McARDLE: Thank you both for your submissions. Ms Haysom, you used the term 'under increasing pressure' to refer to doctors. You also used the phrase 'timely, fair and transparent' in relation to investigations. Could you elaborate on what you meant by that? What historical data or evidence do you have to make those claims?

Ms Haysom: In relation to 'under increasing pressure', I think it is fair to say that doctors do feel under pressure. If you were to look at the submissions that were made to the Senate inquiry which my colleague Mr Bowen referred to, there are a lot of submissions in that inquiry indicating the pressure that doctors are under, particularly in the complaints process but also more widely. We know that there are lots of media reports of when things go wrong for doctors. There is a lot of media around adverse outcomes and the like. Whilst we do not cavil with the notion of the media reporting on things, it does put pressure on practitioners together with pressures within hospitals to meet budgets and the like. I think that is what we mean in that regard.

In relation to the timeliness, fairness and transparency of the process, this has been an ongoing issue in relation to AHPRA since its first inspection in 2010. However, I need to say that there have been improvements with that, but there is a bit further to go. We made some submissions to the committee in relation to the Health Ombudsman's timeliness and meeting the deadlines under the Health Ombudsman's time frame. That is what we are referring to there—the timeliness of the complaints process and the fairness to practitioners and to notifiers.

Mr McARDLE: Are inquiries taking too long?

Ms Haysom: Yes, in some circumstances they are. For example, in Queensland there were several investigations that were outside the 12-month requirement in the legislation. Those time frames are not being met in all occasions and that does cause a significant impact on practitioners and on notifiers.

Mr McARDLE: Mr Bowen, you used the phrase 'education over punishment' when talking about AHPRA and the reports by the Senate.

Mr Bowen: Yes.

Mr McARDLE: There was one this year, was there not?

Mr Bowen: That is correct.

Mr McARDLE: And one late last year as well.

Mr Bowen: Yes.

Mr McARDLE: Would you endorse the comments made by Ms Haysom in that regard?

Mr Bowen: When I talk about education over punishment, it is a need to look at isolated errors—things where a doctor can learn and stop that becoming a process where a doctor has not taken anything away from that. They have been cautioned, but what is the ongoing effect of that? It might have taken a long time to reach that point, whereas if there had been a more collegiate, more engaged process by AHPRA and the board meeting with the practitioner to discuss what went wrong we think that would be a better process. We accept that some matters—matters which reveal broader issues or more serious issues—are not appropriate for that process. We think there is a large number of matters that would benefit from an earlier, more intensive educative mentoring style process.

Mr HARPER: Mr Bowen, I see MIGA has been around for some time—over 100 years—and has 30,000 members. You have a large national footprint. I was interested in the proposed public interest test for taking immediate action and specifically item No. 7 in your submission. You oppose the proposed amendments to powers to take immediate action against practitioners as set out in clauses 24 and 65 of the amendment bill. Can you expand on that?

Mr Bowen: We acknowledge the logic behind imposing power to suspend on public interest grounds. That already exists in New South Wales. Our concern is about the threshold. What we see as being proposed for introduction is a considerably lower threshold than in New South Wales. There is a significantly higher threshold in New South Wales. Our concern with the introduction of a new power is that it is very hard to define and work out how to apply in practice. We will see significant numbers of unnecessary suspensions. We have New South Wales' experience around this. There are views on whether action has been taken too precipitously in New South Wales. That is a much more developed jurisdiction, so the problems that we may encounter down there could be more widespread with the introduction of a new regime with a lower threshold.

Mr HARPER: Can you unpack the difference between 'reasonable belief' and 'satisfaction'?

Mr Bowen: As you would appreciate, there has been a bit of a dialogue between our organisation and those who have been drafting the bill over this issue. We raised those issues, and that is why our submission is so lengthy regarding this issue because we think it is a very important one. As I see it, 'reasonable belief' is about holding an idea that is not too out there; it is not fanciful; it is not unacceptable. It might be a less than 50 per cent belief or satisfaction. Whereas when we talk about 'satisfaction', we are talking about thinking that this is the most appropriate thing to do; we are satisfied we should do this. It is a higher threshold. We might be talking about a 75 per cent level of belief as opposed to a reasonable belief, which might be somewhere between 40 and 50 per cent as we see it.

CHAIR: There being no further questions, I thank you both very much for joining us and thank you for the submissions on behalf of AVANT and MIGA.

FOX, Ms Melissa, Chief Executive Officer, Health Consumers Queensland

Ms Fox: Thank you so much for having me here today. In the spirit of the comments that were just made by the previous speakers with regard to education over punishment and timely, fair and transparent investigations, I would like to remind us all that that we need good regulatory and complaints processes that are focused on building the safest and most consumer focused healthcare system. We do need transparency. We do need a culture of open disclosure and a culture of continuously learning from mistakes and systemic failings. We believe that there are many aspects of this bill which go towards this aim.

CHAIR: There have been a number of different comments and positions taken with regard to the amendment to the Health Ombudsman Act which allows complainants the ability to waive their right to three-monthly updates on investigations. You have also touched on that in your submission to the committee. Can you outline for the committee the views of Health Consumers Queensland in that regard and why you have taken that position?

Ms Fox: We understand that some investigations may take quite a length of time and may rely on the outcomes of other investigations such as when police matters are involved. We think that this provision in the bill allows consumers to make an informed decision about how often they wish to be advised about the progress of investigations. It may be that receiving a letter every three months stating that yet again no action has been forthcoming is something that is distressing, and a consumer may wish to make a decision that until there has been some movement and an outcome they do not wish to receive what are generally administrative letters around no action.

CHAIR: I am interested to know whether Health Consumers Queensland has received complaints or feedback regarding the paramedicine profession. Obviously, the proposal under the bill is that they be treated similarly to doctors and nurses et cetera. Have you received any feedback about how that was working previously? Is this an improvement, or not?

Ms Fox: There has been no specific feedback, but it is certainly something that we support in line with what we have observed with other professions that have come under that regulatory framework. We look forward to seeing the safety and quality and education requirements being standard across the country.

CHAIR: I am just brushing up on your submission. We see some commentary about the ministerial council's ability in regard to—you are nodding already. I am just interested in your views.

Ms Fox: Was that with regard to a community member being the chair?

CHAIR: Not the chair so much, but looking at those nine boards currently there has been discussion around—who maybe get about 12 per cent of the complaints—giving the ministerial council the opportunity to make changes to the registered boards there are now, merge some et cetera. Does Health Consumers Queensland have any views about that issue?

Ms Fox: We supported the comments that we saw with regard to any changes needing public consultation and input.

Mr McARDLE: With regard to your comment that it is important to have transparency and the complaint process in place, naturally we all agree with that. The Queensland Nurses and Midwives' Union made the point that there are matters that come before the board that are clearly without basis and that there should be in place a mechanism whereby they can be cut off at a very early level by a state manager. Would you agree with that?

Ms Fox: We would absolutely agree that there needs to be processes in place to prevent vexatious complaints or prevent situations where complaints take a long time to resolve. We have seen consumers experience a great deal of distress when resolution drags out over time, so we would certainly support the ability to fast-track that.

Mr McARDLE: I am trying to work this through. How would you fast-track it without there being almost concrete God-like evidence that it is vexatious? We both know that what may appear to be vexatious on first blush requires an investigation to establish down the track. I am keen to try and divine how a state manager can undertake that process with any degree of certainty without a proper, if not thorough, investigation occurring.

Ms Fox: I think it comes down to resources and that a state based manager or the national board has the ability to do a speedy and thorough investigation in a timely manner rather than it being caught up in a backlog.

Mr McARDLE: Would that be accompanied by a right of appeal by the complainant which would then go to the board to assess, and if the board said that it needs to be investigated it goes back down again? How do you close the loop with the right of appeal, which I would have thought would be a necessity given there was not a thorough investigation undertaken, as best we can see, by the state manager?

Ms Fox: There would still be need to be the ability to appeal from both the complainant and the person under investigation.

Mr McARDLE: Who hears the appeal? Is it the board?

Ms Fox: That would be my supposition, yes.

Mr McARDLE: You would have the board oversighting the state manager, who would then relate it back to the state manager to complete the process?

Ms Fox: perhaps rather than a state manager, national board staff who are able to be deployed to whichever states have the most number of complaints.

Mr McARDLE: If you have a vexatious litigant, that litigant is likely to keep going and going and going, because we have all seen people of that nature. You then potentially extrapolate the time line even further, and that is a risk to the practitioner or the complainant as well.

Ms Fox: Yes. Conversely, as you alluded to earlier, the situation where you do not want to fast-track something and not receive the fulsome information that is needed to ascertain whether there is a complaint.

Mr McARDLE: The principle is fine: the execution is fraught with questions to be resolved.

Ms Fox: Based on the need for adequate resourcing.

Mr McARDLE: Exactly. Thank you very much.

Dr ROBINSON: With regard to the proposal to recognise nurses and midwives as separate professions, do you have any view on the potential impact on patient care?

Ms Fox: We would see the impact on patient care as a benefit. With the increasing professionalism of both nursing and midwifery as separate professions, we believe that can only lead to better safety and quality with continuously improving education standards, leadership across both professions and separate regulation at a national level under the same board.

Mr HARPER: What changes to the bill do you think will most benefit health consumers in Queensland?

Ms Fox: I believe that, out of all of our recommendations, the strongest are those around public reporting and transparency, particularly those that require information to be shared across jurisdictions across the health professionals' various places of work. That will be very, very important for transparency.

CHAIR: I know that you were in the room and you heard the testimony from AVANT regarding their concern around the section 156 grounds for taking immediate action. This relates to your recommendation 6, and I note that you report the proposed amendments in that regard. Do you have any comments to make about balancing public interest and concerns that that may be applied too broadly?

Ms Fox: I did note the comments around that being more 'business as usual' rather than in certain circumstances, but again I believe that comes down to the use of these powers and caution of these powers. It is something that for us is non-negotiable. It is vitally important for public safety and we are very pleased to see it in the bill.

CHAIR: I think the comment was made that they are being applied too broadly in New South Wales. Where do you feel is the line between them being applied to an appropriate level and not being too broadly applied?

Ms Fox: Of course we would lean more to side of immediate public safety and a line being drawn so as to protect public safety whilst an investigation is underway.

CHAIR: Thank you on behalf of the committee for your submission and for appearing.

RUDD, Dr Shaun, Chair, Australian Medical Association Queensland Board and Council

CHAIR: I welcome our final witness, Dr Shaun Rudd, Chair of the Australian Medical Association Queensland Board and Council. Thank you for coming in today and thank you also for your submission. I invite you to make a brief opening statement. We have read the submission, so there is no need to go through that but rather any additional comments you would like to make before we ask questions.

Dr Rudd: There is not an awful lot to add to what is there. The main thing is the very first thing we mention about the chairperson of the Medical Board. That has obviously been removed from this tranche bill and something being pushed forward that a community member could be a chair of any of the boards, whether it be the Dental Board, nursing and midwifery or the Medical Board. It is one thing that concerns us greatly if that comes back in again at a further tranche, so I just wanted to take the opportunity to say that as medical practitioners my colleagues and I would much rather be judged by our peers to some degree. It is just a fact that we would be more comfortable with the Medical Board with somebody medical in charge. It is just a very simple thing. It is just a professional thing. It is just the way life is. We would trust it much better and we would respect it more. I think they are the two things that would make a difference. With regard to that point, if it comes back again please do not let Queensland be the state that sneaks that in.

The other bit that I want to mention is the mandatory reporting. Again it is not something that is in the amended bill at this stage, but we do think it is an opportunity where you could look at putting in the amendments or putting in what is in the West Australian bill which allows the fact that if you are a treating doctor you do not have to mandatorily report. It does not of course mean that you cannot take your responsibility which would be to report somebody if you were concerned they were going to cause a problem or they were a risk to the public or to the patients. Really, the unfortunate thing more recently is that we have had a few of our colleagues who have committed suicide. We have concerns with people who have not sought help because they are concerned they are going to be reported. Even though that is probably not the reality, that is how it is perceived. We would like to see mandatory reporting operate the same way as in Western Australia if that opportunity was there when the bill was being further amended.

Most of it is fairly straightforward. We are concerned about the fact that the OHO does not want to have too much of an administrative burden by putting forward that people do not need to be told every three months what is happening. We are not particularly concerned so much about the complainant but we feel that the person who is complained about is the one who really needs to know what is happening. We are concerned if you do not need to report, and we all know what happens when you do not need to report: you do not need to do any work, so you can just let it fly for a while. You are not pushed and you are not working hard if you do not need to report. Reporting is a very useful way to make sure that people work and do their work at the rate that it needs to be done. Also, if you were someone who would be complained about as a medical practitioner, you would want to know what is happening and you would want to know all along the way as much as possible so that you are not just sitting in the dark wondering what the heck is going on, because it is not a very pleasant place to be wondering what is going on with the complaint. Most medical practitioners—I should not say most but all or surely the grand majority—are concerned that they spend their life looking after other people trying to do the right thing, but all of a sudden a complaint comes through which may be vexatious or maybe just sometimes mistakes happen, but they end up losing their career or they end up being in such a way. It is very upsetting when you are complained about, especially if you feel that you have done nothing, so you at least want to know what the heck is happening. If you have maybe done something wrong, you also want to know what is happening along the line.

CHAIR: Thank you very much.

Mr McARDLE: Thank you, Dr Rudd, for coming in today. It has been proposed in other submissions that complaints about a practitioner that are clearly vexatious could be eliminated at an early stage by the state manager of AHPRA. I have posed the question to other people: how does a state manager actually come to a conclusion that a matter is clearly vexatious without a thorough investigation? Would that also not require an appeal mechanism by either the complainant or the practitioner?

Dr Rudd: Vexatious complaints are quite common and they are concerning. I think that certainly this is where you need medical input right away because they will be able to give you a good idea right away whether it is vexatious or not or might be or may not be. Sometimes they are very

obvious but, as you say, it depends who is looking at that. How do they know that it is an obvious vexatious complaint? I agree with you that it can be very difficult, but there needs to be medical input earlier on. The earlier you get that input, the easier it is to look at those factors.

Mr McARDLE: And the appeal?

Dr Rudd: You should always be able to appeal.

Mr McARDLE: Who do you appeal to in those cases?

Dr Rudd: You would have to appeal back to the OHO again I presume.

Mr McARDLE: Okay, so Caesar judging Caesar to a certain extent. You made the comment that vexatious complaints are 'quite common'. What do you mean by 'quite common'?

Dr Rudd: That is a very good question. I remember being asked a similar question once and my answer is not uncommon.

Mr McARDLE: Let us try to drill down a little bit.

Dr Rudd: I cannot give you a percentage. I do not know the answer to that question.

Mr McARDLE: Okay, but you would say it is quite frequent?

Dr Rudd: Absolutely. It is not infrequent.

Mr McARDLE: It would not surprise you if a complaint was vexatious; let me put it that way?

Dr Rudd: Absolutely.

Mr McARDLE: Good. With regard to the WA model, how does that work on the ground? Has it historically resolved issues with regard to doctors seeking help? I tie in there the latest report by the AMA on doctors' working hours as well, and there are some fairly shocking figures contained in that report. How do they work together?

Dr Rudd: The first thing is that in Western Australia the number of complaints has not reduced because of that change, so we do not think there is any public safety issue here. It is the doctor safety issue that we are concerned about. Again I cannot give you exact figures on this, but certainly the word is that there are doctors who are not seeking help because they are concerned they are going to be mandatorily reported. They should not be concerned about that because it is only if they are not safe to practise that they would be reported, and that will happen anyway. Even in Western Australia that happens. It allows them at least the perception that the treating doctor will not mandatorily report them unless they absolutely need to whereas the feeling at the present time is that maybe the bar is a bit lower and they go along to a doctor who is their treating doctor and they report them because they have gone there with some complaint. That is how it is perceived, especially in both the junior and senior ranks. At the end of the day there is no question, and it is the same even as a GP or any doctor who is sitting in a surgery: if a patient comes in and says something and we know that the public will not be safe, we report them. That is just what you do. That is part of your profession and your ethics. You will always report.

Mr McARDLE: From the AMAQ's point of view, do you have an opinion of AHPRA and how they conduct themselves?

Dr Rudd: I think that we have this large behemoth that is getting bigger and bigger. That is the way we look at it. It is just another bureaucracy that is getting bigger and bigger and I am not particularly sure what is resolved. Initially one of the main things was that registration would be something that could go from state to state—that is, you could register on a national level and you would not have all of these barriers. That was how it was sold to start with, but unfortunately it is a lot different from that and it is a lot worse and, as you know, each state is a bit different. We have a different set up in this state than other states. Whenever the OHO started, at that stage I asked the AHPRA people when they came up here to tell us what was happening if they could give me some sort of a flowchart to show me how they worked, because to this day I still do not fully understand it. This flowchart—I would have loved to be able to show it to you but I could not find it; I was going to bring it along with me—just had stuff going everywhere. It was classical it goes to you, goes to you and goes to you. Even looking at that, I really could not work out what was happening. I think that we should be going back to the boards and just get on with it. That would be my view.

Mr McARDLE: And complaints dealt with by?

Dr Rudd: I thought the Health Quality and Complaints Commission worked really well in this state.

Mr McARDLE: With regard to AHPRA itself and complaints to AHPRA?

Dr Rudd: I think the general view is—and I do not think this is necessarily AHPRA's fault—that things are slow and they are not dealt with quickly enough. That is a concern to most people in that most people want things reported on and resolved as soon as possible but obviously dealt with properly—not rushed through in a fast way but in a fair way.

Mr McARDLE: I will not ask you the number of complaints given your last answer about that area. Thank you.

Mr HARPER: Thank you, Dr Rudd, for being here today. That is a good segue from the member for Caloundra. I just wanted to ask you to unpack your statement around immediate powers. Your submission states—

AMA Queensland does not support the expansion of the powers of the Health Ombudsman to ... take immediate action 'in the public interest'.

Why?

Dr Rudd: Because we think it is a very broad term. I would suggest to you that reality TV should be removed from the television in the public interest. Anything could be in the public interest. It is just such a broad term. The terms already in the act cover it very well. I am not sure what they do not cover and why that change has to be there. Our concern is that that is such a broad statement that the OHO could just come up with any reason whatsoever which makes no sense whatsoever when the act presently covers it very well and gives the opportunity to immediately suspend registration if necessary.

Mr HARPER: Okay. You seem very set in your ways, particularly around the fact that the AMA argues strongly that it is essential for the chair of the Medical Board of Australia to remain a medical practitioner. I do not think I am going to change your views on this, but I am interested to always challenge the status quo because the heads of large organisations like Qantas are not necessarily a pilot. We need to challenge.

Dr Rudd: Feel free to. The reality is that the Medical Board is not a large organisation. It is not a board as such in real terms. I am chair of the AMA Queensland board. We have people on our board who are not necessarily doctors and we may end up with a chair who is not a doctor, but that is a totally different thing. We are running an organisation. The Medical Board is looking after problems with medical practitioners and trying to look after the safety of the public. That is the two jobs they have to do. For the profession to trust that and to have in any way a feeling that this is being done properly, the person who heads that needs to be a medical practitioner, just as the nursing board needs a nurse to be in front of their organisation. They are not a board of a corporation. They are looking after something completely different. As I say, we have no problem in AMA Queensland having skilled members of our board. We have no problem with that whatsoever, but we certainly have a problem with the Medical Board having someone other than a medical practitioner at the head of that board.

Mr HARPER: Fair enough. Fair comment. Thank you very much.

CHAIR: Could you outline for me, Dr Rudd, why AMAQ felt so strongly around an individual waiving their right to receive three-monthly updates? I know you were not here, but a representative from Health Consumers Queensland was the witness before you and they were commenting that an individual may find it quite upsetting if they receive these ongoing notifications and if they have provided written advice that they do not want to receive them they felt that that was okay and were comfortable with that. Can you outline your position?

Dr Rudd: If you are a complainant and, for instance, if there has been some sexual misconduct, that is one of the ones where people say, 'That person doesn't want to keep hearing about what's happening every three months because it brings it all back to them.' That is fair enough; we do not have a problem with that. We do have a problem with the person who is complained about not being able to find out what is going on.

If they want to waive that right, they may do that not really realising what they are doing. Our other concern with that is, as I said earlier, if you do not have to report, you do not have to do anything. That is really a big concern for us. It is already a slow enough process as it is, but if you all of a sudden do not have to make any reporting as you go along, we are frightened that that might slow down the process further. At the end of the day, for somebody who is a complainant, we can understand if they want to waive that right. We have no problem with that.

CHAIR: So your concern, if I am right, is that it is important to know, if they are waiving it, that they have understood what they are waiving. Is your greater concern about the pressure, if that is the right word, that it places upon the OHO to deal with things in a timely way?

Dr Rudd: I do not think that it is greater; I just think that it is another concern. I would not put it ahead any other concern. For instance, sometimes if a junior doctor—somebody who is maybe only a couple of years out—is complained against they would probably think, 'I don't want to hear what's going on all the time. I don't want to be reminded of what's going on all the time.' The reality is that, because they have never been there before, because they do not know what the situation is, the one complaint that most people make is that they do not know what is happening. They want to know what is happening. It is a concern that some may take that away, which is the wrong thing for them to do. However, the pressure is certainly important as well. I do not think that one is more important than the other. I think that we are concerned about both.

CHAIR: The two are not necessarily mutually exclusive.

Dr Rudd: Definitely not.

CHAIR: Telling you that nothing has changed every three months does not necessarily allay the other issue, which is that they are getting notification but just that the matter is on hold. You raised the point that people want to know more about what is happening.

Dr Rudd: Certainly, they want to know if it is on hold as well.

CHAIR: Are there any supplementary questions from committee members? There being no further questions, on behalf of the committee, I thank you for your submission and also for appearing here today. We appreciate it.

Dr Rudd: Thank you very much.

CHAIR: There being no further questions, I conclude the public hearing. If any members require any information from submitters we will contact you. I understand that one matter was taken on notice. The secretariat will be in contact to confirm when the response is due, but the proposed date is close of business, Friday, 21 July. I now declare this hearing closed.

Committee adjourned at 11.31 am