COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Medical complaints process in Australia

(Public)

TUESDAY, 1 NOVEMBER 2016

SYDNEY

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SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Tuesday, 1 November 2016

Members in attendance: Senators Dastyari, Duniam, Griff, Siewert, Whish-Wilson, Xenophon.

Terms of Reference for the Inquiry:

To inquire into and report on:

The medical complaints process in Australia, with particular reference to:

a. the prevalence of bullying and harassment in Australia's medical profession;

b. any barriers, whether real or perceived, to medical practitioners reporting bullying and harassment;

c. the roles of the Medical Board of Australia, the Australian Health Practitioners Regulation Agency and other relevant organisations in managing investigations into the professional conduct (including allegations of bullying and harassment), performance or health of a registered medical practitioner or student;

d. the operation of the Health Practitioners Regulation National Law Act 2009 (the National Law), particularly as it relates to the complaints handling process;

e. whether the National Registration and Accreditation Scheme, established under the National Law, results in better health outcomes for patients, and supports a world-class standard of medical care in Australia;

f. the benefits of 'benchmarking' complaints about complication rates of particular medical practitioners against complication rates for the same procedure against other similarly qualified and experienced medical practitioners when assessing complaints;

g. the desirability of requiring complainants to sign a declaration that their complaint is being made in good faith; and

h. any related matters.

WITNESSES

GAVEL, Ms Samantha, National Health Practitioner Ombudsman and Privacy Commissioner

Committee met at 08:32

CHAIR (Senator Siewert): I declare open this public hearing and welcome everyone here today. We would like to acknowledge the traditional owners of the land on which we meet and pay our respects to elders past, present and future.

This is the first public hearing for the committee's inquiry into the medical complaints process in Australia. I thank everybody who has made a submission to this inquiry.

This is a public hearing and a *Hansard* transcript of the proceedings is being made. The audio of this public hearing is also being broadcast via the internet. Before the committee starts taking evidence, I remind all present here today that in giving evidence to the committee witnesses are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to the committee and such action may be treated as contempt by the Senate. It is also contempt to give false or misleading evidence to the committee.

The committee prefers all evidence to be given in public, but under the Senate's resolutions witnesses have the right to request to be heard in private session. It is important that if witnesses would like to give evidence in private—or, as we call it, 'in camera'—they let us know as soon as possible because it takes a bit of reorganisation to do that. If you are a witness today and you want to request to give evidence in private, please speak to our secretarial staff, and that will be Josh.

I welcome the National Health Practitioner Ombudsman and Privacy Commissioner. I understand information on parliamentary privilege and the protection of witnesses and evidence has been given to you.

Ms Gavel: Yes.

CHAIR: The committee has received your letter noting that legislative requirements prevent you from commenting on individual complaints and asks all present to refrain from asking questions about individual matters. I also remind witnesses the Senate has resolved that an officer of a department of the Commonwealth or of a state shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution prohibits only asking questions about opinions on matters of policy and does not preclude questions asking for explanations of policies or factual questions about how and when policies were adopted.

Thank you for your submission. I invite you to make an opening statement and then we will ask you some questions.

Ms Gavel: I thank the committee for the opportunity to make a short opening statement. I will briefly cover my role, where my office sits within the national health practitioner regulation scheme, complaints and, finally, some comments on the matters under review. The National Health Practitioner Ombudsman and Privacy Commissioner is an independent statutory agency established under the national law to provide ombudsman, privacy and freedom of information oversight of the agencies under the national scheme. This is primarily the 14 national health practitioner boards and the Australian Health Practitioner Regulation Agency, which I will refer to as AHPRA for ease of reference from now on.

The role of my office is to handle complaints and, where appropriate, conduct investigations into the administrative actions of AHPRA and the national boards in order to assist people who are dissatisfied with the way a matter has been handled under the national scheme. An important part of my office's work is to provide feedback to AHPRA and the national boards to assist them to continually improve their processes and policies. Complaints can provide valuable insights for process improvements to prevent similar problems in future, particularly in relation to systemic issues. The office also has an important role in promoting confidence in the administration of health practitioner regulation by acting as an independent and impartial complaint-handling body for health practitioners and the public. It is important to note that the office was established when the national law came into effect on 1 July 2010. The office has no jurisdiction to review matters prior to this date.

I was appointed as Ombudsman and Privacy Commissioner in November 2014. When I commenced in the role, my focus was on closing an existing backlog of 350 complaints, recruiting suitably qualified and experienced staff and redeveloping the office website as an important source of information for the public and health practitioners. Those matters have now been completed. The office is now dealing with complaints as they are received. I am very pleased to note that during 2015-16 the average time taken to respond to a complaint was 23 days compared with 66 days the previous year. Improved complaint-handling procedures have been

introduced, as well as improved public reporting through the office's annual report and monthly complaints reports.

Turning to complaints, my office is able to take complaints from health practitioners and members of the public about the administrative actions of AHPRA and the national boards. Administrative actions include the way AHPRA investigates a matter and the way the board makes decisions based on the information gathered by AHPRA. In 2015-16, my office received 403 approaches, which included 181 complaints. Most complaints received by my office concerned the administrative actions of AHPRA and the boards in relation to notifications. A notification is a complaint or concern about the health, conduct or performance of a registered health practitioner.

Anyone can make a notification about a registered health practitioner. When AHPRA receives a notification, it is staff assessed and may later investigate the notification and put the information gathered before the relevant national board. The national board determines what action to take if any. Possible action, if the board believes the health practitioner's conduct is unsatisfactory, could include issuing the health practitioner with a caution or imposing conditions on their registration. If a board believes a health practitioner has behaved in a way that constitutes professional misconduct under the national law, the board must refer the matter to the responsible tribunal.

My office does not have a role in reviewing matters that have been subject to decisions by a tribunal or court. It is important to note that the role of my office is not to review the conduct or performance of health practitioners; that is the role of the national boards. The role of my office is to consider the administrative actions of AHPRA and the board in relation to action that is subject of a complaint. We examine whether AHPRA and the board have acted consistently with applicable legislation, have complied with relevant policies and procedures and have taken relevant considerations into account. In particular, we look at whether AHPRA has gathered sufficient information during its investigation to inform the board's decision making and whether the board's decision is reasonable based on the information gathered by AHPRA. I do not have the power to overturn a decision of AHPRA or the board, but I can raise issues with these bodies and, where appropriate, make recommendations for them to consider. These powers are consistent with those of other ombudsman bodies and my office's ombudsman's powers are derived from the Commonwealth Ombudsman Act.

I note that an area of particular focus for this inquiry is on whether the notifications process can be used vexatiously by medical practitioners to bully and harass their colleagues. While it must be acknowledged that there is a risk that notifications can be used vexatiously for bullying or harassment, my office's experience in handling complaints about the administrative actions of AHPRA and the national boards does not suggest there is a high incidence of people intentionally using the notification processes for vexatious purposes.

The national law contains a number of safeguards to protect against it being used vexatiously and also provides for procedural fairness in relation to regulatory action taken by AHPRA and the national boards. These include provisions which allow a national board to decide to take no further action in relation to a notification if it reasonably believes the notification is frivolous, vexatious, misconceived or lacking in substance. Other provisions include the requirement for a national board to undertake a show-cause process in some circumstances and the ability of a health practitioner to appeal most types of regulatory action to a tribunal or court.

I do understand that it is distressing for a health practitioner to be the subject of a notification. It is important that the process for dealing with notifications is managed in a way that reduces the negative impact on the health practitioner. At the same time, it is important to note that the current system under which anyone can make a notification about a health practitioner under international law provides an important public protection mechanism. There is more detailed information about these matters in my submission and I am happy to take questions from the committee.

Senator DUNIAM: Thank you for your submission and for what you have just provided us. What is the general theme or thrust of the complaints that are lodged with AHPRA?

Ms Gavel: In 2015-16, 40 per cent of complaints to the office concerned dissatisfaction with the way AHPRA and the board managed a notification about a health practitioner. So these complaints were actually from members of the public about how their notification was managed. About 14 per cent of complaints were from health practitioners and these were related to the way that AHPRA and the board handled a notification about them; and 34 per cent of complaints last financial year were in relation to registration matters. So those are the main areas of complaint that we see in the office.

Senator DUNIAM: With regard to the complaints that are received from medical practitioners about how complaints against them are handled, is there, again, a general theme about specifics with regard to how complaints are handled, the process of AHPRA, the types of officers handling them or anything like that?

Ms Gavel: Yes, that is right. The general themes in those complaints tend to be that a health practitioner might feel that the information they put forward was not given sufficient consideration by the board, or perhaps there is a concern that a member of the board might have a conflict of interest in sitting on the board for their matter—those sort of administrative matters. So we are able to look at those for the practitioner.

Senator DUNIAM: This is probably very hard for you to quantify, but is there a certain success rate you can claim on behalf of complainers in terms of complaints being resolved to their satisfaction, or is that something you probably do not look at? Once you have discharged your duties and obligations, is that put aside and you do not measure where things are at?

Ms Gavel: My office has a very important role in the scheme to be an independent, third-party reviewer and to look at the matter from an independent perspective. I think that it is very important that health practitioners and the public have that ability to come to an independent reviewer. I used to work in the private health insurance area as Private Health Insurance Ombudsman and, in those cases, you could get what you would call a 'resolution of the complaints'. This is a bit of a different area because we are dealing with the administrative actions of a regulator, but, in general, people who come to the office appreciate a third-party reviewer looking at the matter for them and giving them a response that shows that the matters have been looked at, that their views have been taken into account and that their concerns have been heard. They are usually given a greater explanation when they come to our office about the sorts of issues that the board took into consideration, why they took those issues into consideration and why the complaint that has been brought forward may or may not have other issues associated with it, which I might take back to the national boards and AHPRA to inform future processes. Occasionally there might be an issue that I want them to look at in relation to the individual complaint.

Senator DUNIAM: Sure. At the risk of straying into opinion territory, and I understand if you cannot really answer this, in terms of how AHPRA operates and the theme or thrust of the complaints that you are receiving, particularly from medical practitioners, are there any things that you have recommended over time, without referring to specific cases, that AHPRA might look at changing or legislative changes that might head off at the pass some of the complaints that you are receiving?

Ms Gavel: Yes, an important part of my role is actually feeding back to AHPRA and the national boards areas that I see for improvement. With a number of cases—at least a dozen in the last six months—I would close the complaint, but then I would meet regularly with the senior executive of AHPRA, including the CEO, and with the boards and I would feed back to them issues of concern from the complaint. Some of the areas that I have raised issues with with AHPRA and the boards relate to improving the experience for both notifiers and health practitioners because, as I think we all know, there are particular issues for practitioners—it is a stressful experience for them. For notifiers, they may have particular issues themselves. Sometimes they may be grieving because they have lost a family member in hospital, not necessarily as a result of what has happened in hospital, but they are grieving because it is, for them, a very serious matter, so those are some of the areas. Then, of course, there are administrative matters, such as improvements in the process for registration matters. There was one recently about ensuring that full information is provided from AHPRA to the board on every aspect of a notification that is relevant under the national law for the board to consider. They are some of the areas that I have looked at recently.

Senator DUNIAM: Do you get any visibility of whether the changes you recommended are implemented at all?

Ms Gavel: Yes, I do. When I take those matters up with AHPRA I write the CEO a formal letter and he responds to me with a formal letter. I keep track of those matters. I continually monitor that they are put into place. Obviously this is important. It is fine for me to sit down with the CEO and for us to have a nice chat about what might be improved, but it is really important to finalise that and make sure that it actually gets done.

Senator DUNIAM: This is a relatively new area for me. One of the other submissions that we have seen talks about medical graduates going through to colleges, heading off into whichever specialty. Do you have any oversight of the work of those colleges or is it only government bodies and instruments that you look after?

Ms Gavel: My role is focused on the administrative actions of AHPRA and the board, so, no, I would not have the jurisdiction to look at the actions of the colleges. Sometimes there are accreditation issues that might be relevant to a case, but in general the jurisdiction that I have relates to the actions of AHPRA and the national board.

Senator DUNIAM: Once an outcome is reached with reference to the ombudsman and privacy commissioner, is there an appeals process if people are unhappy? Is there any recourse for them if it has not been resolved to their satisfaction?

Ms Gavel: It depends. For a health practitioner, if regulatory action has been taken they can appeal that to a tribunal. In that case we would not get involved in the matter. For the public, there is not an appeal mechanism for the decisions that my office makes and that I make. That is similar to other ombudsman bodies. But if people are dissatisfied with the way that we have handled a complaint—and we do get people who come back to us and say, 'You didn't look at this,' or, 'You didn't look at that'—we certainly take that feedback on board and if necessary review those matters they have raised and provide them with a further explanation or take further information forward to AHPRA and the board.

Senator XENOPHON: Thank you very much for appearing. I want to go to a Senate committee that looked into AHPRA back in 2011. There was a comment by the committee that it was:

… concerned about inconsistency in the application of complaint processes, the prescriptiveness of the application form and the way in which vexatious complaints are handled. The committee considers that further development of the complaints process is urgently required.

The committee also recommended back in 2011, some five years ago, that there ought to be more accurate reporting of notifications to reduce the impact of vexatious complaints on practitioners. That was a concern of the committee five years ago. We have had many submissions to this inquiry saying that people have been subject to vexatious complaints. I note and agree with you fully that you do not want to discourage people from making complaints where the safety of the public is at risk. You do not want to discourage a legitimate complaint from being made. But what do you say about what has occurred since 2011 when the Senate committee made that quite unambiguous recommendation about the nature of vexatious complaints?

Ms Gavel: Obviously back in 2011 the national scheme was very new. It only came into effect on 1 July 2010, so that was early in the process. I think we all know that there were problems with the notification process in the first few years of the scheme. I certainly know that from the reading I have done, and I have had a look at some of those reports. Since I came into the role, which was two years ago now, I have seen a big improvement in notification processes. As I think I mentioned at the start, I had a backlog of complaints to deal with when I came into the office. So I was able to look at complaints about notifications that had occurred in 2012 and 2013 and then compare them with the way AHPRA have been dealing with things more recently. I have seen a big improvement in all sorts of areas. They have put a number of new policies and processes in place. For example, they have done more training for their staff that take calls on the phone so that they are better able to talk people through the national law, the notifications process and what they can expect. They can keep them better informed about what is occurring. They are now providing far more detailed outcome letters, which is important so that people understand what the board has looked at and why they have come to the decisions that they have. They are some of the areas where I have seen improvements.

Senator XENOPHON: Do you monitor those improvements or does it just come to you on an ad hoc basis—as improvements are made you get to know about them—or does AHPRA consult with you and say, 'This is what we are doing.' Do you have any feedback in respect to that?'

Ms Gavel: I found that AHPRA has been very open to the feedback I have provided to them and the boards as well. I meet with the senior management at AHPRA every month. We sit down and go through what they are working on, what sorts of things they are doing, and we talk about processing improvements. This is an area where you will never be able to sit back and say, 'We've got it right.' There are always going to be ways that you can improve.

Senator XENOPHON: Because time is limited I just want to race through a number of issues, and I will try and be as succinct as I can. Many submissions to the inquiry have expressed a lack of faith in the complaint system's ability to produce a fair outcome. These are current complaints. These are matters that are relatively recent.

Firstly, would you care to comment on this and, secondly, does your empowering legislation allow you to conduct own reviews—that is, reviews that you initiate as ombudsman? Can you also indicate that when someone comes to you with a complaint about a matter being vexatious whether, as a matter of course, you investigate it? What is your process for dealing with a complaint of that nature?

Ms Gavel: I will start with own-motion investigations. I do have an own-motion power and I have an own-motion investigation on foot at the moment. This is something that I need to continually consider, whether there is

an area that I need to conduct an own-motion investigation into. That is dependent on a number of factors, and I have an internal policy on that.

In terms of people feeling dissatisfied with the complaints process—

Senator XENOPHON: No, that was not my question. It was not a question of dissatisfaction, it was a question of whether someone comes to you—a medical practitioner, a health practitioner—and says, 'This is vexatious.' They are not complaining about the mere fact they have had a complaint but are saying, 'This is a vexatious complaint I am being subjected to.' What can you do and what do you do, as a matter of course, to look into that? How do you investigate an allegation of a vexatious complaint?

Ms Gavel: As I said in my submission, we have not had a lot that raise those issues but we have had a small number.

Senator XENOPHON: When you do, what is the process?

Ms Gavel: The process is the same as the process that we would choose to investigate any complaint and that is to look at the issues that the complainant has raised. So if it is about the fact that it is vexatious we will go to AHPRA and ask for all of the investigation material, all of the information looked at by the board and all of the correspondence—and that can be a lot of information, for some of these cases. We will review that information. We get to have a look at everything that the board looked at. If someone said to us, 'Look, I think this is vexatious,' we will certainly look at the information with that in mind.

I think, as I also said in my submission, there might be some issues with the motivation of a notifier but sometimes there are issues there that need to be looked at as well.

Senator XENOPHON: I understand that, but in your submission you say that requiring complainants to sign a good-faith declaration would not likely reduce the number of vexatious complaints. I am just trying to understand your rationale for that because, surely, any good-faith complainant would not be affected by such a requirement.

Ms Gavel: I suppose that is what my thinking was at the time, which is that in all of the matters I have seen I cannot think of one complainant who would not have signed that piece of paper. I note from AHPRA's submission—they have discussed this with me as well—that they are bringing in an online form in the next few months, and that will have something on it where people need to state that the information they are providing is true and reasonable.

Senator XENOPHON: So at least there are sanctions if people make a false declaration, in terms of a complaint? Is that what you would support?

Ms Gavel: AHPRA is going to have a form where people are making a similar statement to what you are suggesting on the form. I have that submission here.

Senator XENOPHON: No, I want to move on, because I think my colleagues have questions to ask.

Ms Gavel: They will be able to comment on that in more detail, as well.

Senator XENOPHON: Can you, on notice, advise how many complaints you received about an allegation of vexatiousness—that it was a bad faith complaint—and what the outcomes have been in respect of those?

Ms Gavel: Yes. Is that for the financial year 2015-16?

Senator XENOPHON: Well, in the last year—yes, 2015-16 and the year before, if you could do that.

Ms Gavel: Okay, I can do that.

Senator XENOPHON: Going also to the issue of benchmarking, in response to part F: you have taken the view that requiring the benefits of benchmarking complaints about complication rates may not be necessary. But surely there would be some complaints where benchmarking would be very much to the point.

Ms Gavel: Yes, and I—

Senator XENOPHON: Are you completely against benchmarking, or are you saying that it may be useful?

Ms Gavel: No, no. My concern was that if this information had to be provided up front with a notification, that that might—

Senator XENOPHON: But if it were not provided up front, but was part of an investigation—

Ms Gavel: Oh yes, absolutely. There are some where you would need to have that information.

Senator XENOPHON: I misunderstood that part of the report. I do have some other questions, Chair, but I am concerned that my colleagues may have questions to ask as well.

CHAIR: We have still got a bit of time, so I will go to Senator Whish-Wilson, then I will go to Senator Griff and, if we have time, I will come back to you.

Senator WHISH-WILSON: How would you define 'vexatious'?

Ms Gavel: There are two parts to it, I would say. First of all you have vexatious behaviour, which all complaint handling bodies would see, but usually it is only a very small proportion of complaints. Then you have, I suppose, where someone brings forward a complaint that is about something that is fairly trivial—for example, they have had a relationship breakdown with their spouse who happens to be a doctor so, as one way of getting back at the spouse, they might put in a notification.

Senator WHISH-WILSON: Do you agree that vexatious can be closely associated with vested interests?

Ms Gavel: It can be. We have businesses that are advertising in the health space, and you might have a business in competition with you that might put in a complaint about the information you have on your website, or something like that. So yes, it can be.

Senator WHISH-WILSON: The healthcare sector is obviously very competitive. Do you ever test for vested interests when you deal with complaints about vexatious claims? For example, whether other competing medical professionals are perhaps behind those complaints, encouraging patients to put in complaints to AHPRA?

Ms Gavel: Usually, if you have a complaint that, sort of information is there.

Senator WHISH-WILSON: Really?

Ms Gavel: As I said, it is a small number where I would identify there might be people with not totally pure motives in putting in a notification. One we do see is psychiatrists who are perhaps dealing with Family Court matters. They tend to get a lot of notifications, usually because one party has put in a notification against the person acting for the other party.

Senator WHISH-WILSON: Have you had many complaints against healthcare professionals where there has been no clear case of harm being done?

Ms Gavel: That can be the case. As I said earlier, when somebody loses a family member in hospital—and it may well not be anything to do with the work of the health practitioners; it may be that they were very sick—when people are grieving they are not necessarily looking rationally at an issue. So in some cases a family member might put in a notification and the health practitioner has not acted unprofessionally or there has not been medical misconduct, but the system is designed so that people can do that, because it is a check and balance on the system.

Senator WHISH-WILSON: I notice you mentioned earlier in response to Senator Xenophon's question that you can do your own investigations. Have you ever, for example, taken evidence that AHPRA has provided to you, like a statement from a patient about malpractice, and investigated yourself whether that was an accurate statement provided by AHPRA in the first place? Do you trust AHPRA?

Ms Gavel: No. It is my role to look at that material independently, but what happens is that AHPRA will do an investigation and that investigation will include a response from the notifier. It will include a response from the practitioner. It may include medical information. Then all of this information is put before the board, so we are actually able to review that information. We need to review it in a way that we are asking questions and we are not just accepting what is there. We are looking at it and we are saying, 'Should they have got a third-party, independent medical review?' That might be something that we would look at. Did they get enough of a response from the notifier? Did they get enough of a response from the practitioner?

Senator WHISH-WILSON: We are shortly having a panel of medical professionals who provided confidential submissions to the committee, but some of those submissions claim they have evidence about fabricated evidence that AHPRA are using—stat decs from patients saying they did not make complaints, yet AHPRA has launched investigations on the back of what looks like fabricated evidence. I do hope that you get access to that detail.

Ms Gavel: Yes, and we would certainly look at that. If the complaint came to us, we would look at all of it, including if the practitioner said to us, 'I think that evidence is false.'

Senator WHISH-WILSON: Okay, good. How often does AHPRA knock back freedom of information requests on the basis of section 24 of the FOI act that, essentially, processing a request would divert resources substantially and unreasonably from its other operations? Are you aware of how often AHPRA just say, 'No, that's going to take too much time and effort for us'?

Ms Gavel: I do not have those statistics, but AHPRA would have them this afternoon. The other thing to note is that AHPRA's decisions on FOI can be appealed to the AAT, so, if we are able to look at administrative actions

in relation to FOI, we usually recommend that people go to the tribunal, because the tribunal can actually make a finding one way or the other for them.

Senator WHISH-WILSON: Okay. The other FOI exemption is 41D, that 'providing information could reasonably be expected to have the following substantial adverse effects on the proper and efficient conduct of AHPRA's operation'—in other words, disclosure would or could reasonably be expected to have a substantial adverse effect on the proper and efficient conduct of the operations of an agency. Are you familiar with AHPRA rejecting FOIs on the basis that it would compromise their investigation? Is that primarily to protect the person who has brought the claim against a healthcare professional?

Ms Gavel: AHPRA have a lot of very confidential information. Of course, we do too because we get to see all of their investigation reports and the information that is put before the board. So they do have genuine reasons for not releasing information under FOI—

Senator WHISH-WILSON: including to protect themselves and the legacy of their investigations.

Ms Gavel: Yes, but, as I said, if they are trying to withhold information incorrectly, the tribunal will make a ruling against them, so there is a check and balance on that.

Senator WHISH-WILSON: Could you tell us a bit more about that process?

Ms Gavel: It is a process removed from my office, but, for example, people in Victoria can go to VCAT, and VCAT will look at the FOI matter for them.

Senator WHISH-WILSON: In terms of not wanting to discourage individuals, as Senator Xenophon said, I can understand that that would be a consideration, but how do you balance that against not at least questioning the motivations of individuals or groups who may be bringing claims through AHPRA against healthcare professionals?

Ms Gavel: In most cases, as I said, if there is an issue with someone's motivation, it is usually quite clear from the documentation. For example, if I had a complaint from a health practitioner about another practitioner down the road or another practitioner within the practice, you know that possibly there is an issue there. Then you know that, perhaps, there are other things going on that have pushed them to make this notification.

Senator WHISH-WILSON: Do you ever ask them if other health-care professionals have advised them to make complaints through AHPRA against other health-care professionals? For example, where they have specifically got advice from a surgeon that they should—

Ms Gavel: The other thing I should comment on as well is that some notifications are mandatory notifications that health practitioners are required to make under the national law. In some cases a health practitioner is actually required by law to notify if they believe there is behaviour that is a risk to the public. If it is a non-mandatory notification, generally when we receive the information from the complainant we will ring them and have a talk to them about the issues that they have brought to us—if there is a need to ask that question. Again, I cannot think of any case that I have seen where we would have needed to ask that, mainly either because it is not a factor or because it is clear from the information we have that there could be something else there that we need to take into account.

Senator WHISH-WILSON: Have you had any cases where, as I mentioned earlier, there has been no clear harm done but it is about potential harm into the future—for example, about advice a doctor may be giving patients?

Ms Gavel: Some notifications do concern matters where there has not been harm done to the patient but there is the risk that harm might have been done. So perhaps someone was given, say, a drug that could potentially have a bad interaction but it did not in this case, but could if they did it with another patient with a different set of comorbidities—you certainly do see cases like that.

Senator WHISH-WILSON: Ms Gavel, I presume you have a medical background, given your background in insurance and what you do now. Would that be correct?

Ms Gavel: No, I do not have a medical background. Because the role of my office is to look at administrative actions, I do not need to have a medical background, and I am able to contract medical expertise if I need to.

Senator WHISH-WILSON: These are very complicated, complex areas. In relation to, for example, the potential risks that you just outlined, are you confident AHPRA has the right qualifications—for example, that their investigators have the right experience to conduct investigations against experienced medical professionals?

Ms Gavel: Yes, because AHPRA also has medical expertise within their organisation and, of course, the board members all have—no, not all; some are community members. Some board members have medical expertise. On most boards there is usually an obstetrician/gynaecologist, an orthopaedic surgeon and, then, other

specialities. If, between the board and the expertise AHPRA has in-house, they cannot look at the issue, then they do contract independent expertise.

Senator WHISH-WILSON: Is there any process in place for preventing conflicts of interest between AHPRA board members who may be sitting on investigations and the person being investigated?

Ms Gavel: Yes, there is. It is quite common when you look at an investigation that a number of board members would have taken themselves outside of the room for a particular notification, because they know the practitioner, they have supervised them or something like. So, obviously, they have to have a very strong strict policy on that.

Senator WHISH-WILSON: Is it common for AHPRA board members to threaten someone under investigation?

Ms Gavel: I am not aware of that happening.

Senator GRIFF: Like all ombudsman officers, you are providing an inexpensive and informal appeal avenue of last resort. What tribunal or judicial paths exist if there is dissatisfaction with your decision?

Ms Gavel: Like all ombudsman bodies, we are usually the end of the road for people with a complaint. There has to be a point where you say: 'This complaint has been looked to the extent that we can. This is the outcome that we have given you, and that is as far as it can go.' But, of course, in fact, people who are unhappy might go to their federal member or they might go to the Minister for Health, so people do take other avenues. But in terms of another avenue to look at their complaint, if they have been to my office then that is as far as they can go. But, as I said earlier, health practitioners can also go to the tribunal if there has been regulatory action taken against them.

Senator GRIFF: A 2015 Victorian survey found that 27 per cent of young doctors had experienced bullying and 9.4 per cent had experienced sexual harassment. Your submission and a number of complaints you deal with seem quite subdued in the face of these surveys and this inquiry's submissions. Do you consider that to be the case?

Ms Gavel: It is not a particular issue that I have seen a lot of complaints about. I think in their submission AHPRA mentioned that because the role for the regulator is to protect the public not all of these issues would meet the threshold for regulatory action. Some would, of course, if the person might be a danger to the public. We would have had some complaints that would involve those issues but they are not large in number. I would take those issues very seriously and they are very serious issues for the profession. They are an area that is being taken seriously. There have been a number of reports. They are very concerning issues.

Senator GRIFF: Do you think they would represent similar percentages for the amount of complaints that you are dealing with? Would you have a similar number or is it fairly minor?

Ms Gavel: I would say maybe two or three complaints that I can think of offhand might involve those sorts of issues. In one case, they are serious issues. That complaint is still under review.

Senator GRIFF: They are not getting necessarily to your office but, hopefully, are being looked at.

Ms Gavel: That is right. Like any ombudsman body we only see a very small percentage, because people have not necessarily got the time to go to the third-party ombudsman unless the issue is very concerning to them. The complaints that we get are very important insights into where there might be problems with the system. If you think about it, AHPRA would have had about 3½ thousand notifications and we had 182 complaints in 2015-16. We know we are only seeing a small section of them, but they are still very important complaints that give us an insight into those issues.

CHAIR: I want to go back to the issue of declarations. Do I understand from your comments that if someone is going to put in a vexatious claim, they would sign the form anyway?

Ms Gavel: When I think of all the complaints we have had, as I have said, there are a small number where there may be vexatious issues involved, or vexatious behaviour, those people think they are acting in good faith. I was more thinking of it from that angle—that those people would sign. I cannot think of any complainant to my office who does not think that their issues are extremely important and that they have brought them forward in good faith, even if we might have reason to question that.

CHAIR: What about in the case where, as Senator Whish-Wilson was talking about earlier, vested interests have made complaints or potentially could use the system to make complaints?

Ms Gavel: Again, they feel that they are doing the right thing bringing these issues forward. They genuinely feel that there is an issue there that needs to be brought forward.

CHAIR: I am having a bit of trouble believing that people who are going to use the system for vexatious claims are all doing it because they genuinely believe that there is a safety risk here, or a risk to patients, and they are not just using the system.

Senator WHISH-WILSON: For commercial reasons—

CHAIR: From the perspective of what you are saying, everyone genuinely believes they are doing the right thing, whereas there is a contention that is obvious through a lot of the submissions that the system is being used.

Ms Gavel: Again, I am basing it on my own experience of my own office. I have a small number of complaints of which I would say maybe three or four perhaps might involve those sorts of issues. I am basing it on the experience of my office. If I were in AHPRA and having a look at 3½ thousand complaints I might have a different view of it, because I would be seeing a lot more complaints. As I said, AHPRA are introducing their online form where they will have something that people sign-off on, and they will be able to talk to you a little bit more about that this afternoon.

CHAIR: You made a point earlier about how the nature of the complaints are about safety and risk to patients. Where the system is being used—or gamed, for want of a better word—is there a need for a process to actually address those particular issues?

Ms Gavel: I think you would want to see evidence. So if you are bringing in a process, it would need to be an evidence based process. On the evidence I have seen—as I said, I have had a small number of complaints that might involve those issues, but, at the same time, they have been issues that needed to be investigated. I would not want to commit to such a process unless I actually had the evidence there and then was able to look at what systems might be best put in place.

Senator XENOPHON: A number of the submissions, or some of the submissions—some of them are confidential, so I cannot refer to them in any detail that would tend to identify the person making the submission or the matter that it relates to—have talked about almost a sham peer review process where a number of colleagues say, 'We think this person is doing the wrong thing', whereas any objective analysis would show that the peer review process was indeed a sham. To what extent do you have the resources, the ability to look behind these complaints? It seems to me there is a parallel process operating here: you may have a complaint made about a medical practitioner; the medical or health practitioner may contact you and say, 'Look, this is a vexatious complaint for these reasons and the way that AHPRA dealt with it was unreasonable.' How do you balance those competing concerns? To what extent can you look behind issues of the peer review to determine whether it was a robust or a sham peer review?

Ms Gavel: We would do what we would do with every complaint, which is get all of the information that the board has looked at and review it ourselves. If someone has been before a panel, they would usually have a right of appeal to the tribunal, so the tribunal would look at that. The more serious matters would go to a panel or a tribunal, so they would not be matters that we would actually look at.

Senator XENOPHON: Can we go to issues of timeliness? I think there is a saying that justice delayed is justice denied, and sometimes speedy justice is no justice at all. One of the submissions we have received talks about a person being reported on, which she considered to be a vexatious complaint, more than four years ago and it is still up in the air. To what extent can you, as ombudsman, go to AHPRA and say, 'Why is it taking so long?' What benchmark do you say is reasonable for a complaint, or what time range is reasonable for a complaint to be resolved? Four years seems to be leaving the health practitioner in limbo; it is very stressful.

Ms Gavel: Yes, I would agree with that. If they contacted us, we would certainly talk to AHPRA about that.

Senator XENOPHON: Have you had cases where you have gone to AHPRA and said, 'What's going on here?'

Ms Gavel: Yes, we have. We have also had cases—

Senator XENOPHON: What has the outcome been?

Ms Gavel: They will expedite it as far as they can. Sometimes some investigations can be very complex.

Senator XENOPHON: Not four years though.

Ms Gavel: Yes, that certainly does sound too long. AHPRA and I have discussed that generally not more than a year for an investigation, but bearing in mind there can be issues. For example, if you are asking for an independent third party report, there might be only a small number of specialists that can actually do that. If that specialist is very busy—there can be those sorts of delays. But I agree with you: I think timeliness is extremely important. When I have seen cases come through where there might be a few months where nothing happened on

the case, I will always go back to AHPRA and ask about that and talk about these issues. But I know they are very aware and concerned about them as well.

Senator XENOPHON: In relation to oversight, unlike other Ombudsman's offices—for example, the Commonwealth Ombudsman can be brought to Senate estimates—there is no parliamentary oversight of AHPRA, because of the very nature of AHPRA as a creature of the states, if you like. It is not a Commonwealth agency or a Commonwealth office. Do you have any concerns about the level of oversight in relation to AHPRA because it does not have as a matter of course that level of parliamentary scrutiny that other agencies would have?

Ms Gavel: I think you would have to say AHPRA has had a lot of scrutiny in the last few years, through various committees. There has been the independent review of the National Registration and Accreditation Scheme that came out in 2014. AHPRA does report, as I do, to health ministers, including the Commonwealth health minister. An inquiry like this can call AHPRA to appear. So I believe that there is sufficient oversight.

Senator XENOPHON: At page 15 of your submission you state that you are currently discussing with AHPRA the issuing of cautions. However, under the national law there is not opportunity to appeal a caution decision, and some health practitioners have questioned the fairness of that situation. What has been the outcome of those discussions with AHPRA? Are they continuing? Can you provide an update. What is your view, as Ombudsman, whether a caution can itself be appellable or challenged if a practitioner feels it is manifestly unfair?

Ms Gavel: The issue with a caution is that it is actually the least action that AHPRA can take. At the same time, I understand—I would have to check—that you can appeal to the Supreme Court about a caution.

Senator XENOPHON: You might want to take that on notice.

Ms Gavel: Yes.

Senator XENOPHON: It seems to me that it might be not on the merits—it may not be a merits review—but on the issue of law, if it was not in fact a caution or something else. I am not sure. The submissions we have seen relate to issues of clinical practice, where a practitioner has been subject to a complaint and is dissatisfied, saying that it is either vexatious or that the time line et cetera is unreasonable. But there is also the issue of bullying and harassment. Senator Griff made mention of a quite startling survey of medical practitioners—

CHAIR: Surveys of colleges.

Senator XENOPHON: and surveys of colleges, as the chair quite rightly pointed out, where in survey after survey we have seen incredible levels of concern about and complaints of bullying and harassment, including sexual harassment. Is that something that you have the resources to investigate? Those figures are quite staggering. The Royal Australasian College of Surgeons undertook their own inquiry as a result of the quite shocking allegations made against a number of surgeons by a surgeon who was brave enough to speak out. This is not a criticism of your submission, but it seems that your submission does not reflect some pretty disturbing results about the prevalence of bullying and harassment, including sexual harassment, in the medical profession.

Ms Gavel: I agree with you. Those reports are very disturbing. But, at the same time, the College of Surgeons has taken on the recommendations of the report. I know that AHPRA, and the medical board in particular, is concerned about these issues.

My jurisdiction is focused on the administrative actions of AHPRA and the board. Really, that mainly relates to notifications, registration—those areas that they deal with. The other issue is, when you already have a number of bodies looking very seriously and closely at these issues, whether there is a need for another body that might muddy the waters.

Senator XENOPHON: It would not muddy the waters to determine whether AHPRA is dealing with complaints of bullying in a timely and effective manner, though. There is a role for your office to determine that.

Ms Gavel: Yes, that is right. It might be an issue that I would look at. As I said, we have not had a lot of complaints that involve those issues. We have one at the moment but it involves other issues as well. But certainly it is an area that bears considering.

Senator XENOPHON: It will be interesting to see if this inquiry sends more business your way.

Senator WHISH-WILSON: You mentioned a caution is the minimal thing that APRA can do but do you accept that a caution is still a black mark against a medical professional's name and even an investigation is enough to do reputational damage to healthcare professionals? Are these things taken into consideration before investigations are launched without some kind of mediation process?

Ms Gavel: First of all, I agree with you; it is very stressful for health practitioners to undergo these investigations. I know from the people that I have spoken to and I think we could all imagine how it would be if we had a regulator investigating us for things that we have done at work. Secondly, the overarching objective of

the national law is to protect the public so that is where APRA and the board are coming from in their investigations and that has to be borne in mind. Yes, it is important that the processes for investigating notifications are timely and that the interactions with APRA are positive interactions that do not add to the stress that the practitioner is feeling.

Senator WHISH-WILSON: Can you just answer the question: do you take into account the potential for reputational damage and why is there not compensation provided at least theoretically, for example, to practitioners who may get dragged through the mud by vexatious claims or by competitive interests?

Ms Gavel: On the issue of compensation, all of the money for the regulation scheme actually comes from health practitioners themselves through their registration so if you added a compensation scheme in as well then all health practitioners would need to pay more for that. Obviously you have got to take into account the difficulties for the practitioner and the practitioner experience and that is something that concerns me; that is something I have spoken to APRA about. I know that it concerns them as well and they have recently put new processes in place to improve the practitioner experience but it is always going to be a stressful experience because a regulator investigating you always will be.

CHAIR: There are some questions on notice. Thank you very much for your submission and for your time today. It is much appreciated.

FETTKE, Dr Gary, Private capacity

FRATZIA, Dr James Demetrios, Private capacity

MANSFIELD, Dr Michael, Private capacity

STOKES, Prof. John, Private capacity

[09:34]

Evidence from Dr Mansfield and Prof. Stokes was taken via teleconference

CHAIR: Welcome. Starting with the witnesses on the phone, do you have any comments to make on the capacity in which you appear?

Dr Mansfield: I am an orthopaedic surgeon practising in Cairns.

Prof. Stokes: I am an associate professor at James Cook University. I have a private medical practice in intensive care and anaesthesia. I am currently practising and working at the university.

Dr Fettke: I am an orthopaedic surgeon from Launceston.

Dr Fratzia: I am an emergency physician and an intensive care specialist.

CHAIR: You have all said that you have been given information on parliamentary privilege and the protection of witnesses in evidence. We have your submissions, thank you very much. I would like to invite each of you to make an opening statement. Please keep these fairly brief because the senators have a lot of questions. Who would like to go first?

Dr Mansfield: I have to be away—to operate—fairly soon, so I will, if I could. I am grateful to be able to make this submission on a really important issue. Bullying and harassment, in my experience, is widespread in the medical profession. I think increased competitive attitudes aided by advertising has fostered this competitive spirit over the collegiate spirit that was more prevalent in my younger days. This has been neither beneficial to the public or the profession.

We have seen our professional colleges as impotent, with respect to any meaningful action, despite the window-dressing. For example, the Australia Orthopaedic Association immediately releases any complaints to the recipient of that complaint, which is a significant deterrent. The main problem, however, is that AHPRA—via its allowed misuse of mandatory reporting guidelines—is facilitating bulling on a level never before seen. This is because the investigators lack any medical expertise. They do not have the necessary perspective to judge serious versus vexatious claims, nor do they have the expertise to judge the merit of differing independent medical reports.

They do not follow their own published guidelines on mandatory reporting, which suggests reporting is necessary for repeated serious breaches of acceptable practice not for one-off minor breaches of no harm to the patient. Their philosophy being punitive rather than educational or rehabilitative has the wrong focus, and they viciously attack reported professionals before establishing the seriousness of the reporting and the veracity of that report. They do not use face-to-face meetings or mediation to establish the seriousness of the complaint. Facilitated face-to-face meetings of accused and accuser would be very beneficial, with regard to reducing the complexity and cost of unnecessary investigations, and it would facilitate a speedy resolution of breach issues.

AHPRA seems to have lost its mantra of protecting patients and seems to focus on harassing professionals. They use the same experts, repeatedly, and do not let these experts report as to whether they are necessarily expert and current in the area they are reporting on. For example, they may not be in the same subspecialty as the accused, making their reports pretty valueless.

AHPRA's selected expert reporters tend to be aggressive and vindictive. I have to say that I have a feeling there is a corrupt element going on, here, and that there is a certain group of unrecognised and unnamed medical professionals who are 'on the inside', shall I say.

The other problem is they do not take effective action against proven vexatious reporting. Everyone is aware of the case of my colleague, a neurosurgeon investigated for numerous claims and eventually forced out of practice, forced out of the country. He very nearly took his life. After he left the country, AHPRA concluded that he was not guilty of any misconduct and offered a weak apology for any distress they may have caused.

All these orchestrated fraudulent reports, which were proven vexatious, were never investigated and no action was taken against the perpetrator of these horrendous crimes. The North Queensland public lost the wonderful services of a world-leading spinal surgeon. Unfortunately, this story has been repeated endlessly across the

country. I believe only a royal commission will get to the truth, as did the royal commission into child sexual abuse, which exposed the systemic corruption we are now aware of.

I think AHPRA would very much benefit by being proactive, establishing meaningful peer review and audits and educating and upskilling those identified as in need, instead of undertaking ad hoc punitive action as at present. Whilst we are not specific specifically dealing with it, WorkCover Queensland has a similar ethos and is causing great distress to patients and treating doctors as well.

CHAIR: Dr Stokes, do you want to go next?

Prof. Stokes: That would be fine. Thank you for inviting me to speak. You have my submission, as you said. Many practitioners are dissatisfied with the mechanism. That is because of the significant unintended consequences of vexatious reporting, which causes practitioner illness. It also causes severe financial hardship and, in a number of cases that we know about, has caused the suicide of very good doctors.

I think AHPRA is slow to reform and address the real problems caused by this. I say this from a perspective of having been involved with medical students, registrars in training and professional specialists. As recently as two weeks ago, a senior surgeon approached me and told me about the bullying his intern son had repeatedly been subjected to during a surgical term and how it was only his repeated intervention at senior levels that eventually brought the cessation of the bullying. But that action—the bullying the intern's son endured and the father's intervention—will lead to that intern never returning to that tertiary institution. Neither the surgeon father nor the intern son feel that official complaints to the college involved will be able to correct that outcome. It is done and dusted.

In part, I would also like to address the final thing, the requirement for people to sign forms. I have read all the submissions that have been made that can be read. I think it would be important to overcome the objection to signing by putting a statement into the salient code of conduct for medical practitioners, in both section 4 and section 8 of those documents. Section 4 concerns working with other health professionals and section 8 is on professional behaviour. So a simple statement in there that it is part of professional behaviour not to make vexatious complaints would make it unnecessary for a mandatory notification. The guidelines from AHPRA are extremely loose. You could drive a truck through them. Such a statement would stop that.

It is very important to take into account that, even if there are only two people in Australia, according to the report that was in the *Medical Journal of Australia*, who are affected badly by vexatious reporting, that is not a reason to ignore it. In medicine, we treat the person with the rarest disease and we put a lot of effort into making sure that happens. It is no good for AHPRA just to say it is a small problem. It is a small problem because there are a large number of complaints. For each individual involved with a vexatious report, it is a great deal of suffering. I think it is important, if medical practitioners are to make a complaint about another doctor, they should have satisfied the code of conduct. It is not in our code of conduct at all, and it should be.

There is an absence of natural justice, an absence of due process, and there is evidence of bias. The colleges are the people that AHPRA turns to, and they are the same people over and over and over again. There is such a thing as sham peer review, and none of that is identified by AHPRA or refused as unacceptable.

In the review of AHPRA itself which was published in the *Medical Journal of Australia* in 2014, I think, the final statement is that it is really early days and there is a lot to do to improve the process. An academic review of AHPRA has said:

> This study is best understood as a first step in establishing an evidence base for understanding the operations and merits of Australia's mandatory reporting regime.

Those are their words, and nothing has happened since then. There is a hidden curriculum in medical student and postgraduate training, and there is a hidden communication system, and what is written on paper does not happen in practice, as evidenced by the fact that an intern in the region I work in has been bullied. It has been allowed to happen and nothing gets done about it because people are scared to respond and they know that the colleges will not take it seriously, and neither will the people in administration. I have references for everything I have said. I am happy to share those. I think there are about 10 things that need to be done. I will not go through them all. There is a great need for this to be corrected. Thank you.

CHAIR: Thank you very much. Dr Fettke.

Dr Fettke: Good morning, senators. I am not here for myself; I am here for many. I used to be a funny guy, but I have lost my sense of humour. That has resulted following systemic bullying and harassment from the public hospital system and a prolonged and vexatious process through AHPRA that I believe has been manipulated by those with vested interests. I have not been involved in a single case of patient harm and have helped thousands of

people, yet I remain under suffocating AHPRA investigations. This has gone on for nearly 2½ years. My opinion is under question, not my surgery, yet the system wants to silence me for promoting prevention and public health.

My written submission details fabricated evidence by AHPRA investigators, threats from Medical Board members and a litany of evidence supplied by those with agendas. It would be farcical if it were not so damaging. Not only have I and my family been victims of this combined assault, but the AHPRA process is nigh on impossible to challenge without significant personal resilience and fortitude. Trying to gain information through freedom of information is blocked because it is likely to affect the operations of AHPRA.

I have been an orthopaedic surgeon for over 23 years. I look after most of the diabetic foot complications in northern Tasmania. My patients are lying around in hospital with obesity related conditions, amputated limbs and non-healing, rotting flesh and are receiving what I believe is nutritional advice that has put them there in the first place. I have dared to challenge the paradigm of nutritional advice given to my patients and the wider community. My crime has been that of quality assurance and advocating preventive medicine for my patients. My recommendations on cutting sugar and processed food intake are those of the World Health Organization and the CSIRO. I have studied the science and biochemistry of our dietary guidelines and found them wanting in substance and riddled with vested interest politics. Raising these issues publicly has resulted in the parties with those vested interests attempting to silence me. The AHPRA process is being utilised in a recurring pattern, to me, to assist those parties. That has involved members of the Dietitians Association of Australia and, unfortunately, members of the Medical Board.

I have also been bullied and harassed in the public hospital system over some years. When I tried to raise the bullying and harassment issue I found that the perpetrators, amongst several, were the very ones that I was reporting to. This involved the most senior administration of the Launceston General Hospital. Dr Peter Renshaw, as the director of medical services, was one of those. Over some months he posted a sustained defamatory campaign on at least one social media hate page. His introduction of me to that hate site has resulted in ongoing cyberbullying to me and my wife, staff and friends. All of us have felt threatened, and that cyberbullying remains today. I tried reporting this behaviour to all levels of the Tasmanian health system, through to ministerial level, with no resolution. AHPRA dismissed a notification regarding Dr Renshaw regarding this, hearing it interstate, against normal protocol. I have questioned AHPRA on this and had no satisfactory response. Every avenue that I tried for three years was thwarted. I have felt abandoned by the system and I do not see that my public hospital workplace is a safe or supportive environment.

My AHPRA experience began in 2014 with an anonymous notification by a hospital dietitian. This was in regard to encouraging people to reduce their sugar intake. My latest 2016 notification—again an anonymous dietician—included a complaint of me inappropriately reversing a patient's type II diabetes. I was unaware that AHPRA was investigating doctors for making patients better. I was also in that same notification reported for what I might say at a forthcoming hospital food conference. AHPRA investigators requested a copy of the speech before it was actually given. I am concerned that AHPRA has decided to become involved in the censorship of free speech. Along the way in my investigation, the evidence submitted has been from members of the Dietitians Association of Australia, those with allegiances to that association and from the medical administration of the Launceston General Hospital. There has been no patient complaint. I have been targeted and I detail this in my submission.

AHPRA has a flawed investigation process that creates falsified evidence. I am deeply concerned that the investigators are inadequately trained, supervised and audited. I have found their efforts to be embellished at best and fabricated at worst. By example, there was an apparent conversation in 2015 between an AHPRA investigator and a patient of mine. This ended up being falsified not only in content but the patient and his family have no recollection of this conversation actually occurring. I presented this to AHPRA and the patient has supplied me with a written statement of support.

The Tasmanian Medical Board is also compromised. Best friends should not be on the medical board and certainly not when one of them threatens me with information gathered during my investigation, who I believe contributes evidence to that investigation. That is in my submission. One of her best friends has also been adjudicating in my ongoing case and also sits on the national AHPRA board. This is just inappropriate.

Like many, I have issues with the whole AHPRA process. There is massive psychological stress when under investigation, far more than in the most complex surgery I have performed, and that stress is relentless. It has affected me deeply and it has affected my wife and my children. For many accused health professionals, the process results in mental health issues, family breakdown and, for some, suicide. I expand on that in my submission. I have sought access to documentation from AHPRA under freedom of information, but it has been denied. The AHPRA process has shifting goalposts for those under investigation. You answer one allegation and

another one surfaces. Trying to defend one's position without knowing the evidence and its accuracy makes for a star chamber circus. If found guilty by AHPRA, there is no adequate recourse and certainly no compensation in vexatious allegations. These situations must be addressed fairly. The process supports vexatious notifications in my case without a single case of patient harm identified ever. I am no angel and admit to treading on some institutional toes, including the Dietitians Association of Australia and those of the food and pharmaceutical industries. I see that their members and alliances have continued to put in anonymous notifications and vexatious notifications to AHPRA and that is likely to continue. The AHPRA process can and has been manipulated by those individuals and associations with agendas and vested interests. This has extrapolated to my own bullying and harassment.

CHAIR: You will need to wind it up because we will run out of time for questions.

Dr Fettke: I am. I am in this position because of my passion for preventative medicine. I have been backed into a corner from trying to stand my ground. Those with vested interests want to silence me. The AHPRA process is aiding those parties. The process is flawed within AHPRA and in the hospital system. I am just one victim of those failings. This Senate inquiry is both timely and personal. I encourage you to place my written submission on the public record as there are no patient names involved. Thank you for listening. I hope you can make a difference.

Dr Fratzia: I have been a medical doctor for 33 years in Australia and I have practised exclusively in intensive care for the last 23 years as a specialist. I have worked in military, private and public hospitals. In the last decade or so I have worked exclusively in the New South Wales public health system, in five area health services and in tertiary, major metropolitan, rural and regional hospitals. I have been mentoring other doctors, medical students, junior doctors and senior doctors for a very long time. In my view, bullying in the medical profession was once unusual, but now it has become incredibly common, particularly over the last 15 years. In my view, this is not simply because the behaviour of the profession reflects changes in the wider Australian society. I think it is predominantly because the profession's ability to deal with bullies within its own ranks has been corrupted by the non-medical bureaucracy that increasingly controls its behaviour, oversees its values and pronounces judgement on it.

Not only have I witnessed the actual bullying of junior and senior doctors but I have seen the impact of bullying upon them. For example, although I have for many years mentored, over recent years I have been providing predominantly pastoral support for those who have been bullied. I have even had to provide intensive care treatment to a vulnerable young female doctor, as a patient, who tried to take her life as a consequence of bullying. This occurred nine months after another young female doctor left mid-contract because of bullying. This occurred three months before another young female doctor became so psychologically unwell because of bullying—by the same people—that she had to stop working and change states. This occurred two years after the same bullies were reported in writing by yet another female victim, which itself was two years after senior colleagues had reported the bullying of yet another young female doctor. The same individuals who were involved in that bullying were largely still involved and protected by the bureaucracy.

I have witnessed complaint systems consistently fail to deal with bullying. I have observed the fabrication of evidence, the victimisation of the victims, doctors who report bullying of others being punished, and bullies actually getting away with it—they are even rewarded or promoted. The extent of bullying is underrecorded and underreported. In May 2015 the secretary of New South Wales Health sent a letter to all senior medical practitioners. She drew to our attention a zero tolerance of sexual harassment of junior medical staff. I have provided a copy of that letter in my submission. This caused enormous distress to many doctors, because the incongruity between what the bureaucracy says publicly and what actually happens is breathtaking. Most doctors who are bullied avoid reporting it, because they are very likely to experience further bullying once the bureaucracy gets involved—bullying by administrative process—as health executive collaborate to protect their misbehaving medical or non-medical colleagues. Employment and careers are perceived to be placed at risk. Despite any good intent of the secretary's letter, it was received predominantly as impression management at the highest level in response to a television program.

I have submitted to the inquiry eight reasons for the failure of the existing processes dealing with bullying in New South Wales. I have also submitted seven proposed changes which will improve the process. I ask the inquiry to consider them, and I thank you for this opportunity.

CHAIR: Thank you. We will go to questions now but I would remind members that we are dealing with systemic issues rather than individual cases. If you wish to explore individual cases, please relate them back to systemic issues. It is not our job to look at individual or specific issues; we are looking at systemic issues.

Senator DUNIAM: I want to go to the qualifications of the AHPRA investigators who have been referred to in the submissions. What qualifications do they have?

Dr Fettke: I have actually asked them but they would not tell me.

Prof. Stokes: You cannot find out unless someone personally tells you during discussions they have with you.

Senator DUNIAM: We do not know whether they have medical qualifications or whether they are someone with an arts degree or a commerce degree who happens to have become a cadet in the public service and worked their way into AHPRA.

Prof. Stokes: It is almost certainly not doctors that you speak to, and you cannot find out who is behind them.

Dr Mansfield: They advertise in an Australian forum and they have to have some investigative background.

Senator DUNIAM: I am sure many of us will explore that a little bit later on with AHPRA. Just with regard to the skillset, as medical professionals what sort of skillset do you think they should have when investigating these sorts of claims?

Dr Mansfield: I think they should be backed up somewhere in the system by very experienced medical practitioners who can advise them. Obviously, it cannot be doctors and that would not be appropriate but they certainly need to have some very serious component of medical advice.

Dr Fettke: I have questioned this, very specifically, as to what they do. What they do is they collate the information and they only provide a selective amount of material to the board. I have asked for all of my material to be put to the board and have it all reviewed by the board, but that does not happen. It is only very select. So the gatekeepers in our investigations are the investigators not the Medical Board.

CHAIR: How do you know that they have only given a select—

Dr Fettke: I have asked them. And I have received a specific response.

Prof. Stokes: There is another issue to this. If you are not in a major city you have no easy access to these people at all. If you are in Mount Isa or Cloncurry or Cairns or Whyalla it is awful. You are a long way away. The central thing is in Canberra and in the major cities and that is it, and you are distanced from your own legal advisers.

Senator DUNIAM: The final decision is made by the board, is that right, after the investigators have compiled whatever and presented a portion of that information?

Prof. Stokes: Correct.

Dr Fratzia: In the case of what I have reported to the inquiry, I am not reporting, predominately, my own experience though I have documentary evidence, which I can provide, about pretty well examples for everything that I have said. Most of the people who have reported bullying or where there have been investigations that I am aware of—and I am talking about people in different area health services, both junior and senior people, in New South Wales—it has never gone to AHPRA. These have been local or area health service investigations.

The qualifications of the people who are involved in those qualifications are sometimes impeccable, but these individuals are compromised, and they are compromised for a number of reasons. They are often hired guns who have a pecuniary interest. They get paid by the administrations who hire them to do these allegedly independent investigations. And if they perform well they get more. I know of at least two who pop up, repeatedly, in New South Wales.

CHAIR: What does 'perform well' mean?

Dr Fratzia: I think it is if they perform well as the administrations require them to—

Senator XENOPHON: Which is what?

Dr Fratzia: which is to suppress the bullying.

Senator XENOPHON: To suppress the bullying or to suppress the allegations of the bullying?

Dr Fratzia: Or to suppress the allegation of the bullying. In my submission I mentioned that one of the problems is the use of management prerogative to not investigate bullying or complaints of bullying or reports of bullying as 'bullying' under bullying and harassment policies. They use management prerogative to deal with those complaints when they have to, under other systems, like workplace grievance problems rather than bullying problems. They call in the hired gun. I have seen it and heard of it many times. The same people. And they always have the same report.

CHAIR: You referred to additional evidence. I think that would be extremely useful to highlight those points. If you could take that on notice that would be great.

Dr Fratzia: Yes.

Senator DASTYARI: Just a point of clarification—sorry, I am a layman here. Doctor, are you effectively saying that there is a culture or tendency to reward those investigators that deliver the outcomes that AHPRA is after by giving them more work?

CHAIR: In this case, it is not AHPRA.

Dr Fratzia: This is not AHPRA. I am not aware of any AHPRA investigations in my submission.

CHAIR: My understanding is this is the first level of whichever board it is going to.

Senator DASTYARI: That was the point of clarification.

Dr Fratzia: Yes, so this is at a hospital level at an area—

Senator DASTYARI: Good, because that is the point of clarification I was after.

Prof. Stokes: I would like to address what Senator Dastyari asked. It is at the level of administration that a lot of it happens. It even prevents things getting to AHPRA. For instance, I was told not to provide truthful information to AHPRA, because that would have adversely affected the negotiations between AHPRA and another doctor. I did at that stage decide that I did not want to be in medical administration again. It happens with information that is held locally, because of, as I say, a secret communication level that you do not find out about. AHPRA never find out about it, because they do not do any face-to-face investigations.

Dr Mansfield: I was involved in an action which I am now on the webpage for and have to be mentored for two years. I will retire before then. Those four years they looked around to find an adverse report on me and all these cases which were gathered. I had a very even-handed report from a highly regarded professional on the one involved in mitigation, which said I really did not have a case to answer. But 4½ years later, after I sat and waited, they came up with someone, and sure enough it was the vindictive, non-factual, opinionated report that you come to expect from these organisations. They found their hired gun. They then used his report plus the report of two other general orthopaedic surgeons, who had no subspecialty expertise, and a general practitioner who does a bit of WorkCover, and so they had four reports against my one, and that obviously meant that I was guilty. That is the way they operate. They just are hired guns, and they just fudge. They are after a vindictive attack on the medico involved. It is just horrific stuff.

Dr Fettke: It is my experience, and the experience of others that I speak to, that the administration does not want to accept that you have actually put in a bullying and harassment claim, and that it is put under a different name or it is just ignored. That certainly happened to mine. I provided to AHPRA 40 pages of documentation to say that I had put a claim in, but it took two years—nearly three years—to recognise that I actually had a claim. The process is to not accept that there is actually a problem. Therefore the whole thing never really gets a ball rolling. I think that is really what James has been pushing towards as well.

Senator DUNIAM: Dr Fettke, in relation to your comment about either falsified or embellished evidence by AHPRA investigators, surely when you have raised this concern with the authorities there have been some attempts to either clarify that or dissuade you from your view that it has been falsified. What response has been provided to you when this concern has been raised?

Dr Fettke: It is one-way traffic. I presented this in a verbal submission and also in a written one. This is what happens: you put in the information and there is no clarification. There was an opportunity for the AHPRA board, in my verbal submission, to ask me questions, to clarify it, and to date nothing has happened. That is my issue. I have put in numerous questions into my claim over the last 2½ years, and I just do not get a reply. So I try and get it clarified. I say: 'What are you going to do? These are serious issues.' Nothing happens in reply. That is why I call it a star chamber.

Dr Fratzia: I think that one of the methodologies that is employed to suppress reporting of bullying or to avoid dealing with it is to find fault with the clinicians who do the reporting of themselves or of others. It is in the finding fault with the clinicians that the fabrication of evidence occurs.

CHAIR: The clinicians that are making complaints of bullying?

Dr Fratzia: Yes. A clinician may complain that somebody else—a junior or somebody else—is being bullied or they may complain of bullying of themselves and the response is often some sort of fault that has been found with the clinician sometimes on the basis of fabricated evidence, of which I have written evidence as well, that has occurred to people.

CHAIR: If you could supply that—

Dr Fratzia: I could. And so there is this culture where the system seems to dissuade the reporting—deal with it any way possible apart from dealing with it under bullying and harassment policies.

Senator XENOPHON: I ask all members of the panel: do you consider that our medical practitioners either give up practice or curtail their practice because of what has occurred?

Dr Fratzia: I know two senior medical practitioners who have resigned from significant positions in the last month because of bullying, which they have reported.

Dr Mansfield: I am at present liquefying some assets so that I can walk before I am pushed.

Prof. Stokes: In general, what you really want to know is that clearly people do leave because of two things which are academically proven to occur in health institutions more than in any other. The first thing is the process of 'mobbing', where either an administrator or a senior person with power gets a whole group of people to make it really difficult for another person to survive in that institution. It is called 'mobbing' and it is described in academic journals and psychologists understand it. It is not accepted in the medical profession that that actually occurs.

The other thing is the difference between honest peer review and sham peer review. If you really want to get rid of somebody, you set up a peer review committee with the outcome already known by the people that you have chosen. This is the problem I have with our colleges and our institutions—on every committee that you have in Australian hospitals where you appoint somebody, it has to be a representative from a college. Why on earth should that be? It gives them enormous control. There is no standard internationally for peer review; a peer review can mean anything. It does not necessarily mean you did things right. We would prefer if it was called 'honest peer review' and 'sham peer review'. These are things that can drive people out of the professions because they can see the injustice of it. In the worst example of it, they get a weird psychological illness and some—very few but a significant number—of really important doctors in Australia recently have committed suicide because of mobbing and because of sham peer review.

Dr Fratzia: I have referred to this 'mobbing' in my submission as the first reason for failure. The methodology that appears to be employed is to not deal with a complaint under bullying and harassment policies but to deal with it as some sort of workplace grievance then convene a committee of people who appear to have discussed in detail the complaint, decided on a course of action and then sit with a clinician who is reported and find fault with them. That collaborative process of finding fault with the reporter is mobbing; that is what it is. I have referred to it as one of the problems.

Dr Fettke: I completely agree that I think that I have been a victim of mobbing. I am seriously considering all of my work options, including those of not working, and I am also moving interstate. If a condition is placed upon your name which is not appellable at this point in time, then I am aware of colleagues who have had jobs not provided to them. It has been seen as a discriminatory practice. So, even though a condition is placed upon your name and it is seen as a lighter sentence, people will lose jobs as a result of that. That obviously has significant financial issues to you and can change your pathway and career significantly.

Senator XENOPHON: Because of time constraints, I just want to ask one final question. This goes to the culture of harassment and bullying. There was that famous comment made in the context of the Defence Force by General David Morrison: 'The standard you walk past is the standard you accept.' Most professions have a cultural system in place where they apply helpful pressure amongst peers to do the right thing. My question is: does this occur? If not, why not? My next question, because of time constraints, is: surely in an institution you have HR managers; do you involve them? They are supposed to be trained in relation to dealing with complaints. And the final step is obviously to make a complaint. I accept what you are saying, but how is it that the system has broken down at so many levels?

Dr Fratzia: The HR managers do not act on behalf of anyone but the organisation. They essentially do what the general manager tells them to do. They are there to protect the organisation. So the HR managers are a problem when we try and deal with these things. We cannot go to HR.

The second thing is: the initial response is generally to involve a whole bunch of people from the bureaucracy, but the individual who has made the report has to remain silent and maintain confidentiality, and the HR managers are consulted by the organisation about how to deal with the bullying. So the HR managers are no help at all. As I said in my opening statement, the profession's ability to support, or to deal with the bullying, is corrupted by the non-medical bureaucracy that gets involved in these things.

CHAIR: Can I just check this with the witnesses and the senators. We have had a witness just pull out because they are unwell. What I intend to do is to reallocate some of that time. So I am proposing that we add

another 15 minutes to this panel and add some time to the other panels. Is that acceptable to our witnesses and to the senators? Okay; in that case, we will go to 10.45—

Dr Mansfield: Chair, I am half an hour late for an operating list, so I really cannot push it any further out. I thank you very much for my opportunity to be involved here and apologise for having to go.

CHAIR: That is fair enough. Thank you. If it is satisfactory to the other witnesses, we will continue to 10.45. That means that, for those other witnesses, we are shifting by 15 minutes.

Senator WHISH-WILSON: Dr Fettke, you raised the issue of bullying using social media, which is not something I have heard before. Can you elaborate on your situation at the Launceston General Hospital?

CHAIR: Can you also do that in a general sense, please?

Dr Fettke: Yes. My issue is not just bullying in that situation. I have had the examples of defacement of posters and a picture of our family kitten stabbed on my locker in the operating theatre. And when you raise these issues—and actually I raised this, and I am just using a little personal example—and go through the process of, 'Who do you report to?' then they are ignored. My situation at the hospital—and not just the cyberbullying—was that I requested an investigation, and an apology letter was supplied in February 2014 and I received it in July 2015. I think it was withheld by the chief executive officer and the director of medical services for 16 months. I knew about that letter, and I believe that to be specific provocative behaviour upon my situation. I put in incident reports about the fact that it was not being assessed. Incident reports have to be acted upon. Then one CEO left, and on the day of his resignation he said, 'We should have a meeting and sort all this out,' and then left the position. The next CEO took it on board, and it took me four months to get that apology letter. Then, when I tried to develop conciliatory actions between myself and the director of medical services, she said, 'We should meet, we should meet, we should meet.' Then that all got cancelled and then she resigned. So I am on to my third CEO now.

You try all these pathways to try and sort the situation. Whilst all this was going on—the AHPRA investigation, and the hospital administration was submitting information to AHPRA—I found out that the very person submitting information to AHPRA was the same one who posted defamatory material on a social media hate site called 'Blocked by Pete Evans', which he has finally stopped. But he has now exposed me to that group. I am the only doctor persecuted in that group on an ongoing basis. Now my wife has been attacked in that group, and my staff and a dear patient of ours, who is in a fairly threatened position and quite vulnerable.

The issue of cyberbullying has not been addressed at all in this. We talk about in-hospital bullying, but we are now in a situation where most of the colleges are advising us as practitioners to be in that space and educate the community. I have been active in that over the last four years. There are very clear recommendations from that. The Medical Board has not addressed that and neither has the AMA. The doctor-patient relationship in relation to media—whether or it is print, electronic or social media—is not defined.

CHAIR: Can I seek a clarification: when you say the colleges are advising you to be active in that space, you mean in the social media space?

Dr Fettke: Yes. The College of Surgeons.

CHAIR: I just wanted to clarify that.

Dr Fettke: There is a position statement on it. It is all about public health, the community and trying to get the message out to a broader area. That is the space; it is called e-health now. Accepting that our patients are on social media, they are now trusting strangers on social media more than they are trusting institutions. It is a sad indictment, but that is what is happening. We are now in that situation where, once you are involved in that space, you put yourself in a degree of vulnerability, and I accept that. But I should not have been put in that position of vulnerability by the director of medical services. In any other institution, any other business organisation, if your boss starts cyberbullying you, that is a grave concern. But, in the public health system—despite breaking every social media policy within the Tasmanian health organisation—that has not occurred.

CHAIR: I want to ask our other witnesses about that specific issue of cyberbullying.

Dr Fratzia: I have not seen any cyberbullying. What I have seen is the use of email copying, and so on, to essentially denigrate the target at that time.

CHAIR: Professor Stokes, have you seen cyberbullying?

Prof. Stokes: Yes, I have seen it. One of the doctors that had complaints about him made to AHPRA, and restrictions placed on his practice—several of the mobbing group arranged for that webpage to be on in the operating theatre so that everybody that walked past it saw it. That was a really nasty thing to do to him. He was

reminded of it all the time. So, yes, I have seen it in practice. I have seen out in the open, not just by accidental clicking but made obvious to all the staff that somebody had had a complaint about them.

Dr Fratzia: This raises something that you may not have considered—that is, the people who are involved in doing this to the complainants, or those who complain about the bullying of others, get away with this with impunity. There are no consequences for them. In this entire process the only consequences are for the clinicians.

Senator XENOPHON: I know the chair's quite reasonable suggestion is that we do not go into individual cases, but, when it comes to issues of defamation, Dr Fettke, did you seek advice in respect of defamation and were you told that it was not actionable or just too difficult to pursue?

Dr Fettke: I have had formal legal advice on that, at the cost of many thousands of dollars, and the advice is that there is a long, protracted course which is just messy and that there is no winner in that and not to do it.

Senator XENOPHON: Have you been advised that the Children's eSafety Commissioner—it is a bit of a misnomer—does actually deal with complaints more broadly? It is unfortunate that people think it is just about children in that the Children's eSafety Commissioner does have a role for that sort of harassment.

Dr Fettke: It is one avenue I have not pursued. I have looked at—

Senator XENOPHON: Probably because of the name—because people think it is about children only.

Dr Fettke: On cyberbullying, in view of letting AHPRA know and letting you know, on the Blocked by Pete Evans page, they regularly post the method of reporting health professionals to AHPRA. They show you: 'This is how you do it. We should report Legless Fettke'—that is what I am called—'You should put in Legless Fettke to AHPRA. If you're worried about any health professional giving advice which isn't mainstream, this is how you do it.' They give you the website and all the links and they tell you how to do it. I call that cyberbullying. I do not know these people.

Senator XENOPHON: The final question to all of you is: leaving aside defamation, which can be very hard to access for costs and the risks involved, and the e-safety commissioner, what about the professional conduct rules that relate to the medical professions, whether it is the AMA or various colleges? Have any of you approached them to say, 'This is happening. Why isn't this covered? Isn't this a breach of the rules? If not, why aren't the rules amended to cover this sort of behaviour?'

Dr Fettke: I have done exactly that and I have gone through the AHPRA process. It was heard interstate, which is against the normal protocol, and I suspect that is because of the person's seniority within Tasmania. I have questioned that and it was just dismissed—'Oh, he's not dangerous to the community,' even though he has failed in codes of conduct. You try that pathway within the health system in your own state and it fails. I am travelling another pathway now. All we are doing is seeking conciliation and a cessation of behaviour. I do not know what other pathways to take, but I am not alone in my story. I have colleagues, and you will read this in the submissions. You try all the normal avenues and it is brushed aside because bullying and harassment are too hard a topic to talk about in the health system.

Prof. Stokes: This is at the heart of the issue. It is not in the code of conduct and it should be. It must be recognised. I can tell you from a personal point of view that a bully that approached me had to sign a document for one of the senior colleges here that he would never do it again. It has never been made public. I found out about it because of the secret culture and somebody told me. so the college actually recognised this chap was a bully and made him sign an affidavit that he would do no more vexatious reports. But that is not public knowledge. He suffers no consequences of it. He gets away with it.

There is a book that is really worth reading if you have time called *Unaccountable*, published by Martin Makary, who is a professor of surgery and patient safety with the World Health Organization. The full title is *Unaccountable: What Hospitals Won't Tell You and How Transparency Can Revolutionize Health Care*. There is no transparency about AHPRA and there is certainly no transparency in how some of these decisions are made in our hospitals.

Dr Fratzia: Again, this is not to do with AHPRA, but this is to do with what I am aware of and what I have seen in the system dealing with doctors who are bullies. Generally, it is quite easy to deal with a doctor who is not protected by the administration. The colleagues tend to deal with them. It is those who are in the administration in some way—medical administrators or managers of divisions or whatever. Doctors in those positions get away almost with murder. In the case that I mentioned earlier of those young female doctors, none of those have been dealt with. They happened years ago and were reported, either by the individuals or by senior practitioners, but they were not dealt with because those involved are a part of management. When you try and deal with them privately—outside of the system—it is impossible. It costs too much money; you cannot do it.

Senator WHISH-WILSON: Dr Fettke, who regulates dietary advice in Australia? Does AHPRA have oversight into the provision of advice by medical professionals?

Dr Fettke: No. I think that is a central issue.

Dr Fratzia: I think they do, actually. They have to be registered with AHPRA.

Dr Fettke: No, I have explored that: the Dietitians Association of Australia is not under the governance of AHPRA and they have proclaimed that they are the peak body for nutritional advice for the country. Medicare and private health funds accept that they get a rebate accordingly. I think there is a central issue in that, as doctors, we are all supposed to be giving nutritional advice, that the AMA statements make that point accordingly and that my MBBS, my first medical degree, is the same as every other doctor's. What has been raised in my situation is that, because I am an orthopaedic surgeon, I am not allowed to give nutritional advice. I have raised this with AHPRA. I said, 'Either I'm a doctor and I can give nutritional advice or all doctors can't give nutritional advice, because the Dietitians Association of Australia is the peak body, in which case AHPRA don't have the ability to give jurisdiction.' I realise that is specific, but you have asked a specific question.

Senator WHISH-WILSON: Yes. I was interested in the implications of that. It is very brave of you all to front the inquiry today, tell your personal stories and raise these issues so we can get solutions, and I hope the committee can do that. Could you tell me, if you feel comfortable answering, about the impacts that not only appearing here today but also your ongoing work that you do and the investigations are having on your personal and family life.

Dr Fettke: It has changed me as a person. I think we all go into medicine for all the right reasons: to try and make a difference. When you try and make that difference and you are hammered not only by your institution but then in the wider community, it changes you. I am more defensive about what I say to my patients. When you are under investigation, particularly for a vexatious claim, you think, 'Actually, I've done nothing wrong here; I'm helping people.' It becomes all-consuming. You lose sleep. My wife and I spend hours beyond normal work hours trying to sort this out. It has affected our children with a combination of anxiety, depression and becoming more introverted. What should be a pleasant experience of helping people is now something you question every day: 'Why do I keep doing this?'

Senator WHISH-WILSON: How many patients would you have seen in your 20-plus years in Tasmania as a surgeon?

Dr Fettke: A few thousand.

Senator WHISH-WILSON: Dr Fratzia, do you want to make any comment?

Dr Fratzia: I think what Dr Fettke has said is common to all practitioners in that situation. From what I have seen happen—particularly to others, but also, to some extent, to me—my response is to tell my children and everybody else to stay right away from medicine; to do something else. Even though they are mainly adults now and they are interested in researching cancer treatments, immunisations against pandemics and so on, I have told them to stay right away from medicine, because of what I see every day.

CHAIR: Dr Stokes, did you want to make any comment?

Prof. Stokes: When I had two complaints made about me—each of them were for different things, and none of them true; found to be without foundation over a period of six months—it was the most devastating part of my life to have to put up with that. The thing it did teach me was resilience. Having been found that the complaints were all unsubstantiated, it taught me that I should actually devote a lot of my time to trying to right this wrong. That is essentially what I have done: I have re-established my practice and I am passionate about making a difference with this and getting the people in AHPRA to realise that, individually, a lot of damage is being done.

So, if anything, that is a positive I can take out of it. The thing I cannot take as a positive out of it is that a good friend of mine is now suicidal and is not practicing because of what his colleagues did to him. I find it very hard to put up with the fact that it can actually be like that. The example I give is that we are like a mob of sheep being attacked by wolves. The wolves usually attack the sheep on the outside—an outlier. The herd moves away; it does not help. If the herd of doctors actually stood up against bullying it would stop; the bullies would be forced away from the herd. But that is not the way it works, unfortunately. I have grown up in a culture where it is tolerated. It has gotten worse, particularly since mandatory reporting was introduced and all you have to say: 'In good faith, I am reporting Dr Stokes for whatever he did.' You get away it. You walk away scot-free. You can brag to all your colleagues that you managed to make someone's life miserable. That should stop. What is severely wrong with the whole system is that you can get away with it. You should not be able to get away with it.

Senator WHISH-WILSON: Just one very quick question: when you are being investigated, is it made public or do you have to make it public yourself?

Prof. Stokes: You have to tell all your employers, which for me involved about four hospitals where I work as a BMR, and I had to tell the university where I am an academic. That is immediately a change in your life, because everybody goes, 'Well, that could be true' and it is not true. Afterwards, when it is found out, people say things to you like, 'Well, get yourself a dog if you want a friend.' It is something that lives with you forever after. It is AHPRA's process that destroys people. I can understand people who continually get complaints being completely driven to give up medicine and do something else.

Dr Fratzia: What happens is that the individual usually receives a letter which says that you are bound by confidentiality. The confidentiality immediately isolates the person. They are often given the name of someone within the organisation who is a counsellor or somebody else that they can go and talk to, but that person has no insight into what they do. The person who has made the complaint or about whom a complaint has been made immediately becomes isolated. I think Senator Xenophon said earlier that justice delayed is justice denied. It then gets delayed by months and years before anything else happens, and that person is isolated for a significant period of time. That destroys them. It is a pastoral disaster.

CHAIR: We have two different responses here. Dr Stokes, you said that you have to tell your employer. Dr Fratzia, you say that you are bound by confidentiality.

Dr Fratzia: That is right.

CHAIR: Which is which?

Dr Fratzia: They get a letter. You are bound by confidentiality.

Senator WHISH-WILSON: Do you have a different view, Dr Fettke

Dr Fettke: Because I am in that process—

Prof. Stokes: The letter says to tell your employer.

CHAIR: So it is confidential but you have got to tell your employer.

Dr Fratzia: You get the letter from your employer. The confidentiality essentially protects the bullies; it does not protect the person who is reported.

CHAIR: It sounds like we are talking about the other complaint systems, not just the AHPRA system.

Dr Fratzia: That is right.

Dr Fettke: Under the AHPRA system, if you are looking at potential employment or as an employee, you are supposed to notify your employer of the fact that your under investigation. Therefore—and this is the whole process—you are guilty under the AHPRA process, the health complaints commission. You are guilty until you prove yourself innocent, and there is no help in that. I have had two previous vexatious notifications under the health complaints commission, and, without going into the detail, they were both thrown out. It is a long, drawn-out process. AHPRA does the same thing. At the end of those investigations, I got a letter saying, 'Look, there was no problem.' It takes months to years.

Senator WHISH-WILSON: How is it that your investigation was reported in the *Sydney Morning Herald* by a journalist? If it is confidential then how is it that that situation was made public in a media report?

Dr Fettke: I utilised the fact that the proposed action was to silence me on the whole field of nutrition and giving that advice, so I made that public. But as a result of that, members of the DAA, and particularly reporters affiliated with them—in fact, they are award-winning journalists—decided to publish that material in *The Age* and *The Sydney Morning Herald*, with no right of reply from me. I do not have the ability to take on *The Age* and *The Sydney Morning Herald*.

Prof. Stokes: There is no requirement for the person who reported you to remain quiet, and they sit on aeroplanes bragging about what they have done. People find out.

CHAIR: To clarify that, if the complaint is made against you, you are bound by confidentiality, but if I am making the complaint, I am not?

Prof. Stokes: You are not likely to even bother if you are bound by it, but I do not think you are. For instance, I will give you a good example. On the second complaint that was made against me, I forgot—I overlooked—one hospital, and the medical superintendent rang me up and said, 'John, you haven't told me about the second complaint about you.' How did he know there was one? I have no idea, but I actually know I had not told him, so I had to write a report for him.

CHAIR: We will check about the whole issue of binding the complainant.

Dr Fettke: They write you a letter and they say, 'This is private and confidential,' but I do not know if it is private and confidential for them or private and confidential for me. That has not been clarified, and it would be nice to know.

CHAIR: We will clarify that.

Dr Fratzia: I know of one doctor in New South Wales where a fault was found with that doctor for telling his wife.

CHAIR: That there was a complaint going against that doctor?

Dr Fratzia: That there was an investigation.

Senator GRIFF: I would be interested in hearing from the panel, and from Dr Fettke in particular: have you raised any of these issues with the ombudsman at all?

Dr Fettke: Yes, just recently. I have raised both the issue of freedom of information with the national ombudsman and the issues of the board members being best friends and contributing advice to my investigation. Both of those letters have referred me back to AHPRA, so I have said, 'I've come from AHPRA.'

Senator GRIFF: So it is AHPRA's responsibility?

Dr Fettke: It has gone to the national ombudsman and then back again to AHPRA. That is all still in progress.

Senator GRIFF: Dr Fratzia, do you have a similar situation?

Dr Fratzia: I am aware of the New South Wales Ombudsman being sent information stating that particular behaviour towards two doctors was related to bullying, and the ombudsman essentially said that it does not fall under their jurisdiction.

Senator GRIFF: But you have not had that discussion with the National Health Practitioner Ombudsman and Privacy Commissioner?

Dr Fratzia: No.

Senator GRIFF: In your case, Dr Fettke, you did speak to that originally? Correct. I have a brief question to Dr Stokes: in your submission, you talk about the desirability of requiring complainants to sign a declaration that their complaint is being made in good faith. You make the statement that you support the introduction of a signed declaration with consequences. What sort of consequences do you think are appropriate?

Prof. Stokes: It is professional misbehaviour to try to destroy somebody's reputation and stop somebody from providing medical care. AHPRA have every right, under the current legislation, to take that person on, but they choose not to and they protect this. That is my attitude towards it. It would be solved by putting it into a code of conduct, and you would not have to find anything; it would just be expected of a doctor that he would not make vexatious complaints. It is something that I cannot understand why we defend. I do not want to stop patients from making complaints, but I want to stop the use of destroying doctors for financial reward or power, or for stopping safety measures from being introduced into hospitals.

Senator GRIFF: What would you see as the consequence to the doctor of doing the wrong thing?

Prof. Stokes: He might be fined, he might be cautioned and have to undergo some remediation—that sounds very communistic!—but he should realise that professional misbehaviour carries a consequence of sorts. Maybe he should have to reimburse the doctor that had to stop practising for 12 hours or had his practice damaged. It is not good enough just to be able to get away with doing it, and with just those few good words—'in good faith'. I would say this: that is not good enough for a professional. So if it is part of a code of conduct, so be it—and we all live by it and work by it. And then you would do it seriously—not do it frivolously or to try and destroy somebody's career.

There are two interns in Australia whom AHPRA has cooperated in making virtually unemployable. They were passed for their intern year but had restrictions put on their practice because the director of clinical training objected to them. They were a minority group from overseas who did their medical training in Australia. They cannot practice because they have restrictions on their practice. It was a catch 22 situation. They have satisfied the requirements to be made doctors but they are not allowed to practice without restriction—and nobody is going to employ them in that strange land. I think the director of clinical training who did that to them should really face the consequences of what that person did to two young lives.

Dr Fettke: As I said at the beginning of my statement, I am speaking for many. I am at a certain age and security in my life where I can speak out. Many junior people try and speak out and they have minor conditions, minor words of mouth. I have intervened in an email exchange between significant heads of the college. I said, 'You can't say that about someone.' That person's career was ruined by this email exchange. I have now upset

most of the heads of the orthopaedic association because I have dared to call them out on misbehaviour in email communications. So I am in a position to say this is not just my problem; junior staff, and their entire careers and lives, are being devastated by the process of bullying and harassment aided and abetted by the AHPRA process.

CHAIR: We have run out of time. Could I ask you to take something on notice. It seems to me that the AHPRA process at this stage—and obviously we have still got a lot of the hearing to go—is not necessarily the best system for dealing with, in particular, bullying and harassment because it is hard to fit it into their definition of patient safety and risk. Dr Fratzia, I note your seven-point plan. I would like each of you to give some further thought to the best way to deal with bullying and harassment given the process that exists for AHPRA at the moment. Is it by amending the national law? I realise that there are different stages where bullying and harassment are dealt with but, in terms of the AHPRA process, what would be a better national process? I would appreciate it if you could give some thought to that.

Prof. Stokes: That is not a new suggestion. It was done in the United States over 15 years. And the disappointing thing is that despite a major university trying to stop harassment by junior doctors, interns and medical students, over the 15 years, having put a huge amount of resources into it, it made no difference—education and things. I can tell you that reference. It was published in 2010.

CHAIR: One of you has already mentioned that in your submissions. I remember reading the citation. If you have any further thoughts about how to deal with this issue as opposed to—I understand the vexatious claims issue, but there are is the bullying and harassment process. If you could take that on notice, that would be appreciated. Apparently there are some media who would like to come and take some photos. We are suspending for a break now. I just want to confirm that you are okay with them taking photos in the room. And I will ask each witness afterwards if they are okay with photos being taken, in case they are not in the room.

Proceedings suspended from 10:49 to 11:05

BUISSON, Miss Elise, President, Australian Medical Students' Association

CHAIR: Have you been given information on parliamentary privilege and the protection of evidence?

Miss Buisson: Yes.

CHAIR: We have your submission. I invite you to make an opening statement and then we will ask you some questions.

Miss Buisson: When the story of bullying and sexual harassment in medicine broke in early 2015, it was of significant interest to the media and the public. In response, some members of the medical profession expressed surprise at the news or sought to downplay its accuracy. Conversely the surprise expressed to me by students was that any doctor could claim to be unaware of the occurrence or prevalence of bullying in our profession. In the time since and in response to extreme public pressure, the Royal Australasian College of Surgeons has developed a response to bullying in its ranks. However, it is not a surgeon's problem; it is a doctor's problem. Anybody overseeing medical education or the medical profession be it a college or medical school should be asked what the prevalence of bullying is within their institution. If they do not know 18 months on from being made aware that the issue exists, I believe there is a case to answer as to why that is so.

The impact of bullying and harassment has long been dual—both detrimental to the mental health of the profession and detrimental to the care received by patients. I would argue that there is now a third impact as recent public revelations of bullying erode trust in a profession that cannot operate effectively without trust from the population it serves.

In a 2013 beyondblue survey of the profession, a quarter of doctors acknowledged having suicidal thoughts and one in 10 had done so within the past year. For medical students, the number who have considered suicide in the last 12 months is one in five. There are many reasons for that and I do not want to oversimplify it but a culture of bullying and harassment plays its part. Our profession exists to serve patients and where we allow bullying to occur we fail them. As noted in our submission, published evidence states that being a victim of mistreatment or observing unprofessional conduct from superiors can contribute to the decline in empathy over time that has been documented in students and doctors alike. Further, communication failure is the leading cause of medication errors and delays in treatment and the second leading cause of operative mistakes and fatal falls.

We have outlined in our submission a number of barriers to reporting bullying and harassment and options to move forward. Barriers include systemic issues such as inadequate protection of students either under the hospital policy or the university policy, cultural issues including the hierarchical nature of the profession and beliefs including a view held by up to 50 per cent of students that mistreatment is necessary and beneficial contributor to their medical education.

AMSA conducted its own study into students' experiences of bullying and harassment and found that two-thirds of respondents had either experienced or witnessed bullying and discrimination with women, students over 25 years and lesbian, gay and bisexual individuals being at particular risk. The most significant lesson drawn from the survey was the ingrained cultural nature of the abuse. The following is a part of a response submitted by a medical student to this survey:

> It is natural for bullying to exist. Unfortunately people who are weak minded find anything that goes against them or anything that is a form of hardship as being bullying. If you want to solve bullying, fix the people that are getting bullied. No matter what, bullying will always exist in medicine.

The medical profession restores health, has the most difficult conversations with grieving families and makes life-and-death decisions in an instant. It defies belief that we as a profession cannot set out to achieve a task such as stamping out bullying and be successful. It is achievable and it will require each and every college and medical school to take responsibility for driving this change within their institutions. Removing barriers to reporting is an important strategy for decreasing bullying, but culture will ultimately prevail. It is only a profession-wide change in culture that will decrease bullying, improve the mental health of doctors and protect the safety of patients.

Senator DUNIAM: Thank you very much for your submission. With regard to the work that the college of surgeons has done to address bullying, do you think it goes far enough to knock this issue on the head?

Miss Buisson: There is probably a different response on whether or not in theory it has gone far enough and whether or not it has achieved the change that they wanted. I think that what they have developed is very comprehensive. To relate a story of the cultural issues remaining among surgeons as this process of addressing the issue has been underway, mid-last year the surgeons ran a survey of all of their trainees, asking them whether they had experienced bullying and harassment. I think that was a great move. During that time, a student reported to me that they were sitting in surgical grand rounds, so that is when all the surgeons in the hospital come together and have an educational meeting. Someone presents some research to them. A trainee doctor stood up, gave an

absolutely outstanding presentation—they had put a lot of work into it—and a quite established male surgeon was very loudly interrupting her as she went on, saying, 'My, my, my! Haven't they let you out of the kitchen a lot this month!' and various other statements about her being female.

At one point she stopped her presentation and said: 'Don't you know that the college of surgeons survey is being undertaken at the moment? I could go back and do that again if you would like.' He laughed, and everyone laughed, and the head of surgery at a medical school in that city was sitting in the room and did nothing, as did everybody else. So I would say I hope and I am sure there has been change in some areas, and I believe that the efforts from the college of surgeons are absolutely authentic. However, I think that you have to have real disciplinary action for people if you want to see absolute change. I do not think we have seen that totally occur yet.

Senator DUNIAM: Based on what I have read and what I have heard, I have concerns about each of the specialist colleges and what they are doing in this space, but they are matters I will raise with them when we get the chance. Some of our last witnesses referred to a couple of cases where people had gone through the training and then became virtually unemployable because of conditions placed on their registration. It was implied that that was because they came from a minority. I did not ask and there was no detail given of what sort of a minority background that was. I just wonder from your point of view whether that is something that you have observed as widespread or at least not uncommon—where, because of someone's background, race, gender or whatever, there are restrictions placed on people who complete the training and they find it difficult to gain employment.

Miss Buisson: In the specific case of someone having restrictions placed on them, I think that would be quite uncommon. I do not know of a case that I have heard of where, as a result of coming from a minority background, someone has had restrictions placed on them. Having heard the evidence this morning, though, I think they would probably also say that those are, I assume, isolated incidents.

I think that incidents of sabotaging someone's career in other ways for those reasons are probably quite common. For example, a student told me a story of sitting in a room with a number of high-up people in a particular college. They did not tell me which college it was—that is left to our imagination. But they were discussing how they pick candidates and they said, 'We could use CVs; we could use referees,' and then one of the senior members of the college said, 'Well, we all know who the real referees are—they're the people who we call, who we know.' That is really reflective of how it works in medicine, oftentimes. If you have upset somebody, whether that is because they just do not like you or because you are actually not a good medical student, they can then prevent you from progressing your career. They do not need to place resections on you formally through a process. They can prevent you from working in other ways.

Senator DUNIAM: Going back to the specialist colleges, I noticed in some of the ways forward that AMSA suggest you have actions for the medical specialist colleges to undertake. If they undertook all of those actions, do you think that there would be enough accountability or rigour within each of these organisations to actually overcome bullying? Or do you think we need to overlay it further, to somehow put a stronger governance regime over these specialist colleges to ensure that we stamp out bullying?

Miss Buisson: I suspect if the colleges put their mind to it that they could. Whether or not you will have every college really putting in what is necessary to stamp it out is probably quite questionable. As you can imagine, it is very difficult if you are the representative of a group of people to then be the person who is also cracking down on a subset of those and saying that those are the bullies and those are the problem, and I suspect there is a reluctance from them on that front.

Senator DUNIAM: And I think therein lies the problem with part of this.

Miss Buisson: Yes. I do not think they lack the capacity to do it through the colleges, but they perhaps lack the will.

Senator DUNIAM: Sure. I guess that is the point I am making—that is, whether they are the right entity and whether they are geared appropriately to do it.

Senator XENOPHON: Thank you very much for your submission. In terms of the Royal Australasian College of Surgeons and their landmark report, instigated as a result of some very controversial allegations that were made and that triggered that review, do you think things have changed? Or are you saying that it is still business as usual with some doctors not changing their behaviour—what seems to be quite egregious behaviour on their part?

Miss Buisson: I do think there has been significant change, but I do not think it has been all surgeons. And I think that change has been focused within the College of Surgeons because the other colleges have not had that same pressure applied to them. We have developed this kind of media idea that it is the surgeons who are

particularly at fault, whereas I think there are quite a lot of poorly behaving doctors who are not surgeons who are getting away with it just fine. There absolutely are some surgeons who are still behaving badly, but I do think it is substantially less than it was a year-and-a-half ago. Whether that change will be sustained for another 18 months or the 18 months after that I am a little less certain of.

Senator XENOPHON: I want to explore the relationship between a complainant and a respondent, and the role the respondent has in the complainant's training progression. Is there a reluctance amongst the medical students you represent to make a complaint because they will then be a marked man or woman in terms of their careers? To what extent are medical students thinking that by making a complaint their career will be brought to a standstill before it actually starts?

Miss Buisson: That is absolutely the case. Even very well-meaning clinicians or faculty members will advise you not to report certain things: 'Look, it's probably not that bad. If you are to do it, it's going to have a really negative effect on your career.' And if someone was to come to me and say, 'Should I report X', I would find it very difficult to know what is the best course of action for them.

Senator XENOPHON: Maybe if you can use another letter of the alphabet rather than X?

Miss Buisson: I do think that it is a significant contributor to why students do not report. I also think that they feel that the mechanisms being used to deal with people once they have reported are probably not that effective.

Senator XENOPHON: So what is the difference between the student-teacher relationship in a university, where there has been allegation of inappropriate behaviour by the lecturer or the professor in that teaching relationship towards a student, and the student-medical practitioner relationship? Can you comment on the contrast between inappropriate behaviour in the student-teacher context and what happens in the context of a medical student with a medical practitioner? Are the rights equivalent? Are the processes equivalent? Or is there a real distinction between the two?

Miss Buisson: They are different. I would say that it is easier to gain satisfactory dealings with a complaint through a medical faculty if they are employed in a teaching capacity, not because medical schools themselves are necessarily so determined on stamping out bullying—I think up until this media exposure last year, they were pretty much the same as the rest of the profession—but because in a university if you are not happy with how your medical school deals with something, there are higher levels you can go to. You can complain and you are protected under the university policy. In a hospital, if you are being taught by a doctor—which does not mean that they are employed at the university anyway, it just means that you are following them around for perhaps three months at a time—and you make a complaint against that doctor, that complaint needs to be made to the hospital ostensibly, but you are not covered by hospital policy. That generally covers employees and volunteers, and you are neither.

Senator XENOPHON: I have just a few quick questions and, hopefully, you will have a quick response, if you are able. What is the level of under-reporting of this sort of behaviour? What is your assessment of the level of under-reporting of claims of harassment and bullying of medical students by the profession? What percentage of people do you think actually come forward to make a formal complaint?

Miss Buisson: It is very low. The number of people in the survey who said they took any action—speaking to absolutely anyone—was 30 per cent. That is where they went and spoke to a peer even. So the amount of people who went and formally reported—

Senator XENOPHON: What percentage made an actual formal complaint?

Miss Buisson: They did not mention. That was not asked in the survey, which is a shame, but I would expect that it was significantly smaller than that.

Senator XENOPHON: From your assessment, is it that 90 per cent of people may not go any further with complaints?

Miss Buisson: I think that is a very fair number.

Senator XENOPHON: Ninety per cent of instances do not actually get formally complained about.

Miss Buisson: Easily.

Senator XENOPHON: And only 30 per cent of people actually talk to somebody else about it. I want to go to the issue of AHPRA. What relationship has your organisation had with AHPRA? Do you have any observations about the way they deal with cases of harassment or bullying?

Miss Buisson: As students, we have very little insight, I think, into the way that AHPRA works. Much as you will hear from other people, things happen, and people often do not feel that it is a satisfactory response, but for students it is very rare that a formal complaint is made high enough that it then deals with that doctor's

registration. I do not know of any student who, as a result of their complaint, has had AHPRA intervene and place some kind of limitation on the doctor's registration.

Senator XENOPHON: Are you saying the system is not effective in dealing with bullying and harassment either because of under-reporting or because, if it is reported, there is not usually a satisfactory outcome?

Miss Buisson: Yes. I think that perhaps the difficulty with AHPRA is that, if you are dealing with patient safety, they are not always going to be able to make a direct link between the incident and patient safety. You can talk about the evidence and how, overall, it contributes to a decline in patient treatment, but that is probably tricky.

Senator XENOPHON: Finally, can you give instances, in a de-identified fashion, of the sorts of matters that do not get complained about, in terms of what has come to your attention in your role with the Medical Students' Association? Can you give us two or three short, sharp examples of the sorts of things that people are getting away with?

Miss Buisson: There was an example of a class being taught by a male clinician who would come in at the start of every class and, before they had been taught any of the content, pick two women at the start of every class and ask them a difficult question from the content they were yet to be taught. They would inevitably get it wrong, and then he would make the comment, 'Aren't women supposed to be smart in our days? Isn't that why we're letting them in?' There was another instance where a female was asking a particular senior member of a college about working in that field. She was really excited about it, asking them about their hours, asking them about how you get in. They gave a long explanation to one male and one female student, and at the end they said to the female, 'Oh, and for you, I would say perhaps radiology, because you can do that at home while you supervise the play dates.' There was also an incident in the teaching of anatomy in which a surgeon who was teaching tried to describe trauma surgery and some of the instances you face to the students. He said, 'Yes, when we're dealing with trauma and someone's been stabbed, if the assailant was male then they're going to stab low because that's a firm assailant. But if it's a woman, well, they're going to stab up because they are gripped with a female frenzy—as many of you will be at some point in your life.' No-one would imagine that women stab up because they are likely to be shorter than the people that they are attacking! But that was not the way that the surgeon saw it. I would say that those sorts of instances where it is verbal and they are making some kind of broad remark are extremely common. I would say the second most common is when they are specifically attacking a student over their knowledge—they are calling them stupid or useless in front of their peers, or potentially in front of a patient. Then probably less common are examples such as one told me by a young woman. In surgery she was told her suturing was sexy. Then, as she left later that night, the surgeon put their arm around her and was stroking her lower back as they were walking along in a deserted corridor, and she felt there was nothing she could do. I think that kind of physical extension of matters is probably the most rare. That would be a spectrum of things you are looking at.

Senator XENOPHON: Thank you for depressing me!

Senator WHISH-WILSON: Does it concern you that the committee has heard evidence today from very experienced medical practitioners, some of them surgeons, that they are considering leaving medicine, their colleagues are leaving medicine and they are advising their kids not to go into medicine?

You are obviously younger, with the world ahead of you. Does this kind of thing concern you at all?

Miss Buisson: It concerns me deeply. I would not consider leaving, myself. While I am struggling to recall the study itself, there was one done in Australia that found 30 per cent of people who reported some kind of bullying were considering leaving. I suspect that the number who actually do so is much lower. It is really an indictment on our profession. It is very sad that we, for all the things we do, are able to drive people to such despair that they would be willing to give up two decades of training to become a fully qualified doctor.

Senator WHISH-WILSON: That is what I was going to ask you next. The taxpayer investment and the importance you have in the communities, that we all rely on you, especially where I am in Tasmania: it is very hard to get specialists and good people down there. What is it about medicine? You are a young person. You are at college. Do you see this in other faculties, if you know people in other faculties, or is this something specific to medicine, and why is there this culture? If you could put your thumb on one, two or three things what would you say it was?

Miss Buisson: I think it is specific to medicine. In particular, we have an issue because there is a perception that you need to be tough: you are dealing with life and death; you need to be able to handle it. It is really seen by medical students and many doctors as beneficial, because this abuse is like a testing ground: if you can make it

you are tough enough to do medicine. It is no surprise, then, that we see these documented studies of decline in empathy over doctors—because 'tough' is what we are aiming for rather than compassion.

The hierarchical nature of the profession is probably the other key aspect to it. There are a lot of wonderful things about the hierarchy that exist so the patients are safe. As an intern, I do not get to make big decisions. I have to go up and up and up, and that is good for us. But because those people are then deciding your future and because we are a very small community, ultimately, specifically when you go into a certain college and there are not that many people there, and if you get on the wrong side of someone it is very difficult to succeed in that career after that. That just amplifies this idea—that you have been treated badly as a student intern, you get a little bit of power and you want to use that power, and you do use that power. Those two things come together to make quite a problem.

Senator WHISH-WILSON: Essentially, it is elitism, because you are dealing with life and death situations and you train for a long period of time and it is the pressure.

Miss Buisson: It is a genuine belief among many people that it is beneficial and it creates the kinds of doctors they want to see.

Senator WHISH-WILSON: Have you seen any particular pressures or cultural issues around research, given that medical research is evolving, that it is not an exact science, in many areas, and perhaps there are differences of opinion about research outcomes and perhaps vested interests behind funding medical research? Do you have any thoughts about that at all?

Miss Buisson: Are you asking whether I specifically know of instances of—

Senator WHISH-WILSON: Instances of bullying in the research side of medicine.

Miss Buisson: No, I do not. I suspect if you asked junior doctors they would give a different answer. For medical students doing research, it is very small time for the university and is probably not even published. Junior doctors are competing and more senior doctors are competing, so that is where you would find those sorts of stories.

Senator GRIFF: I know Senator Whish-Wilson asked you a similar question, but I want to go back to your submission and the *Medical Journal of Australia*—that 74 per cent of medical students experience teaching by humiliation—and we have talked about this previously, and the fact that you noted that 30 per cent of students have been mistreated and consider dropping out and wish they had not chosen medicine as a career. In your view, what is the current proportion of medical students who commence studying but do not complete due to those issues?

Miss Buisson: Complete medical school? Very low, perhaps one per cent. It is extremely low. If you were to drop out of medicine I suspect that would be in the prevocational space, which is after internship, your postgraduate year 1, and before specialisation, which is perhaps 10 years after graduation—that is the period where people disappear. But I do not think it would be a large number of people. While this is high numbers considering leaving, I do not think there are a lot of people who actually leave. They have invested far too much, at that point, to bow out.

Senator GRIFF: What about medical students during medical school?

Miss Buisson: That is about one per cent.

CHAIR: Did you say one per cent?

Miss Buisson: Yes, one per cent maybe two.

CHAIR: I want to go back to the issue around the number of female students who are bullied and harassed. Your evidence, and that of others, suggests a greater number of women are subject to this bullying and harassment. Do you think part of your earlier comment that 'you are tough' is related to the perception that women are not as tough? Is that where you were going with that comment? Does the evidence show that women cop the lion's share of the bullying and harassment?

Miss Buisson: Partially. It is probably a view that women are weaker in some way and need toughening up or need more proving before they are able to be an adequate doctor. Another part is probably that when it comes to comments about careers and dismissing people's prospects for careers in things like surgery, which is seen as a real man's job, people view flexible work and part-time work as dirty words—it is not on in medicine. There has been work done by some colleges to make flexible work happen, but for other colleges that is extremely rare. The people seeking to do it are generally female. That is seen very negatively. Some doctors whose views have been established for many decades would see that as evidence that the women are poorer or weaker doctors. There was

an article written some time this year, I think, by a doctor in the UK, discussing the feminisation of the medical workforce and how it will bring everything to an end.

Perhaps another issue is something that was mentioned by an earlier witness: they pick the people they perceive as weak, and that can be someone who is a bit quiet or less confident in their medical knowledge. Even though they are very good, they are less likely to speak up. Societally, men are more likely to be the people who are taught to be assertive and strong—put their opinions out and fire away. Women are more likely to be societally taught to be polite and wait their turn. That then feeds into the perception that they are a bit weak and they are not quite suitable—they do not shout out their answers and are not getting in there. In terms of further evidence I am not sure that I can think of anything that has been published, for example, for why that is the case. I suspect there must be some studies available.

CHAIR: In your submission, did you have figures for the proportion of men and women are bullied and harassed?

Miss Buisson: I do not think we have given a figure.

CHAIR: I did not think you had. There are figures for the number of people reporting being bullied and subject to humiliation and those who have witnessed it.

Miss Buisson: There is a figure from AMA WA. They published a survey earlier this year. I cannot recall it off the top of my head, but the survey delineated male and female experiences.

CHAIR: We will chase that down. Thank you. In your opening comments you mentioned that 50 per cent of students have come to believe that mistreatment is necessary and beneficial to learning. That links to your comment about that is what you have to do to be tough. At what stage in their undergraduate degree do they come to that conclusion?

Miss Buisson: I would say very quickly. As soon as you start to get into a clinical environment in a hospital—for some people that is not until the third year; but in some universities that is from week 1, one day a week—you see it as the norm. I am not saying that every doctor behaves that way by any means, but everyone has experienced it. You walk into the common room and hear a story about it going on. As soon as you see that is the norm and that people are not doing anything about it, you very quickly adapt to it. People drink the Kool-Aid, especially because you respect the people who are superior to you. You feel the need to impress them and you model yourself after them. If they are bullying or harassing and you see no-one stand up to them, you quickly adapt to the fact that this is the status quo and you are going to stick with it.

Senator GRIFF: Are there any specific subjects at uni that cover harassment and bullying?

Miss Buisson: Medicine at university is quite different. It is often only one subject all year. It is called: medicine year 1.

Senator GRIFF: So there is no content that covers harassment and bullying?

Miss Buisson: I do not know of any specifically. Some universities might have it, but there are different curriculums at every one of the 20 medical schools. So, it is possible that it exists, but I do not know of it.

CHAIR: In terms of the 50 per cent who come to believe that it is necessary and beneficial, is there a gendered breakdown of that 50 per cent?

Miss Buisson: That is an excellent question. I do not have it with me and I would have to check where that reference was from. It is referenced in the submission, but I would have to have a look.

CHAIR: You say, 'existing literature' and it is seven.

Miss Buisson: I do not have that number on me, but it may be the right reference.

CHAIR: Would you mind taking that on notice. I am reluctant to give you any homework but, if you could take that on notice, it would be appreciated.

Miss Buisson: I am happy to take that on notice.

CHAIR: Thank you very much for your submission and for your time today. It is very much appreciated and, as Senate Xenophon expressed, depressing.

Miss Buisson: Thank you very much.

ARMSTRONG, Dr Benjamin, Board Director, Australian Indigenous Doctors' Association

DINKLER, Mr Ludger, Policy Officer, Australian Indigenous Doctors' Association

DUKES, Mr Craig, Chief Executive Officer, Australian Indigenous Doctors' Association

RALLAH-BAKER, Dr Kristopher, Board Director, Australian Indigenous Doctors' Association

TATIAN, Dr Artiene, Board Director, Australian Indigenous Doctors' Association

[11:36]

Evidence from Dr Rallah-Baker was taken via teleconference—

CHAIR: Welcome. I will let you know, and I think you have probably been told, that the witness appearing via teleconference is not covered by parliamentary privilege, because he is not in the country—you are covered, but he is not. Dr Rallah-Baker, I was saying to the other representatives of the association that, because you are in New Zealand, you are not covered by parliamentary privilege.

Dr Rallah-Baker: Yes.

CHAIR: I am making sure that everybody is aware of that. Thank you for coming here today. Can I check that everybody has been given information on parliamentary privilege and the protection of witnesses and evidence. Thankyou. I invite you to make an opening statement and then we will ask you some questions.

Dr Armstrong: I would like to start by thanking the committee for asking the Australian Indigenous Doctors' Association to be in attendance today and to give evidence in relation to the inquiry. Our submission focuses on addressing the first two terms of reference:

a. the prevalence of bullying and harassment in Australia's medical profession;

b. any barriers, whether real or perceived, to medical practitioners reporting bullying and harassment;

Australia's first Aboriginal doctor graduated in 1983, and the number of Aboriginal doctors has been slow to increase. AIDA turns 20 this year and is a young organisation with members who are mostly in the early stages of their professional careers. The AIDA directors that appear before you today are not only elected representatives of the AIDA membership but are also representative of the bulk of AIDA's membership, in the sense that we are young doctors at various training stages. We are progressing at various stages through the public health system. We work largely on the ground at a grassroots level, interacting and in touch with all other layers of the healthcare profession.

Prior to appearing today, we asked a number of our members if they would join us here, and the majority of the responses to us were in the negative. We hold that this is representative of the great and generalised fear held by members of our profession at large, with regard to giving negative feedback. The vast majority of our members fear negative repercussions should they be known to be critical of any medical establishment. Even as representatives of a national organisation appearing here today, there is a fear of potential repercussions for our careers as individuals.

AIDA's submission is informed by extensive research, the most important of which consists of a large survey of our members. AIDA's submission makes it clear that bullying and harassment often occur in the form of racism that creates and perpetuates a culturally unsafe work environment, lacking in respect and support, and that has a highly detrimental effect on Aboriginal and Torres Strait Islander medical students and doctors, as well as on their recruitment and retention. AIDA advocates that workplace bullying and harassment cannot be fully examined without also exploring racism in depth.

We know from our survey that almost all of our members report having directly witnessed bullying in their workplace, and over half report having witnessed racism at least once a week. Almost all report having been the subject of racism and bullying within the last year. Of these members, well over half did not formally report the incidents, and the primary reason cited for this was a fear of negative personal repercussions on either themselves as the reporter or the victim. Our members also reported that the majority of the bullying and racist behaviours or attitudes originates from supervisors or more senior colleagues. They report feeling that this negative behaviour is overlooked or even sanctioned by senior management and is underpinned by a level of often inadvertent racism that is deeply engrained in the structures, policies and practices of Australia's western dominated medical system and its institutions.

AIDA aims to achieve a culturally safe health system, and we aim for this to be reflected in all health sectors and national policies relating to Indigenous doctors and medical students. Racism needs to be recognised as a strong barrier to achieving this. AIDA also advocates that the establishment of a safe, effective and culturally

appropriate reporting mechanism for non-acceptable language and behaviour would go a long way to fostering culturally safe work environments and attracting Aboriginal and Torres Strait Islander students and doctors to a career in medicine. Thank you.

CHAIR: Did anyone want to add anything before we go to questions. No? Senator Duniam, do you want to kick off?

Senator DUNIAM: Thank you, chair. With regard to the bullying experience, particularly for Indigenous doctors or those studying to become doctors, what sort of form does the bullying take on? Is it isolated to treatment, or are there restrictions placed on their future career paths? If you could elaborate on that, I would be grateful.

Dr Armstrong: That question requires multiple layers of answering. There are barriers right through the entire medical profession to Indigenous doctors progressing. There are barriers before medicine as far as education and expectations go for people to not have a professional career because they are Indigenous. When you reach medical school, as soon as people find out that you are Indigenous the first assumption is that you have received special treatment, you do not deserve your position and you are only there because you have ticked a box saying that you are Aboriginal and essentially you have stolen the place of someone else. Then, as a junior doctor, you are exposed to a lot of racism on the floor—casual or directed—and that, again, can be based on assumptions that you do not deserve to be where you are or assumptions that, as a practitioner, you are not of the same quality as other people because you have not earned your place. Particularly for people like me there is a lot of almost inadvertent surprise that you could be Aboriginal. There is the, 'You don't look it; therefore, you are not Aboriginal, therefore you're a fake on multiple levels.' Then once we progress into the college system, again, it becomes an assumption that you have not earned your place. So really I cannot give you one answer for that.

Senator DUNIAM: I think someone described the thought processes people may have towards Indigenous doctors or Indigenous individuals training to be doctors. Does it manifest itself in the form of people making comments like that, or are there actions they take to—

Dr Rallah-Baker: If I may add, I think the answer is that the feedback that has come to me from our members is that it takes the form of direct comments as well as indirect comments and behaviours. Members have suffered questionable complaints being made about them, or a grouping of individuals belonging to whatever institution it may be, which has been informed by their own opinions of Aboriginal and Torres Strait Islander people. In essence, it can be direct or indirect, and the indirect form can take the form where institutionalised mechanisms adhere to that individual.

Senator DUNIAM: Thank you for that. In terms of AIDA's plan to contribute to ways of tackling this, have you had direct conversations with AHPRA or any other entity with regard to formally setting up ways of dealing with this either at law or some other way?

Dr Armstrong: Certainly not AHPRA as such. We do not really have a relationship with AHPRA as an organisation. But, for example, since the recent report and changes of the College of Surgeons they have formed a much closer bond with AIDA. We are working strongly now with RACS to assist them in making their college a safer environment, and other colleges are following suit. So that is potentially more where we are aiming our activities. We have had a long relationship with the medical schools, so that relationship is much more concrete.

Senator DUNIAM: So you are encouraged by the work you are doing with RACS and potentially the follow-on from the other entities?

Dr Armstrong: Yes.

Dr Tatian: To add to that a little bit more, colleges are often private institutions, so they have approached us previously to get involved with things. I know that I personally sat on the Australian Medical Council and helped them write their reconciliation plan. But the main bulk of cultural safety training has really started in essence to grow from medical school. I think that is where AIDA has really been able to find some involvement with some culturally minded people and try to get cultural safety happening from the beginning and then having that progression into the new generation of doctors that will come through. Hopefully, that again will begin to emerge in college training processes as well. I know that some of the colleges are now starting to include Indigenous content in their training process.

Mr Dukes: We are also doing some work with the Committee of Presidents of Medical Colleges in relation to cultural safety and speaking to the colleges through that mechanism, as well as the Medical Deans of Australia and New Zealand and our individual contacts with universities and deans of medical schools. So we are tackling a number of things on a number of fronts, and cultural safety is one of those things.

Senator XENOPHON: Thank you very much for your submission and the evidence you are giving. I am just trying to work out what happens when you get those instances of, 'You don't deserve to be here,' or 'You're taking our place,' that you have outlined, Dr Armstrong. Do people let it slide? Do they complain within the hospital or within the organisation? Do they go to AHPRA? What normally happens, and what level of reporting is there? We have heard from medical students that only 30 per cent of people subject to some form of harassment or bullying actually tell a peer about it and an even smaller number make a complaint. What happens with that sort of behaviour and how do you address that, in terms of tackling that unacceptable behaviour?

Dr Armstrong: From our survey we know that only about 40 per cent of our members have initiated some sort of complaint reconciliation, and not all of those were formal complaints, although the majority were. They said that the vast majority of those complaints were ignored or not actioned, and they often had negative repercussions, which discouraged them from making further complaints. Certainly, in my experience—

Senator XENOPHON: Sorry, what percentage of those had negative experiences which discouraged them from ever doing it again?

Dr Armstrong: It was over half.

Senator XENOPHON: You might want to take that on notice.

Dr Armstrong: We will take that on notice.

Senator XENOPHON: Are these complaints to AHPRA?

Dr Armstrong: Mostly to more local establishments.

Senator XENOPHON: Can you tell me, or on notice, of your experiences with AHPRA—this inquiry is focused on AHPRA, the complaints process—and what the feedback has been, in terms of complaints to AHPRA? I do not know if Mr Dukes wants to jump in on that.

Mr Dukes: I think we will need to take that on notice.

CHAIR: That would be appreciated, thank you.

Senator XENOPHON: What percentage of instances that you referred to, where the only objective measure would be seen as bullying and harassment, do you think actually get up the chain to a complaint either at a local level or to AHPRA?

Dr Tatian: **The** evidence from the membership and the statistics that we did was that more than half did not report. Of the 40 per cent that did report, the portion that did not report said that they did not because of a fear of negative repercussions, which I think is intrinsically built into the medical hierarchy. Of the 40 per cent that did make a formal complaint, 100 per cent of them said that their complaint was either dismissed or did not progress any further. I think that is quite a startling figure.

Senator XENOPHON: How big is the sample base? How many complaints are we talking about?

Dr Tatian: We are talking about the 50 mark. The thing to acknowledge, here, is that we have a very small sample of Australian Indigenous doctors to begin with. Many of us are quite junior, and the main feedback we got from members when we asked why we had this kind of engagement was that they were unsure where this information would progress and whether they felt safe disclosing these negative things—because all of us are aware of instances where people have reported something and it has negatively reflected on them and halted their career progression.

Senator XENOPHON: Do you think that amongst Indigenous doctors there is a greater reluctance not to go forward? Do you think it is even more so than for other minority groups?

Dr Tatian: Our membership reflected that we already have so many barriers in front of us, so many barriers that we started off with to get this far, and a complaints process in bullying would just be another barrier. We already have all these things that we need to overcome, so would we add another piece of wood to the fire.

Senator XENOPHON: Sure.

CHAIR: You were here when we had our previous evidence—the evidence we got from the students and some earlier evidence—that women seem to be disproportionately targeted for bullying and harassment. Has any of your survey work identified any gender basis on top of the racism element that you have identified?

Mr Dinkler: Maybe I can answer that: probably not, because the sample is just too small. We can say, however, that the majority of people who answered were females.

CHAIR: You make a number of recommendations, and you have spoken a little bit about mandatory cultural awareness training or cultural safety training. I know that you have already articulated that you have been

working with the colleges and medical schools, and I am wondering how the mandatory nature of that is being accepted, and whether there is some progress there in terms of making sure it is mandatory.

Dr Armstrong: From a New South Wales perspective, which is where I live and work, cultural safety training is mandatory. It is mandated at all levels of staff no matter what the profession is so, certainly, it has been accepted from the high levels and put in place. It includes both face-to-face training and online literature and activity-based training, and I think I have seen some positive influence from that. I have seen more people say no and refute racism when it happens, but that is not to say it has solved the problem.

Dr Rallah-Baker: I think there are two levels there. There is the level of the employer, whereby they are usually state departments, so they have their cultural safety programs. Then there is the level of the colleges as private institutions, and my understanding is that it is variable between them—the degree and amount of cultural safety training that is available.

Mr Dukes: I agree with Kris that it is variable across the colleges, but I think there is a general acceptance, particularly through the national work through the Committee of Presidents of Medical Colleges, that there is an appetite for this to happen—to have culturally safe workplaces or systems that actually support Aboriginal and Torres Strait Islander specialists and the training of Aboriginal and Torres Strait Islander people. From my experience, even though I am fairly new in the role of CEO, there is an acceptance, or there is an appetite, for this to happen. I think it will vary in the take-up between the colleges but, because it is on the agenda through the CPMC it will take hold, I think it will be accepted as part of the training program through the specialist colleges, eventually. I am fairly confident of that.

CHAIR: It seems to me that that also goes on with the zero tolerance approach to bullying, harassment and racism on a national level. In terms of progressing that recommendation, what steps are you taking and where are things up to in terms of implementing that zero tolerance approach? And what level of support are you getting from the colleges and the schools? I know it is closely associated with the other issue.

Mr Dukes: They are associated, yes.

Dr Tatian: I think the nature of the beast here is: how do you implement a zero tolerance policy in the context of the hierarchical medical system that exists? It is a lovely kind of theory, but its translation is something that I am very much looking forward to seeing. Our membership expressed that more senior people are doing the bullying, and a complaint against the senior person who is the person who will select you or will pass you in an exam makes that quite an interesting theory to see in practice.

CHAIR: I was just bearing in mind the evidence that we received from the students' association about the ingrained nature of it, and even having 50 per cent of students believing that that is beneficial and necessary to turn out good doctors. It seems to me that there is a bit of an automatic conflict there if you are already getting people saying, 'Well, it's part of being a doctor.' Is it?

Dr Rallah-Baker: I think it is something that is ingrained from very early on in medical school that you try to avoid rocking the boat, because of the significant power imbalance between individuals and the wider system—as Artiene suggested, the medical hierarchy. That is, I think, the big challenge: addressing the power imbalance so that people who do wish to make complaints are protected from punitive action which could, in the worst case, curtail or stop their chosen career or their chosen area.

CHAIR: So then how do you address that? I take from what you are—

Dr Rallah-Baker: My feeling is that at the moment, particularly for post medical school, there is no circuit-breaker for complaints. The complaints are dealt with internally within private organisations. Some organisations are better at dealing with those complaints than others, but it is an entirely internalised situation.

Dr Tatian: Flowing on from the idea of a circuit-breaker, I think there is much of this fear around reporting bullying in the membership, which stems from the fact that the people who you might wish to complain against in the medical system are the people who will select you for a college training pathway. I think that is somewhere maybe to have a circuit-breaker in there—that there is safety for people who do report, and there are not those repercussions later on in life. That is something that we heard from the membership as well.

CHAIR: Have you discussed that circuit-breaker with the colleges?

Mr Dinkler: No. I do not think we are quite at that level yet.

Dr Tatian: I think that is not an intrinsically Indigenous issue either. I think that stems through the entire cohort of doctors.

CHAIR: That is certainly what has been coming out of the evidence—that there is not a mechanism there for that. But you have the added element—from your submission and your comments today—of the racism element, so your doctors and students are copping both.

Dr Tatian: Yes, definitely.

Dr Rallah-Baker: Yes, I agree. That is true.

CHAIR: We were asking about dropout rates. Are you noticing a higher dropout rate for Aboriginal and Torres Strait Islander medical students or early young doctors because of the racism and the bullying and harassment? I know they are also linked.

Dr Tatian: I think the answer to that question is yes, and I very much believe that the statistics are higher in the Indigenous doctors population than in the non-Indigenous doctors population. Starting at medical school, we already have a quite high rate of people not progressing to the end of medical school, so graduating an Indigenous doctor is such an amazing feat to begin with, and then the doctors who are coming out on the other end of the spectrum as well, who are experiencing these things, are also leaving, and many of them are not continuing in a pathway of medicine. I think part of that may be the concerns that they cannot pursue a particular career or a particular college that they see as being their goal and being something that they could do to give back to their Indigenous community. The other part is that people are feeling as though, with this bullying and harassment, the nature of medicine is not for them. I think the HETI workforce in New South Wales have recognised that. They have set up an Indigenous doctors forum, because we are losing our Indigenous junior doctors. I know that this year we have lost another one who has left medicine as well. In a cohort of so few Indigenous doctors, to lose even one is an incredible loss.

CHAIR: And that is just in New South Wales, you said.

Dr Tatian: Yes.

CHAIR: Does anybody have any experience in any of the other states that they are doing a similar sort of forum?

Dr Rallah-Baker: There is nothing in Queensland. I think it is fair to say, from the membership, that even if we were to reach parity in terms of people succeeding and getting through programs, I think it is true to say that, for those going through training programs, in general it takes them longer to get through.

Mr Dukes: I think it is not only really hard to give evidence and data on the exact numbers of Aboriginal and Torres Strait Islander people coming into medicine but also really difficult to get data on comparing that with completion rates. One of the things we are working with the medical deans on is looking at how we can get better data around Indigenous enrolments, Indigenous completions and comparing the same things.

CHAIR: Thank you for your evidence today. It is very much appreciated.

KANE, Dr Donald William, Chairman, Health Professionals Australia Reform Association

[12:07]

Evidence was taken via teleconference—

CHAIR: Welcome. Could I confirm that you have been given information on parliamentary privilege and the protection of witnesses and evidence?

Dr Kane: I have.

CHAIR: I would like to invite you to make a short opening statement and then we will ask you some questions.

Dr Kane: I have nothing more to offer as an opening statement, apart from what I have put in my submission. I realise that you have quite a number of submissions, and some of the submissions, I understand, have come—

CHAIR: Sorry, we have a crossed line or something. Is there someone in the background on a phone or speaking where you are?

Dr Kane: No, I am cocooned away in my own home in my study.

CHAIR: We are just going to have to check what is going on because I am finding it very difficult to hear you with the crossed lines that we have.

Senator DUNIAM: Maybe there is a radio going.

Dr Kane: No, I have no radio going in my house at the moment.

CHAIR: Ah! It is the recording of proceedings playing again. I swear I have not touched a thing! It seems to have stopped now. Dr Kane, when did you send your submission in?

Dr Kane: Only very recently. I anticipated putting a submission into the inquiry that was in the 44th Parliament but the double dissolution election meant that I did not get it in.

CHAIR: Could you go over some of the points that you were making in your submission, and then we will ask you some questions.

Dr Kane: The main point I want to make is that the authority, AHPRA, is not functioning as it should. That needs to be seriously looked at with regard to the regulation of health professionals. The HPARA, our organisation, represents a broad section of health professionals. The problems that exist, from our point of view, are across the whole sector; there is no one sector that is more damaged than any other.

CHAIR: Do you mean it is across the board?

Dr Kane: Yes, that is right. It includes allied health, nurses, psychologists, dentists—the whole box and dice of health professionals.

Senator DUNIAM: Dr Kane, sorry, but I have not received your submission either. Based on what you are saying and the point you make about AHPRA not functioning as it should, are you able to elaborate on that a little bit more with some specifics?

Dr Kane: Yes. Without quoting particular cases, because so many of them follow the same modus operandi, the AHPRA processes are flawed. There is improper use of mandatory notification. These notifications as they concern our members are vexatious in most cases. They are not related to clinical issues, but more related to personal and commercial interests of the people making the complaints. What happens is that AHPRA quite precipitously applies conditions in many, many cases to people's registration without going through a proper investigation first. For a person who is the subject of a complaint this is very damaging, because it appears on the public website of the regulator and it causes a lot of distress. There is the denial of natural justice, fair process and presumption of innocence with regard to how AHPRA deals with things. I know of one particular case where this action of AHPRA was challenged by an individual in the Queensland QCAT, and the appeal was successful on his behalf. It was stated by the presiding justice that he had been denied natural justice. That applies to quite a number of our members.

The other thing is that the use of sham peer review is quite right, but by AHPRA and by people who make so-called mandatory notifications. The whole system really is compounded by the fact that the legal representation provided by indemnity insurers for these people is ineffectual. These people quite often fail to challenge AHPRA, but merely act as a conduit for relaying requests from AHPRA to the individuals concerned for responses. The professional bodies, I think, carry a big responsibility for not representing members in this sort of area. The AMA and the colleges seem to have forgotten about ethics and professional behaviour and concentrate more on

membership and their budget bottom line. It hurts me immensely to have to say that, having been a member of the AMA and a member of the royal college for quite some time.

Senator DUNIAM: You talk about processes. In terms of personnel, we are told that the chances are there is no—or at least very little—visibility of the qualifications of those who conduct the AHPRA investigations. Do you have any insight into how they operate and who these people are and what sort of background they have?

Dr Kane: Some. The impression I get is that they are not well qualified to be in the positions they are in, and the use of sham peer review both by AHPRA and by people who lodge complaints to AHPRA, be they administrations or individuals, is quite a common practice, and it is very, very damaging. They do not seem to have the expertise to realise that a health service, whether it be in medicine, nursing or otherwise, is very complex, and if you have reviews done by people who are not actually expert in the work of the person that they are reviewing, you are very likely to get a review that is not as it should be, and AHPRA does not seem to have the wherewithal to recognise that.

Senator DUNIAM: Thank you very much for that.

Senator XENOPHON: Thank you very much for your submission. You have a number of medical practitioners in your association from various specialties and the like. How representative would you say your group is? Does it represent doctors in a number for states?

Dr Kane: Politicians like to talk about a broad church. We are a broad church, as far as health services are concerned. On our committee we have members from quite a number of different organisations or professions, and that is the way that we have purposely formed the association.

Senator XENOPHON: I want to go to some of the terms of reference. Do you think benchmarking would be appropriate in some cases? Where there has been a complaint against a medical practitioner, there ought to be some objective benchmarking of outcomes before there is a final decision made about the veracity or otherwise of a complaint.

Dr Kane: Before we get to the final decision, there needs to be a look at the immediacy of the action that AHPRA takes, without looking into the complaint.

Senator XENOPHON: Do you say that involves an improvement in processes? We do not want to go into specific cases, other than to look at systemic cases. Are you saying AHPRA is taking too long to resolve matters, or are you saying that when a matter is being investigated they are not clear as to what needs to be done? What do are some of the headline issues that your association thinks ought to be addressed as a matter or urgency?

Dr Kane: I think AHPRA has to look at their processes and, as a matter of fairness and natural justice, ensure their processes and the presumption of innocence is in effect right from the beginning. There seems to be an assumption that these people are guilty. I can give you one very poignant example of that in the case of a Queensland member of ours who had a cascade of complaints put in against him for commercial and personal reasons. AHPRA immediately placed conditions on his registration. Then he was subjected to having to work under supervision and be closely monitored. He complied with all that the whole time. There were no faults found with individual audits of his that he had organised on a biannual basis prior to this, and the supervisers who were put in place by AHPRA found no problem with any of his work.

In the end, that practitioner was reduced to considering suicide. He then departed the country and went back to his native land where he is now practising successfully in the specialty that he occupied here in Australia. What do you know? Two years and one month after the original complaint was made, AHPRA revealed their decision. The decision was that he had no case to answer in any of the multiple complaints that were put in. They then went on to criticise the people who had placed the claims into AHPRA. I do not see AHPRA taking action against those people for vexatious claims or whatever turns out to be a very malicious act.

Senator XENOPHON: No, and that actually is a public case that was featured on *Lateline* involving Dr Emery, but I think the issue there is that it took so long for the complaint to be resolved. You mentioned a QCAT—

Dr Kane: That is not the point. It is not that it took so long; the complaint is about the complaint against him right from the very beginning. That is the nub of the problem. If it had been handled properly right from the beginning, there would not have been any debate like that at all.

Senator XENOPHON: Sorry: I am making it clear that the delay is part of the problem in the way that the complaint was handled, was it not? There wasn't procedural fairness in your view—is that what you are saying?

Dr Kane: A complete lack of procedural fairness.

Senator XENOPHON: You mention a QCAT case that ruled that the AHPRA process had denied procedural fairness. Is this the case you are referring to or was that another case?

Dr Kane: No, that is another case and—

Senator XENOPHON: Can you tell us—

Dr Kane: there was no natural justice—that was the finding of the judge. That is a case that is well known. It is in the public arena.

Senator XENOPHON: If it is in the public arena, what is the name of that case, please?

Dr Kane: That person is a Dr Vega Vega who practised in Rockhampton. The upshot of the whole thing was that AHPRA was ordered to remove the conditions on his registration. He then resigned from his public hospital position and went into private practice. His wife, who was a very highly regarded cardiologist in the area, did the same. So the public sector lost two very experienced and skilled professionals, and I do not know whether that public hospital has replaced them or not.

Senator XENOPHON: How long ago was that? Was that about two years ago?

Dr Kane: It is not all that long ago. It would have been around 18 months ago—I would have to look up my records.

Senator XENOPHON: If you could assist the committee with the details of that, that would be helpful. Finally, has your association attempted to engage with AHPRA about your concerns; if so, what was the outcome of those approaches; and, if not, will you be doing so as a matter of urgency?

Dr Kane: It is a very difficult organisation to talk to. I know that several of our members have talked to the senior executives in AHPRA. I am told, from the results of their conversations with them, that the outcomes are very disappointing. AHPRA seems to be an organisation that is more interested in protecting itself than looking at ways of improving itself.

Senator XENOPHON: If you do go down the path of, as an association, meeting with AHPRA and setting out your concerns, could you please let the committee know, if it is in the near future.

Dr Kane: I can certainly do that, but we have a lot on our plate at the moment. To me, that would be a fruitless exercise, because several of our committee members have already tried that and it turned to dust.

Senator XENOPHON: Okay. Finally, if you have any documents or any material that confirms approaches to AHPRA and a response that you consider to be unsatisfactory, I would be grateful if that could be provided to the committee, as it may be of relevance.

Dr Kane: I would be very happy to do that, if I can find it. The other thing that has to be looked at is the indemnity insurance industry at the moment. It is just not fulfilling its function for members, who pay high annual fees to be represented. They are really getting a dud deal.

Senator XENOPHON: Thank you.

Senator DASTYARI: Thank you, Dr Kane, for your evidence so far this morning. I am not sure if you had an opportunity to listen to all the evidence that was given earlier today through the internet porthole?

Dr Kane: No, I didn't.

Senator DASTYARI: We have a panel of doctors this morning and they touched on some of what you touched on, which is—I guess 'frustration' is probably understating it—the effects of vexatious complaints and vexatious disagreements being played out in this arena and the damage they can do to reputations and careers. The system seems to be geared such that the person making the complaint bears no responsibility. I note that the eighth of our terms of reference is 'the desirability of requiring complainants to sign a declaration that their complaint is being made in good faith'. I wonder if you can expand on that. It is one thing to have people make a declaration or a statement, but I wonder how something like that could even be policed or looked at. I would hate to see you create a system where you have a form that people have to sign, but then who is responsible for looking into that? It could all become circular. I do not know if that was a clear enough question, but could you talk to that point?

Dr Kane: Yes, I am quite happy to talk to that. The thing about it is that it is difficult to get the message through to AHPRA that they are on the wrong track. The colleges and the AMA seem to no longer place a high priority on ethics and professional behaviour. Quite some time ago, that was high on their list of priorities. They would come down like a tonne of bricks on anyone who transgressed. Now they do not seem to worry about it.

Several of the colleges have a lot to answer for, from that point of view. I think the AMA as well has not been forthcoming. For example, I knew personally a former president of AMA Queensland, gave him a briefing on

what had been happening in Queensland and asked him if he could get the AMA to address the whole problem. He took it away—that would have been about two or three years ago—and I have never heard from him since. So that is the sort of disinterest in these organisations that is really contributing to the problems that we are having with the regulatory authority.

Senator WHISH-WILSON: One of the most important things the committee has to determine from today's hearing is whether the issue we have heard about is systemic or whether these are isolated cases. Could you comment on whether you think it is a cultural problem and whether this is widespread?

Dr Kane: As far as HPARA is concerned, it is systemic. Everyone would agree that you need regulation—but it needs to be done properly, and that is not happening.

Senator WHISH-WILSON: As to the previous system, before AHPRA came into existence, do you think that worked better? Or is there some kind of compromise we need to make between the two types?

Dr Kane: No, there were still problems when you just had the state medical boards; there is no doubt about that. But I think the centralisation of AHPRA, even though they have state branches and things like that, contributes to it because it makes them more remote. I will give you an example. With regard to the previous case I mentioned that took two years and one month to resolve: I went to the Queensland Office of the Health Ombudsman to get an appointment to sit down and talk to him about that. The people on the front desk said that he was not available and they would ring me and let me know. I got a phone call a few days later to say that he did not want to meet with me. I find that absolutely appalling from a public official. That is the sort of barrier that you have to jump over to try to get this fixed, and then, when you do jump the barrier, you find that you have wasted your time.

Senator WHISH-WILSON: We talk about vexatious claims. I am not sure why people might make frivolous claims through this system. Do you believe that there are vested interests using the AHPRA process to get outcomes?

Dr Kane: That is definitely the case. These people are misusing AHPRA for their own personal reasons. It is very rare, if ever, that AHPRA have taken action against people who have lodged vexatious claims. There is an absolute abuse of the mandatory notification process. It was put in there in the guise of being in the public interest, but really it is in the interests of the people making the complaint.

Senator WHISH-WILSON: In terms of how AHPRA works, do you think it is an issue with the actual boards, or do you think the investigators do not have sufficient training or background or guidance?

Dr Kane: That is part of it, but it is much broader than that. The issues are: the behaviour of people who make these sorts of complaints; the support that their professional organisations give them, which is poor; the legal representation they get from the indemnity insurers, which is poor—it transgresses a lot of areas. It is a very broad problem, and there is not one simple fix to it. To the mind of our committee, the only way that you are going to get to the bottom of this problem is to have a legal inquiry into it, and it would seem that a royal commission would be the way to go there, because what is happening in the health services area is as bad as what has happened in other areas that have had royal commissions, such as the unions or the sexual abuse areas. These people are mostly highly intelligent—they have a high intellect—and are very difficult to deal with when they go feral like this, and the way to deal with it is to get them into a situation where they are bound to give evidence on oath and sort it out that way. It is such a wide-ranging area where there are problems in a heap of areas that need to be sorted out, and you need to get people where you can extract the proof from them.

Senator WHISH-WILSON: Do you have any idea about using the AHPRA complaints process around malpractice or issues relating to harm? How many applications are genuine?

Dr Kane: A lot of the complaints that I am talking about that concern our members are not to do with malpractice; they are due to the fact that someone has taken a personal dislike to someone because they are looked upon as either a threat to their status or a threat to their income. In the case of the fellow from Townsville who went back overseas, he was head of the Asia-Pacific education program and with the orthopaedic spinal association. He has a world reputation. They just destroyed him. He wanted to stay in Australia. He was married to an Australian lady. Their two children were born in Australia. They just wore him down. I must say that the administration of the local private hospital where he worked in Townsville has a lot to answer for in this case. The director of medical services there who stood by this fellow suffered the same fate. He resigned because he could not tolerate the attitude of those people or the administration at the hospital. This has huge ramifications in a hell of a lot of areas.

Senator WHISH-WILSON: Dr Kane, in terms of different people bringing complaints or requests for investigation to AHPRA, we have heard evidence today that some of that may be from other medical

professionals or it may be from the hospital administration, but presumably a large number of them are victims or potential victims of some kind of malpractice. In terms of the committee's recommendations and how AHPRA has evolved, how do we not throw the baby out with the bathwater if we are recommending a different structure?

Dr Kane: If you are going to have AHPRA as the organisation, it has to be thoroughly looked at and cleansed and robust structures need to be put in place to deal with things properly. You need people on the front line who really do understand how health services work and what is right and what is wrong. I can digress a bit here, I hope. We have taken several cases to the ACCC. They obviously realise that there is a problem but because what we put before them does not fit within the statute for them to take legal action against these people, they have been unable to do so. In their report, they advised people to take legal advice. It is a very difficult problem to deal with.

Senator WHISH-WILSON: Would that be around false and misleading claims or unconscionable conduct in terms of referring things to the ACCC?

Dr Kane: We were talking to the ACCC because, in the cases that we went to them with, it was obviously an attempt to stop these people from being in competition with these other people who had lodged the complaints.

CHAIR: Dr Kane, you took quite a number of questions on notice. The secretariat will be in contact with you about the details of providing that.

Dr Kane: I am happy to provide information as required. We have records that we can make available but probably not in a public arena such as this.

CHAIR: Thank you very much for your time today. We will be in contact with you very shortly.

Proceedings suspended from 12:39 to 13:27

BIVIANO, Mr John, Director, Fellowship and Standards, Royal Australasian College of Surgeons

FROST, Professor Gavin, Dean of Fellowship Education, Royal Australasian College of Medical Administrators

ILOTT, Mr John, Chief Executive Officer, Australian and New Zealand College of Anaesthetists

SMITH, Mrs Linda, Chief Executive Officer, Royal Australasian College of Physicians

YELLAND, Dr Catherine, President, Royal Australasian College of Physicians

CHAIR: Do you have information on parliamentary privilege and the protection of witnesses and evidence?

Dr Yelland: Yes.

CHAIR: We have your various submissions, thank you. I invite whoever would like to make an opening statement to make and opening statement and then we will ask some questions.

Mr Biviano: Thanks for the opportunity to present at this inquiry. The Royal Australasian College of Surgeons is the leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand. We represent over 7000 surgeons and 1300 surgical trainees and international medical graduates. The college, or RACS as it is typically known, acknowledges that there is no doubt that bullying and harassment occurs in the surgical workplace and takes very seriously the subject of this inquiry.

Over the past 18 months, in particular, our college has dedicated enormous resources to ensuring a comprehensive response to this issue. Every individual has a right to a healthy workplace. Discrimination, bullying or sexual harassment demeans individuals and prevents them from reaching their true potential. Sadly, it is also the cause of a great loss of invaluable talent from the health sector. This insidious and unprofessional conduct cannot be tolerated. We welcome the opportunity to participate in this inquiry to share our experiences and to assist in any way we can.

By way of background, media reports profiling discrimination, bullying or sexual harassment by surgeons were first published in late 2014 and continued throughout 2015. In response, the college appointed an independent expert advisory group in March last year to look at the prevalence of discrimination, bullying or sexual harassment in the practice of surgery and to understand the extent of the problem in Australia and New Zealand. So we commissioned a lot of research, both qualitative and quantitative. Amongst all our fellows, trainees and IMGs, it found that 49 per cent of these people had experienced some form of discrimination, bullying or sexual harassment—I will abbreviate it to DBSH, if that is okay. Sixty-three per cent of trainees had experienced it; 30 per cent of women had experienced sexual harassment; and 71 per cent of hospitals experienced this form of harassment by surgeons. Many international medical graduates also reported discrimination.

The expert advisory group provided its final report to RACS in September last year, which outlined that the college needed to do much more to prevent and address DBSH in surgery. The college accepted in full the 42 recommendations in the report and made an unreserved public apology to anyone who had suffered from discrimination, bullying or sexual harassment in the practice of surgery. In brief, the report found that there is a sense of no consequences for perpetrators. The fear about the impact on career or training of making a complaint effectively stops people from reporting complaints or speaking out. Hierarchy and power are central issues. There is a lack of any mechanism to raise and address concerns or issues early, which means that they are either escalated into formal complaints or not addressed at all. Despite their legal obligations, hospitals are reported to be reluctant to take action on badly behaved surgeons for a range of reasons.

We kept hearing that some offenders unwittingly reproduce behaviours they have learned from previous role models, and this is quite typical. Others are more deliberate or determined perpetrators, often with a reputation for misbehaviour that frequently goes unchecked. So in November last year we launched an action plan—and I have brought copies of the action plan here for you—and in response to the recommendations. The action plan is a comprehensive approach designed to promote respect, counter discrimination, bullying and sexual harassment in the practice of surgery and improve patient safety. It is actually called 'Building respect, improving patient safety'.

We will be reporting publicly each year on what has been done and what has been achieved. There are three key areas of work. One is around cultural change in leadership, which is about taking a stand. We cannot do it alone; this is about working with partners to influence the agenda—hospitals, health departments and other colleges. We have an 'Operating with respect' campaign in hospitals as part of this agenda. The second key area is surgical education, which is about the principles of respect, transparency and professionalism. We have mandated a number of courses for surgical educators on how to teach and build in awareness of DBSH. The third area is

complaints management. How can we improve this area in a fair, timely and transparent manner? The college now has a comprehensive complaints management system with dedicated expertise and centralised reporting.

On other issues, the oversight of health professions is complex and difficult to navigate. It involves medical colleges, health departments, hospitals and regulators, including the Medical Board of Australia and AHPRA. There is a clear lack of coordination between these bodies and fragmentation of the system. One of the key findings from the expert advisory group was that the responsibility to end a culture of bullying and harassment does not reside with any one individual or entity. Employers, hospitals, governments, health professionals, industrial associations, regulators and other partners in the health sector must all commit to sustained action. While each of these groups can and should develop individual solutions, at the core of the issue is the need for cooperation and collaboration across the health sector.

In terms of benchmarking complaints about complication rates and so forth, we welcome the publication of surgical outcome data, and every effort must be made to ensure that what is published is reliable and is in a form that facilitates interpretation by those for whom it is intended. The best way to achieve this is to fund audits and registries, use agreed definitions for disease, procedures and outcomes and ensure that everyone is able to understand, interpret and value the reports. RACS certainly supports the public release of outcomes based data on surgical performance at a team, institutional and national level—but there are caveats. The reports need to be valid, reliable and trustworthy so that surgeons and patients can be confident that the reports accurately reflect the standards of health care. RACS does not recommend the release of reports on individual surgeon performance as there is so much dependence on surgical teams and institutional support in the delivery of surgical care. Thank you.

Senator XENOPHON: Chair, I do have a copy of the report online but is it possible to get copies now?

Mr Biviano: Yes. We have copies here for you.

CHAIR: You have finished, haven't you?

Mr Biviano: Yes, I have. Thank you.

CHAIR: Dr Yelland.

Dr Yelland: On behalf of the Royal Australasian College of Physicians, we considered the terms of reference of the committee, and I will speak about two terms of reference particularly relevant to the role and the work of our college. They are the prevalence of bullying and harassment in Australia's medical profession and any barriers whether real or perceived to medical practitioners reporting this bullying and harassment. My comments to the committee today relate specifically to the physicians and trainee physicians who are often referred to by the public as 'medical specialists'.

The college is a professional organisation for about 16,000 physicians, whom we call fellows, and nearly 8,000 trainee physicians in Australia and New Zealand. We are an educator, not a regulator. We are responsible for the training, examination and specialist accreditation of physicians, and we set the standards of clinical practice for physicians practising in Australia and New Zealand. We also oversee continuing professional development of fellows. We educate our fellows and trainees on behaviours ensuring safe patient care and the best learning environment for our trainees. We regard bullying and harassment as unacceptable, and the college has no tolerance of these behaviours. We work to prevent and mitigate the risks of their occurrence with our members and other organisations, including employers. However, training by the college takes place in the workplace such as hospitals and health services and they are not controlled by the college. We do not employ the supervisors or the trainees. They are employed by their place of work. But we do have some influence in their workplace, including through accrediting workplaces as suitable places for training.

What we are doing about bullying and harassment: we aim to ensure that trainees are well supervised and supported. We have well-documented policies and processes, including a code of conduct, complaints mechanisms and a robust education program for all those involved with trainees. During 2015 we responded to the concerns about bullying, harassment and discrimination across the medical profession, and our board set up a working party to further ensure our current systems, policies, procedures and practices were robust. We strengthened our complaints response process and we appointed an external company to provide fellows and trainees with confidential independent advice. We have developed an additional e-learning module on bullying and harassment for fellows and trainees and we have clarified the steps for trainees so that they understand what they can do to resolve a problem with their supervisor.

Our ongoing work: these responses were built on existing measures which were already in place. We have a program called the Supporting Physicians' Professionalism and Performance. The guide gives practical guidance to all physicians on expected standards of professionalism. We continue to develop resources supporting and

strengthening the philosophy underpinning this guide. In 2012 the pilot of the Supervisor Professional Development Program was launched. Its first full year of operation was 2014. It is three workshops that give supervisors core skills so that they can effectively supervise trainees. This includes practical skills, setting the culture for learning, feedback and performance, and providing feedback in challenging situations. The workshops are well attended and highly regarded.

There is significant evidence in Australia and overseas that bullying and harassment are a problem across all healthcare professions. We can provide more detail if required. We regularly survey trainees, seeking feedback on the quality of their training, supervision and support. We may include questions on bullying and harassment in the future.

In summary, we continue to strengthen our education programs and policies designed to prevent bullying and harassment within health care. We regard these as wholly unacceptable behaviours. We continue to work collaboratively with our members and other colleges as well as employers to respond proactively to these matters. Thank you for the opportunity to talk to you today. The CEO and I are happy to take questions.

Prof. Frost: The Royal Australasian College of Medical Administrators is one of the smaller colleges. We have around 900 fellows and members. As with my colleagues, our college has zero tolerance for harassment and bullying of any kind and our policies and procedures clearly set that out. As Dr Yelland has also said, we do not employ our trainees or our fellows in the workplace and we also understand the obligations of the workplace to assist in the stamping out of harassment and bullying wherever it may occur. We also have the possibility, through the accreditation of our training posts, as Dr Yelland has said, to ensure that procedures and processes are clearly in place in a workplace before we grant it accreditation for training of our fellows. I am happy to answer further questions as well.

Senator XENOPHON: Chair, can we get a copy of Dr Yelland's opening statement? It is just there are some aspects of it that I may wish to refer to in questions.

CHAIR: We will get some copies of that.

Mr Ilott: The Australian and New Zealand College of Anaesthetists has approximately 6,000 members, including the Faculty of Pain Medicine. Colleges have an important role to play, and one of the barriers that is being highlighted is the fact that bullying, discrimination and sexual harassment are actually cultural issues that needs to be overcome. ANZCA is addressing that through addressing the cultural issues, and it has strengthened the trainee program and also the CPD program.

ANZCA also provides support for notifiers and fellows, and believes that there is a genuine fear within employing hospitals among supervisors of training, not just the notifiers of BDSH but also amongst supervisors of training. We take very seriously our support for the people who are acting in a training capacity on behalf of ANZCA within hospitals. We are receiving considerable anecdotal evidence that if a notification of bullying and discrimination is received, then it is seen as a career-limiting complaint for a supervisor of training even if it is found that it may not be substantiated. Lasting improvements can only be achieved with the cooperation of the health services in both private hospitals and public hospitals.

When we considered the Medical Board of Australia and AHPRA we made a number of comments in our submission, and we reiterate here that there is a need for prompt resolution of notifications. The effect on practitioners in the system that we have is quite considerable. While we do not know how many notifications are eventually not proceeded with, it is a very stressful time for all practitioners who receive notifications against them. We believe that DBSH can constitute patient safety issues and we are not sure that the Medical Board of Australia acknowledges that to the extent that we do.

ANZCA, like all the medical colleges, is a standard-setting body. We believe that there is an important role for the colleges in working with the medical regulator in maintaining standards, and particularly in the area of remediation of doctors who are found to be falling short of the appropriate standards. We enjoy a sound professional relationship with the Medical Board of Australia and the Medical Council of New Zealand. It should not be overlooked that most of the medical colleges in Australia are binational colleges. The important role of the colleges should not be diluted by the formation of more co-regulatory jurisdictions. While we understand that this is a state matter, we would like to place on record that we support the principle of a single national regulator. Thank you for the opportunity. I am happy to take questions.

CHAIR: Thank you.

Senator DUNIAM: This was referred to in the opening statement from RACS. I think it was referred to as a fragmented relationship between the colleges and AHPRA. What is the arrangement between the colleges and

AHPRA? Is there a formal arrangement? Is there anything you could explain to us about how the interrelationship works?

Mr Biviano: I guess the context there was in relation to complaints management. What we found is that, in relation to complaints, depending on the nature of the complaint, it is difficult in terms of that relationship with AHPRA. We have actually had discussions with the regulator about how we can collaborate better in this area so that, if they are aware of a complaint early, we can share information at an appropriate point. These are very early conversations that we are having, but what we are saying is that we can work better together to resolve these complaints much earlier if we have a mechanism for doing that. At the moment we often hear about the complaints much later in the piece. We would rather hear about them earlier.

Senator DUNIAM: A number of submissions have referred to problems with peers and complaints lodged. What do you mean by the college being involved in the complaints process earlier? What role do you see the college having in the work of AHPRA when it comes to complaints resolution?

Mr Biviano: I am referring to where there is an issue with a particular practitioner. Often what happens is that it is notified to AHPRA, and we would like to see a much more timely response in terms of us notifying them of the problems with that particular practitioner. It is really timeliness more than anything else, and having that much more up-front as opposed to finding out much later in the piece, if that makes sense.

Senator DUNIAM: So the college is in charge of informing the practitioner who has a complaint lodged against them—is that right—or does AHPRA direct the communication?

Mr Biviano: No. Normally the complaints that AHPRA get are about a person's competence and they concern patient safety. Some of the complaints that colleges get are a little bit different in that they may refer to behaviours and they are things that would counter our code of conduct. The complaints that AHPRA get are the ones that concern patient safety, just to be clear.

Senator DUNIAM: Okay. The timeliness issue is a big one and everyone has raised that. That is a pretty clear one. In terms of the view that everyone has expressed, that bullying should not be tolerated, what sorts of tangible changes have you made—and a number of you may wish to respond—in terms of trying to address that? Obviously it is a cultural change, but are there any specific measures that any of you have in place to deal with these things, be it training or ramifications for members who are caught bullying?

Mr Biviano: I might just make a few comments and then open it up to others, because I do not want to do all the talking. If you have a look at our action plan, which is widely available on the web, there are three main areas that we have tackled. Just to cut to the chase: we are working very closely with the health departments in terms of making sure that everyone has got a strategy around how to counter discrimination, bullying and sexual harassment. We have been going around talking to all the health departments and talking to a lot of the hospitals. We are developing memorandums of understanding to work together in three key areas about how to change the culture. Education and training: we have mandated courses for our surgeons who are involved in education. One of the issues was that surgeons, while brilliant technically, clearly had a gap in terms of communications skills and the softer skills and how to teach. Now every surgeon that is involved in education has to do a mandatory one-day course on basic adult education principles, how to give feedback and so forth. We have also mandated two other courses. One is about how to build awareness of discrimination, bullying and sexual harassment. That is an e-module. We are also working on a face-to-face course, which is a one-day course and will be mandatory for all our supervisors. Again, that is about awareness and also how to deal with discrimination, bullying and sexual harassment, how to give feedback and so forth. The other key area is complaints management, where we have devoted more resources. We have employed a psychologist to manage that complete area. We have a centralised database and a centralised process for it. We have different pathways that we are utilising to resolve complaints.

CHAIR: That is complaints to the college?

Mr Biviano: Yes, complaints to the college. That can be complaints about fellows, or complaints from trainees against fellows, or complaints from the public against fellows or trainees, and so forth.

Mr Ilott: In addition to what John Biviano has already said, our college has strengthened the internal professional conduct framework. We have also established a centralised complaints-handling process, which is for complaints to the college. While our education program has not been as extensive as that of RACS, we acknowledge the generosity of RACS in providing much of the material that they developed at their own cost, which has been made available to other colleges.

Mrs Smith: There are a couple of things I would say in relation to this. One is that we took the opportunity, when things came to light, to look at what we were doing and ensure that it was sound. There are some changes that we have made. We improved our supervisor training workshops that deal with this topic, and it is compulsory

to complete these workshops to be a supervisor. We are introducing education leadership and supervisor support, which is a new process that allows identification of inappropriate supervisor behaviour and a process of working with supervisors to change behaviour. We are in the final stages of producing 'Creating a safe culture', a new e-learning resource for fellows, plus online curated learning collections on bullying and harassment. We have extensively assessed the resources other colleges are providing in light of what the College of Surgeons are doing. The College of Surgeons have been very generous in allowing anyone to talk to them about anything and also, as John said, sharing. The other thing that the College of Physicians did, as mentioned by Dr Yelland, was to implement a confidential online support service for our fellows and trainees. They can access that 24/7, and it is not just limited to problems they may be having in the workplace; they can access it over anything. That has been received well and is ongoing.

CHAIR: Professor Frost, did you want to add anything?

Prof. Frost: Just what they said.

Senator GRIFF: Mr Biviano, I understand that the college has partnered with Converge, an external provider of counselling and support programs to surgeons. What does the program specifically do?

Mr Biviano: It is similar to the employee assistance programs that a lot of organisations have in place. We actually had this in place about two years ago. Basically it allows surgeons to ring up a number where they can have a confidential conversation and receive counselling on various aspects of what is happening in their lives, particularly around discrimination, bullying, sexual harassment, or issues they may be having. It is very similar to what is available in many hospitals, for example, but we felt that there was a need to have an independent service that was funded by the college.

Senator GRIFF: Does it have any investigative powers if there is an issue that they are aware of?

Prof. Frost: No, it does not. We do receive regular reports from Converge but they are confidential reports. It is a confidential service.

Senator GRIFF: Is the service available to trainees?

Prof. Frost: It is, yes.

Senator GRIFF: How many calls or incidents would they have?

Prof. Frost: I do not have the figures with me but we have had in the order of 30 or 40 calls in about six months. They are modest numbers but it will be interesting to see over time what happens with the numbers.

Senator GRIFF: Is your Let's Operate with Respect program still operational?

Prof. Frost: Yes absolutely. That is a campaign put in place again to raise awareness of the issue amongst all our surgeons. We have had some really good success with hospitals that have actually taken this up. We are cobranding with a lot of hospitals and so forth around this issue to generate awareness and to make people stop and think about how they are behaving. Again, it is trying to build that insight in people.

Senator GRIFF: How many people have completed that program?

Prof. Frost: It is a promotion, a campaign. We have sent out posters to all teaching hospitals so that is about 300 hospitals across both countries. We are working very actively with a number of different hospital partners that we have engaged with across the country. It has been going now since May.

Senator GRIFF: You have on your website a fact sheet of unacceptable behaviours. How many surgeons have been sanctioned by you for what is not just unacceptable but perhaps even illegal behaviour?

Prof. Frost: The numbers are very low at this point. What we are finding is that we are getting a lot of complaints very early on so we are able to deal with them. In terms of numbers, we are looking at up to five. It is very low at this point. We are finding that, of the issues that we deal with, we are able to deal with them by discussion very early on, by mediation. We have fellows on staff that we employ for those purposes, who work very closely with the manager of complaints resolution. A lot of these issues we are able to resolve fairly early on. We have an escalation process so when bad behaviours are reported we do ask fellows to sign a deed of agreement promising that they will not do it again. It is a way of trying to stop the behaviours from recurring.

Senator GRIFF: Prof. Frost, we have had reports of surgeons working in private hospitals who have physically assaulted nursing staff and prosthesis company reps because of their inability to regulate and manage their anger. When this happens, it appears that some private hospitals quietly refuse ongoing accreditation of that surgeon and that surgeon then moves to another hospital. Do you know if APRA requires mandatory notification when a hospital declines to renew or cancel accreditation for reasons other than—

Prof. Frost: I believe they do but I am not absolutely certain.

Dr Yelland: When you complete your registration form each year for APRA, there is a question about credentialing and if that has ever been refused that is for the practitioner to fill in.

Senator XENOPHON: On the question of whether it has been refused, the word 'refuse' can be fairly broad. It might be that they did not refuse it; they just suggested, 'Don't apply—otherwise, you'll be refused.' So they just do not apply. It could be done that way, couldn't it?

Dr Yelland: Don't quote me on the exact wording—it is a few weeks since I filled in my AHPRA form.

Senator XENOPHON: Yes. I am sure you were not refused. But there is an issue there, is there not, in that a doctor may be told quietly, 'We don't really want you back here, so don't apply'? We do not get to find out about those doctors who are not welcome back at some private hospitals. Is it fair to say that that could happen, Dr Yelland?

Dr Yelland: I do not personally work in a private hospital and I am probably not the one to answer that.

Senator XENOPHON: But the form does leave some latitude in it, I suppose.

Dr Yelland: I think I would probably need to have another look at the form and exactly how it is worded.

CHAIR: Let's get a copy of the form ourselves.

Dr Yelland: It is filled in online.

Senator GRIFF: Dr Yelland, earlier on you said you were an educator, not a regulator. You state that in your submission as well. Do you believe you should have investigative powers?

Dr Yelland: It is not really an issue that has particularly come up for the college. We manage settings and trainee issues through a number of processes, and one of those is accreditation. If there is a problem with a site, there may be various reasons for that. It may be the supervisor, it may be the type of patient load or it may be the educational program that is available. There are a whole lot of issues in accreditation. It is not necessarily the supervisor.

We can, at quite short notice, send an experienced team out to do an accreditation review. That will always, in those sorts of circumstances, include interviewing trainees. I do not know whether you call that 'investigative powers', but it is within our control. That team would certainly have considerable experience in accrediting settings and yes, they can recommend that the site have provisional accreditation. They can withdraw accreditation, and it is a serious issue for a hospital to lose accreditation—very serious. So 'power' is not quite the right word, but in fact we do have the ability to manage that issue.

Senator DASTYARI: Firstly, thank you so much for the evidence that you have given already. I have a couple of quick questions. Your associations obviously cross the Tasman. I am wondering if there is anything in the New Zealand experience that we should be looking at. You are obviously working across two jurisdictions. Are there examples there that we should be looking at as part of this inquiry? Should we be looking to them for some guidance? Do they do it better? Do they do it worse there? How is their structure different? I suppose that is the question I am asking.

Dr Yelland: Interestingly, in our discussions with the New Zealand board members and so on, this has been much more an Australian issue in terms of the attention that is has received. That is not to say that it does not happen in New Zealand, but we have applied our actions across the whole college. So they are just as important in New Zealand as elsewhere, but I am not aware that there have been specific issues in New Zealand for the physicians.

Mr Biviano: When we did our research and looked at the prevalence of discrimination, bullying and sexual harassment, we found no difference between Australia and New Zealand. So it was a similar issue in New Zealand when we looked at the numbers and we looked at the responses. Also, between the various states and territories it was very similar across the board. So the numbers were very similar. I guess the difference in New Zealand is that their government system is obviously different with one less tier. So that does help in terms of resolving the issues.

Mr Ilott: I think one of the things that we have noticed in the difference between the Medical Council of New Zealand and the Medical Board of Australia is that the Medical Council of New Zealand is more prepared to acknowledge that bullying discrimination is likely to constitute a patient safety issue.

Prof. Frost: Just briefly, all of the colleges represented here today, and all of the other colleges, if binational, undergo accreditation by both the Australian Medical Council and the New Zealand Medical Council. Part of that process involves assessment of our ability to handle the very issues we are talking about today, and both Australia and New Zealand are agreed that colleges need to have the processes demonstrable and carried out in terms of

their trainees and their fellows, in both the workplace and the training environment. So colleges also undergo assessment of their ability to deal with these issues.

CHAIR: Who does that assessment?

Prof. Frost: The Australian Medical Council, AMC, and the Medical Council of New Zealand together, if the college exists in both countries.

Senator DASTYARI: I am probably showing my trade union roots here, but it seems like you have, to an extent—and maybe I am misunderstanding this—dual objectives. On the one hand, obviously, you have a responsibility to maintain standards and to make sure that high standards are being reached by the association and by your fellows and members. At the same time—I do not know if pastoral is the right word—but you want to support and help the members and fellows to grow and improve and become better. Is that a fair assessment of the kind of dual responsibility? If it is, how do you reconcile managing those difficult responsibilities or objectives?

Dr Yelland: Of course we have a responsibility to the community and the patients, but we also have a very specific responsibility to trainees and to the supervisors who do the college's work on our behalf—they teach trainees, they supervise them, they fill in reports for them and they mentor them. If that relationship becomes strained, we have a responsibility to both sides, and our policies aim to provide fairness and support to both sides. We use the same Converge system as RACS. Anyone can ring that—a trainee or a supervisor. There are various sorts of ways that both parties can seek support. There is a director of physician education in each facility. There are training committees, with an experienced person chairing those, where advice can be sought. So there are many informal, workplace and college mechanisms to provide support on both sides. Plus, as we have said, there is the educational framework that we provide for supervisors and all the policies and the information that we give to trainees. So I think that we actually do try pretty hard to support both sides of this training-supervisor partnership.

Mr Ilott: I do not think that the dual role is in any way in conflict. I think, as we have all explained, we are dealing with a cultural issue. People have been brought up in different cultures and we are all trying to change that. Just because people were brought up in a different culture does not mean that they are bad doctors, and there is a lot of work that we can all do, and that we are all doing, within our colleges to support and change the attitudes of people around bullying and discrimination. If our internal processes do not work at a certain level, we can escalate. They might go to three or four different levels of escalation until we reach a point where this person should not be a member of the college. I am not aware that any of us has reached that point at this stage but, in that respect, it is no different from employees of an organisation. The organisation will gradually escalate levels of support and levels of discipline until it reaches a point where the relationship no longer works. But, as I said, I do not believe any of the colleges have reached that point at this stage.

CHAIR: I want to pick up on your last comment. I struggle with some of these issues. We had the Medical Students' Association before us today and they made some very strong comments, particularly about gender and bullying and harassment, including sexual harassment, of female students.

I am 55, so I am probably around the age of some of the doctors we are talking about. Ever since I have been through university and school it has not been accepted practice to pick on women, and we have had equal opportunity. So I do not accept that for most of the doctors who have come through the system it should be an accepted practice. It has been wrong for a long time. Yet the evidence we have received quite clearly shows that women, in particular, are bearing the brunt of some of this bullying and harassment, including sexual harassment.

What are you doing, specifically, about helping women and not accepting that this is a practice that needs to change? It is unacceptable and it has been for a long time. Sorry, I am pretty worked up about this. I am sure you heard the evidence given today that it is still going on. This has not been accepted practice for a long time; neither has the racism that the Indigenous Doctors' Association talked to us about. It has never been accepted practice—or not for a long time; sorry, I should correct that.

Dr Yelland: The first thing is that there is in no sense any way that any of the colleges tolerate that, in principle.

CHAIR: I hear what you are saying: in principle, but it is still happening.

Dr Yelland: How do we deal with it in the workplace? I work at one of those hospitals and yes, we do get those kinds of comments from time to time, or we witness those, and every single time we need to call out that behaviour. We also need students to feel empowered to bring that to attention. Very often, they simply tolerate that and it is not necessarily known about by anybody who can do anything about it. That is, I think, one of the challenges. The students will talk amongst themselves. The junior doctors will talk amongst themselves. Unless it

is witnessed by an administrator, a colleague, who is in a position to challenge the person and say, 'That is not acceptable behaviour,' it will continue.

We need to enable students, junior doctors and other employees in hospital systems to feel that there is somebody in whom they can confide and that there are formal reporting systems. If we do not know about it we cannot deal with it. A lot of it goes on, out of sight. I cannot challenge one of my colleagues unless I am aware that it has happened.

CHAIR: How do you make it safe for people, women in particular, to report?

Dr Yelland: You create a culture. I would like to create a culture, and that is what we are trying to do: create a culture where it simply never happens in the first place. Have we achieved that? Not yet. I hope we are better than we used to be about that kind of behaviour, and what all of the colleges are doing is creating a culture where it just does not get said in the first place. Then, we need to create both formal and informal systems where people who are subject to that behaviour—it is not always females; it may be—

CHAIR: No, I acknowledge that. But certainly the evidence we have suggests that a lot of it is focused on women.

Dr Yelland: informal things; it may be your medical student network telling you that one of your colleagues is making inappropriate remarks. I have had that experience. As you know, the first step in that process is actually an informal conversation with that colleague. In many cases, that is actually the first part of the process of dealing with that behaviour: to discuss it with the person. But what I am saying is that sometimes students will tell you that, but they will not tell us who can do something about it.

Mr Biviano: The college is obviously very aware of it and we are doing a lot of things at different levels. It is going to take a lot of time, there is no doubt, to change this around. People can complain to us and we can take action through the various pathways we have available. We encourage hospitals to do that as well, within the workplace. We have set up MOUs with hospitals where we can work together on this issue.

In terms of better diversity, particularly around gender, we were successful last year in attracting a lot more women onto our board or our council. Now 30 per cent of our council are women, which is fantastic. Considering that only 11 per cent of our members are women, I think that has been a great success. I think that was all spurred on by what was happening last year around this issue, obviously. That has been terrific. Having those women around the table at council has been fantastic in highlighting a lot of the issues that women face, particularly around part-time training, for example—how we can improve access to part-time training, which has been a real issue in surgery—and so many other associated issues, like having adequate childminding facilities, for example, and being able to breastfeed and things like that. We are looking at those issues much more seriously now, obviously. So hopefully, in turn, as these issues get brought up, it becomes much more accepted. But certainly we are looking at a number of different ways of tackling this.

CHAIR: Could you provide us with a copy—I do not know if it is confidential—of the sort of MOU you are talking about?

Mr Biviano: Absolutely.

CHAIR: One of the issues that came up and has come up through the day and in submissions has been the concern, particularly for students, about not having a process to report through in the hospitals. So it sounds like the MOU you are talking about enables a better process there. Is that correct?

Mr Biviano: It does. These are MOUs that we developed between the college and the hospitals to work together on these issues.

CHAIR: What about dealing with the complaints process? The issue that came up specifically was: not having a pathway, when you are in the clinical setting, to be able to complain.

Dr Yelland: But medical student teaching is actually not, strictly speaking, a responsibility of the colleges—although of course our fellows and our trainees are involved in medical student teaching. So there would be an issue about how the university which is responsible for the students is dealing with it, not just the college—

CHAIR: Yes, I totally understand that, and I take your point.

Mr Biviano: On that point, I think that what has happened, particularly with the College of Surgeons, is: whilst there are issues around who employs the trainees, we certainly take it very seriously that these people are actually part of the college, whether they be a trainee or a fellow; they are part of the college. So we have a responsibility to curb these behaviours, as a professional organisation. So we are certainly doing that, recognising that they are employees of hospitals—hence the work that we have been doing with hospitals around these memorandums of understanding to actually work together on these issues.

CHAIR: The other issue that has come up is that of being tough. Doctors have to be tough. And I am sure you have read the student submission; their submission is that therefore bullying and harassment is part of that process. In fact, 50 per cent of the respondents have come to believe that it is a necessary part of becoming tough, and one of the reasons they are saying they are picking on women particularly is because they need to toughen up to be a doctor. Given that it is 2016, I found that quite incredible, quite frankly. Is that an issue that has come up, or is this just the way that students and some of the junior doctors are seeing it, from their perspective?

Mr Biviano: It has definitely come up. Certainly we do get that feedback from a lot of our trainees, and I guess these are really old-fashioned attitudes that are prevailing there. Again, it is how we change this culture to one which embraces diversity, and we have a diversity action plan as well, as part of the work that we are doing. So again it is how we change this culture, and that is why we are putting a lot of effort into these awareness campaigns to start people thinking about it and get them to stop and think before they do these things. Obviously it is going to take a while to get through; it is going to take a few years.

Dr Yelland: Could I make another comment, and again this is probably a more personal one, both as a previous medical student—a long time ago—and as a supervisor and so on, and now as the mother of medical students. Sometimes what we are actually saying to students and junior doctors is, 'This is tough,' and it is tough. Patients die, and we have difficulties with families. You work in a complex environment. We sometimes say, 'This is tough,' and that may be taken, unfortunately, as, 'You need to toughen up.' That is not always what we are really saying. To a certain extent—I am not absolving anyone of that—

CHAIR: No, I understand that.

Dr Yelland: But one of the things that that it is necessary for us to do is to mentor our junior doctors and students to manage and to learn the skills, resilience, mindfulness and all those other qualities to survive in what is a very challenging environment at times. I would like to see that as a completely separate issue from what you are describing, which is: 'Toughen up. I'm bullying you. Just take it.' That is not what I mean.

CHAIR: I totally understand what you mean, but it is not the context in which we had the conversation this morning. That is an accurate reflection, isn't it? Professor Frost, did you want to add anything? You look like you want to comment.

Prof. Frost: I am not sure that it is appropriate, because my other role has been as the dean of a university medical school. Certainly I would agree with Dr Yelland in that one of the first things our students learn is, for example, how to give bad news, which is not easy but necessary and totally important. The university at which I worked also has a clinical debriefing session for all students in their first and second year, with a GP. So, for an hour a week, they have the opportunity to discuss what they saw, heard and felt in the general practice or the hospital, and a number of those 'toughen up' issues do come to light there, and we have been able to deal with those from a university perspective in that institution—the teaching hospital, other hospital or general practice, for example. So we are all aware that it is an issue, but from the very first days—and I think I could generalise to all medical schools—the understanding is that harassment and bullying are not acceptable in any way, shape or form, from anyone, to anyone, but that medicine is not an easy profession to undertake.

CHAIR: Thank you.

Senator XENOPHON: I have staple questions, Mr Biviano, and I will be as quick as I can. The British Association of Urological Surgeons, on their website, in relation to a surgical outcomes audit, makes reference to publishing surgeon-level outcomes data, something driven by the UK government in December 2012. It gives, approvingly, this quote from a surgeon:

Soon, there will be a time where our scholars & colleagues will not be satisfied with general comments on surgical quality outcomes—instead, they will call any physician a charlatan who is incapable to quantify his results.

Would you agree or disagree with the general tenor of that comment?

Mr Biviano: I think the whole issue about health outcomes is really important, and I guess how you measure health outcomes is the question here. We have done a lot of work with Medibank Private, for example, in looking at various procedures and looking at how they are conducted by various surgeons and so forth, and we have been able to do that through an educated type of response.

Senator XENOPHON: I really do not have much time. Can I say that the quote that was given approvingly by the British Association of Urological Surgeons made specific reference to 'calling any physician a charlatan who is incapable to quantify his results'. Do you think that surgical benchmarking, quantification of results and publication of those results, as has been occurring in the UK for a number of years in terms of surgical outcomes, is a good or bad thing?

Mr Biviano: We do not agree with individual quantification of results—

Senator XENOPHON: But it does occur in the UK, doesn't it?

Mr Biviano: It does; absolutely.

Senator XENOPHON: To be fair, the quote I referred to was from Christian Billroth, who is known as the founding father of modern abdominal surgery. He said that back in 1860, so it has been 166 years since he made that comment. You do not agree with the comment made 166 years ago?

Mr Biviano: No.

Senator XENOPHON: Okay. Dr Yelland, you made a very important point. You have students who are not fellows, obviously, because they are medical students. The teaching is done by fellows but the student is under the university, so isn't there a big jurisdictional gap where the students fall through? Professor Frost, you may want to comment on that. It is not a criticism; it is just an observation that there seems to be a situation where the students are in this no man's land where they cannot get appropriate redress if there is a problem.

Dr Yelland: This is one of the complexities in medical training. The responsible body for a student is the university, but they also are in a hospital environment and there are agreements between the universities and the teaching hospitals about standards and so on. Any staff member who is responsible for students will have accountability to hospital management. In professional standard terms, yes, we expect them to comply with college standards, which include respect for everyone and responsibility for teaching. Can the student complain to the college? Yes, they could. I am not aware that it has ever happened. I do not think it is a route that they would particularly think about. They would first go to the university.

Senator XENOPHON: One of the issues here is that a student or junior doctor will not make a complaint—I have spoken to them privately and they say they will not do it—because they are terrified about their future. Do you acknowledge that there is a real fear that if you make a complaint early on in your career or while you are a student there is a perception that you are finished in that profession because it is relatively tight-knit?

Dr Yelland: I agree about that. We understand that. We put all these things in place, but there is still a perception and there may be a reality that there will be some retaliation. You do not want to be labelled a troublemaker. We understand that in many areas the medical community is relatively small. I think that is a very strong argument for getting the culture right—that we never do it in the first place; that we do not conduct our workplaces and our training like that.

Senator XENOPHON: I invite all the panel to comment on this. We can go round and round in circles and do a bit of hand-wringing as to what the culture should be, but unless there are sanctions for those who behave badly nothing will change. Mr Biviano, how many of your fellows have had their fellowship stripped from them for bullying or harassment in the last two years?

Mr Biviano: We are looking at—

Senator XENOPHON: You have how many members?

Mr Biviano: Seven thousand.

Senator XENOPHON: How many of them have actually lost their fellowship because of bullying and harassment?

Mr Biviano: Up to date, we have not. There may be one soon to happen. Obviously, I cannot pre-empt that, but we certainly had two fellows who lost their fellowship for not completing their continuing professional development program over the last couple of years—

Senator XENOPHON: No, I am talking about bullying and harassment.

Mr Biviano: Not at this stage, but there are cases before us.

Senator XENOPHON: You may have heard the medical students earlier on. We are not talking about 'toughen up'. We are talking about situations where women seem to be picked on with difficult questions that have not even been part of the lecture—singled out by one particular surgeon and being told that their suturing was 'sexy' and they should really be in the kitchen, or asked: 'Why are you practising? Why are you in medical school?' Those words, or words to that effect, from the Medical Students' Association are in the *Hansard*. Is that the sort of thing that ought to be the subject of sanctions? Do any of you wish to comment on that?

Mr Biviano: We have a code of conduct, obviously, as do all the colleges. We would encourage people like that to come forward with those complaints, and we can actually deal with those complaints through a process that we have, which would look at the actual—

Senator XENOPHON: We are running out of time.

Mr Biviano: Sure. It is a long process that we go through.

Senator XENOPHON: Is it an effective process, because you have said there is yet to be any sanctioning, whereas there is the evidence we have heard and the submissions we have received, including some where people are fearful of them being made public? If you look at the survey—and I commend the college for undertaking that survey for that whole process; I unambiguously commend you for it—you had 3,516 surgeons—a 47 per cent response rate—responded to the survey. By specialty, it was from 32 to 58 per cent. Ophthalmology and orthopaedics were lowest and vascular and neurosurgery were the highest in terms of instances of being bullied or harassed. Forty-nine per cent experienced discrimination, bullying or sexual harassment and over 60 per cent stated that it had not been resolved to their satisfaction. Is there something broken in the system that there does not appear to be any effective enforcement?

Mr Biviano: We accept there is work to be done. What we have done this year in particular is increased resources in that area. We have looked at improved pathways for complaints resolution. A lot of these cases take a lot of time to work through. They take months and months of work, because obviously you have to do it in a fair and transparent manner and you have to look at principles and natural justice. I guess what I am saying is that we have looked at our complaints process and we have taken steps to improve that process.

Senator XENOPHON: Are you seriously saying it is a robust process, given that sort of response rate from your survey and the outcomes where there is yet to be one person to lose their place?

Mr Biviano: It clearly wasn't. That was the survey that was done last year. Since last year, we have taken steps to improve that process.

Senator XENOPHON: Before Professor Frost comments, I want to ask the question generally: do you keep records of trainees who commence training but who drop out: they have had enough because of bullying and harassment? In other words, if someone actually drops out of their traineeship to get their fellowship, do any of you actually ask them why? Is there an exit interview? Does someone ask them frankly, 'Why have you done that?' And do you get responses?

Dr Yelland: There is another side to this, and that is that there needs to be natural justice for the accused, if I can call them that. To take away a fellowship is an incredibly serious issue and may affect someone's livelihood. So the usual sorts of processes apply, and there would have to be substantiation. In many cases, the student or junior doctor will not necessarily want to take it that far. That process would be rigorous, because it needs to be fair. To look at how many people have exited training because of those issues is again a complex issue, and we need to be fair on both sides. Trainees cease training for many reasons. Often it is lack of success in examinations. It may be other difficulties with supervisors. To simply attribute it to one thing may be making it overly simplistic. If trainees make a complaint about the supervisor, there are a number of avenues available to them to redress that, including changing supervisors. But we would not be able to say that a trainee had discontinued training simply because of one issue; it may well be quite a number.

Senator XENOPHON: Do you actually ask the question?

Dr Yelland: Do we ask the question why? The majority of trainees do not continue with training because they actually do not pass the examination.

Senator XENOPHON: Can I just put that on notice to all of you. I just want to ask one more question.

CHAIR: Professor Frost has been trying to make a comment for a while.

Prof. Frost: It is simply to clarify a point you raised, Senator Xenophon, and that is that I think a medical student would clearly associate him or herself with the university rather than with the college. Trainees, of course, associate with the college because they have enrolled in a college training program. So I am not sure that the gap you suggested is really there in terms of where a student can go for assistance.

CHAIR: The gap is there, because students have raised it with us. They do not feel they have an avenue, besides the university. If it is happening in the hospital, they feel like they fall between the gaps. It is an issue because students are saying it is an issue.

Senator XENOPHON: Dr Yelland, on your comment about the issue of natural justice, of course it is important, but there is a flip side to that, isn't there, of the intrinsic justice of a medical student or a young doctor being able to undertake their training without bullying or harassment, which in some cases may lead to them abandoning their chosen career or feeling that they cannot continue. It affects their livelihood as well, does it not?

Dr Yelland: Yes, and we are totally supportive of removing that whole issue. That is what this is all about. We do not want it to ever happen again that somebody feels unable to continue with their training because they are put in an impossible position by a supervisor.

Senator XENOPHON: I do have a specific question for Mr Ilott, but right now is it fair to say that, if you are a bully—a serial harasser—the odds are you are going to be able to keep doing it without too much risk of getting in trouble because the strike rate is pretty low? I know it is Melbourne Cup day and I do not gamble, but—

CHAIR: Somebody had to bring it up.

Senator XENOPHON: Only as a cautionary tale, Chair! But the odds are pretty low. Right now, there would have to be a one in 5,000 chance of anything happening to you, statistically.

Mr Biviano: I hear what you are saying. I think it is a major problem. We are starting to hear, I guess, as we go around talking to hospitals, that it is starting to shift, particularly in hospitals where they have implemented culture change programs. It is going to take a while.

Senator XENOPHON: Mr Ilott, in your submission I am very grateful for this reference at the bottom of page 3, where you mention:

> … some anecdotal evidence that suggests allegations against private specialists are being used to exclude them from being credentialed in private institutions. This has the impact of restricting their ability to practice which in small towns could be quite devastating.

How do you resolve an issue between two members on both sides? In other words, if there are two anaesthetists where it seems like a turf war, how do you deal with that? I thank you for putting it out there, because that could actually be the basis of a vexatious complaint, could it not?

Mr Ilott: Yes, it can and, as you rightly point out, it is very complex—and it is not always between two members of the same specialty but in fact is more likely to be specialists of different specialties. In one case I can think of, we are working very closely with the other college. We also work closely with the private hospital to make sure that the private hospital recognises its responsibility to carry out a proper investigation of whatever is happening. In the normal process that we go through, once we receive what I call a notification of bullying we will perform an assessment, and that is before a full-blown investigation. We will commission a third-party organisation, usually, to perform an assessment for us and give us a report in some recommendations. But we certainly do take it seriously.

On the other point that you were talking about, I think there is another piece of the jigsaw. We are talking about the loss of fellowship or about sanctions or disciplinary processes imposed by colleges. I think another part of the jigsaw is: what is the medical board's role in all of this? At this stage, even if a practitioner is excluded from fellowship, that practitioner is still a registered specialist in this country and can still practice. They would not be able to teach as part of the college teaching program but could still practice. At this stage, there are no regulatory consequences for people who are excluded from fellowship.

CHAIR: Thank you for your submissions and for your time today. It has been extremely useful for us. We will now take in camera evidence, so I ask all present, other than the secretariat, the senators and our witness, to please leave.

Evidence was then heard in camera—

AYSCOUGH, Ms Kym, Acting Chief Executive Officer; Executive Director, Regulatory Operations, Australian Health Practitioner Regulation Agency

CASEY, Ms Veronica, Board Member, Nursing and Midwifery Board of Australia

FLYNN, Dr Joanna, Chair, Medical Board of Australia

HALLINAN, Mr David, First Assistant Secretary, Department of Health

SOUTHERN, Dr Wendy, Deputy Secretary, Department of Health

[15:17]

CHAIR: Welcome. I remind witnesses that the Senate has resolved that an officer of a department of the Commonwealth or of a state shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions being asked for explanations of policies or factual questions about when and how policies were adopted. I would also like to double-check that you have all been given information on parliamentary privilege and the protection of witnesses and evidence. Okay. We have your submissions, and I would invite whoever would like to to make an opening statement. Then we will ask questions.

Dr Flynn: Thank you for the opportunity to meet with the committee. I am the person who will make the opening statement on behalf of us. I am the Chair of the Medical Board of Australia and I am a general practitioner based in Melbourne. Kym Ayscough is acting as Chief Executive Officer for AHPRA at the moment, as CEO Martin Fletcher is away overseas. Kym's normal role is as Executive Director of Regulatory Operations, leading the day-to-day work of AHPRA across Australia, including the management of notifications. Ms Veronica Casey is representing Dr Lynette Cusack, who is chair of Nursing and Midwifery Board of Australia. Both Dr Cusack and Mr Fletcher apologise for not being here today.

We understand from reviewing the committee's website that the main focus of the committee is the prevalence of bullying and harassment within Australia's medical, nursing and midwifery professions and how these behaviours impact on both the practitioners themselves and on patient outcomes. The Medical Board and the Nursing and Midwifery Board recognise the seriousness of bullying and harassment within our professions and the significant impacts these behaviours have on those who experience them. Last year I was part of the expert advisory committee set up by the Royal Australasian College of Surgeons to investigate their issues in relation to bullying. The evidence that group gathered was shocking and distressing. The impacts of bullying, discrimination and harassment can be devastating for practitioners, for healthcare teams and for patient outcomes.

While the Medical Board and Nursing and Midwifery Board and AHPRA have important roles to play, the medical complaints process and our regulation of health practitioners will not, on its own, address bullying and harassment and deliver the change in culture that we seek. That is why we work in partnership with the professions, employers, colleges, health departments and other health complaints bodies to help end bullying and harassment.

In relation to the national scheme, 657,000 health practitioners are currently registered by the 14 national boards. As you, Senators, would know, the National Registration and Accreditation Scheme is a national scheme which was established in 2010 under state and territory legislation. It is not a Commonwealth scheme. The objectives of the national scheme are clearly set out in the national law. The primary role of the boards and AHPRA is to protect the public. We do this by setting registration standards that registered health practitioners must meet, accrediting education and training programs, managing notifications and complaints about health performance and conduct of registered practitioners, and monitoring compliance with national standards and any restrictions that are placed on practitioners' registration. And we have provided further detail about how we work in partnership between the boards and AHPRA in our submission.

National boards set clear requirements for the behaviour of registered health practitioners through codes of conduct. We also manage notifications or complaints about the behaviour, health and performance of registered practitioners. And in our submission we have provided data on notifications and on the number of notifications we have received respectively for nursing and midwifery and medicine in the last year and our analysis of how many of those relate to bullying.

We make the point in our submission that co-regulatory arrangements exist with local health complaints entities in New South Wales and Queensland. This means that AHPRA and our boards do not deal directly with

complaints in relation to health practitioners in New South Wales and only deal with those complaints referred by the Health Ombudsman in Queensland.

But we recognise that, for any practitioner, being the subject of a notification or a complaint is very stressful. It has been alleged that the way AHPRA and the boards deal with complaints is a form of bullying. We reject this allegation. We fully accept that it is our responsibility to make sure we deal with notifications fairly and efficiently. We have worked hard to improve the timeliness of our processes and to improve our communication with both notifiers and practitioners. We have streamlined how we work with other health complaints entities to make sure that the right body is managing the complaint from the outset.

But our primary focus is patient safety. Notifications that raise serious issues must be dealt with rigorously, and we must take appropriate regulatory action where there is a risk to the public. The community comes to us with their concerns when they have had a bad experience or a bad outcome. They want us to take their concerns seriously and to take action to ensure that whatever happened to them does not happen again.

In response to evidence about the stress inherent in our professions and the high level of psychological distress in both practitioners and students of medicine and of nursing and midwifery, both of our boards have made significant funding contributions to establishing national health programs for our respective professions. Bullying and harassment within the health professions and the health sector much more widely are multifaceted issues. The Medical Board of Australia, the Nursing and Midwifery Board of Australia and AHPRA are committed to playing our part in working with others to help end bullying and harassment in the health sector. We are very clear that these behaviours are harmful and have no place in the health professions we regulate.

CHAIR: Thank you. Did anybody else want to make any comments? Senator Duniam, do you have some questions?

Senator DUNIAM: Yes, thanks, Chair. Dr Flynn, thank you very much for your opening statement. A question that I asked some of the medical practitioners that have appeared before the committee was in relation to the qualifications of the investigators that AHPRA has. Can you give us a bit of insight into what qualifications your investigators actually have.

Dr Flynn: We certainly can. I will ask Ms Ayscough to answer that question.

Ms Ayscough: Across the national scheme we employ probably around 100 investigators. They come from a variety of backgrounds. When we are recruiting we are particularly looking for people who have the skills to gather information around a complaint, synthesise that information and write reports for the information of the boards, who are the decision makers in the matter. They come from a variety of backgrounds. Some of our investigators have clinical backgrounds; others have experience working with other regulatory agencies, with ombudsman's organisations and some have backgrounds from the police service.

In terms of qualifications or credentialing, we have for the last two years been delivering a standard training program to all of our investigators based on the national certified investigator training program from the Council on Licensure, Enforcement and Regulation. That program has been running for more than 30 years and has trained over 19,000 investigators. We deliver that now as baseline training for all of our investigators.

Senator DUNIAM: You mentioned that some of your investigators are clinicians; do you have an idea of how many actually come from that background?

Ms Ayscough: I am sorry but I do not have that information with me today.

CHAIR: Could you take that on notice.

Ms Ayscough: Yes.

Senator DUNIAM: What discretion do the investigators have with regard to the passing on of information, provided by clinicians who are being investigated, to the board? Is it the case that they compile a report and everything is passed on? Or is it as was suggested to us earlier on that there is some discretion whereby some information is passed on and other information is deemed unnecessary to pass on?

Ms Ayscough: It is the case that submissions that are made by practitioners who are the subject of a notification are made available to the board and they form a part of the board's decision-making process.

Senator DUNIAM: Does that mean that every piece of information that clinicians provide in the course of an investigation into them is available to the board for its consideration?

Ms Ayscough: It is the case that the investigator will provide a report to the board, will identify the material that has been provided during the course of the investigation and will make that material available to the board for its consideration.

Senator DUNIAM: Just to be absolutely clear, a report is prepared and everything that has been provided may not be passed on but there is a list of information that has been compiled by the investigator, which then the board could access if it wanted. Is that what you are saying?

Ms Ayscough: Yes, the investigator compiles a report of the process of the investigation including the information gathered and that material is available for consideration by the board.

Senator DUNIAM: So the investigator has no discretion and cannot just decide that the board does not need to see that?

Ms Ayscough: No, the report of the investigation is extensive and to inform the board about the information available to support their decision.

CHAIR: I can see what you are trying to clarify. There is a list of information provided. A report is provided with a list of information from which that is drawn. But then the board would need to ask for some of that specific detail, report and material if they want more information?

Ms Ayscough: There will be material which is not necessarily appended to the report but will be available to the board on inquiry.

CHAIR: If the board asks?

Ms Ayscough: Yes.

Dr Yelland: If I could add to that briefly, the decision that is made is made by a committee of the board, which consists of community members and practitioner members. They are provided with the investigator's reports electronically via an iPad distribution system. Often those reports are hundreds if not thousands of pages and they are read very diligently. The concern often is around giving people too much information rather than not enough but that is why the investigator tries to prioritise what is there and present that clearly to the board. But the boards are very diligent and seek access to the primary documentation and read it in great detail in the electronic papers.

Senator DUNIAM: In the case of an allegation that an investigator has falsified information in an investigation or at the very least embellished it, which is a claim that has been made, if that claim is then raised with APRA, what action is taken? It is been put to this committee that it is not acknowledged, not responded to but just ignored. Could you tell us what process you go through in dealing with claims like that?

Ms Ayscough: First, I would say I am not familiar with any specific allegation of that sort.

CHAIR: Can I suggest that you are going to need to have a look at the *Hansard* from today. We will be sending it out for adverse comment anyway. But you are going to need to have a look at the *Hansard*, to respond to some of it. Just bear that in mind.

Ms Ayscough: Certainly. What I would say is that we take seriously our obligation to present to boards the material that is relevant to support their decision-making. An allegation of that sort, particularly that an investigator may have falsified information in an investigation report, would be a very serious allegation and one that we would expect to investigate ourselves to determine whether there is action that we need to take, either about the notification in hand or the investigator and their employment.

Senator DUNIAM: Senator Siewert, is it the case that once the *Hansard* is distributed the witnesses will be able to provide a further response, in relation to the specific allegation?

CHAIR: Yes, very definitely.

Senator DUNIAM: All right. Once you have had a chance to look at that—I will wait to see what you are able to say in response. With regard to this issue of timeliness of investigations that has been raised by a number of witnesses, at least one witness has said it is nine to 12 months sometimes for an investigation. Is there an average time taken to conclude an investigation?

Ms Ayscough: Yes. In the material that we have to 30 June 2016, the median age of open notifications is 137 days, and that is a five-day reduction in median age from the same time last year. This has been a particular area of focus for us. We know there was a lot of criticism, in the early days, of the national scheme about the time frames, and we have continued to work diligently, both AHPRA and the boards, to bring those time frames within reasonable expectations.

Senator DUNIAM: My final question, with regard to the investigators, and I may well be straying into the area of opinion, is that it seems to me this anonymity or disconnect between investigators and medical practitioners and what is perceived to be—again, you will have to have a look at the *Hansard*—a lack of two-way communication, in some cases, adds to this feeling of some medical practitioners that the system is stacked

against them. Is there any way that this issue, as raised by some witnesses, can be dealt with in a slightly more interactive process?

Dr Flynn: We have been working with the Australian Medical Association, over the last three years, to look at the issues raised with them that give practitioners concern about the way the Medical Board and AHPRA investigate their complaints. One of the clear concerns that was expressed, when we started this work, was the impersonal nature of the communication, the infrequent communication and the feeling that practitioners were a bit at sea and did not understand what was happening. That goes back to the point I made earlier about how stressful it is and us recognising how stressful it is to be subject to a notification.

We have done a lot of work to change the culture in the organisation and to change the method of communication so there is more verbal communication, there is more frequent communication and people are given an unidentified officer with whom they can follow up their concerns. We do have staff turnover at times and sometimes there is discontinuity but, wherever possible, we try give somebody one point of contact that they can follow up with, and we try to respond to things in a much more timely and helpful way. We do recognise it is stressful, and a lack of information about what is happening and the lack of a sense that you can speak to anybody about what is going on is one of the things that adds to that stress.

Senator DASTYARI: I want to go back to the media reports that initiated the request from Senator Xenophon and, I think, Senator Madigan at the time for this inquiry—and I thank them for their efforts. In the media that was around at the time, the member for Leichardt, Warren Entsch, told *Lateline* that he would ring former health minister Peter Dutton and then Minister Ley about the Dr Emery case and the *Lost in the Labyrinth* report. Are you the right people to be asking about that? Is that something you are aware of?

Dr Southern: Yes.

Senator DASTYARI: Mr Entsch told *Lateline*—and this is coming straight off the transcript, direct from the *Lateline* interview—that he 'received no real response' from Mr Dutton. Do you know whether a response has now been issued?

Dr Southern: I do not know the answer to that question. I can certainly take that on notice for you.

Senator DASTYARI: Obviously, you do not have a copy of that correspondence with you.

Dr Southern: No.

Senator DASTYARI: Nor would you be expected to. Perhaps you could take three separate questions on notice. Firstly, Mr Entsch told *Lateline* that you had received 'no real response'. Does that mean there was no response? I am not quite sure whether that means there was a response and he did not feel it was satisfactory or there was no response at all. Secondly, did Minister Ley respond? Thirdly, would there be any reason why you could not take on notice the decision to table that correspondence? Again, I know that will be a decision that will go up the chain.

Dr Southern: Certainly. I am happy to take those questions on notice.

Senator DASTYARI: I now want to touch on an independent review. Your submission notes that COAG health ministers released an independent review of the National Registration and Accreditation Scheme in 2015. Correct?

Dr Southern: That is correct.

Senator DASTYARI: You point out that the ministers agreed to the midyear implementation of recommendations 9 and 28. Could you just quickly explain what recommendations 9 and 28 were?

Dr Southern: Recommendation 9 went to measures to be taken within the scheme to ensure that certain principles were met within the design and operation of the complaints and notifications process. Then there were several parts to that recommendation which went to establishing processes where complaints and notifications involved a shared assessment of the appropriate means of investigating in addressing the issues between AHPRA and health complaints entities, that investigations and reports be shared between national boards, AHPRA and health complaints entities as required to establish benchmark time frames for completion of key aspects of notification management. The rationale for deliberations and progress reports would be routinely quarterly conveyed to notifiers and health practitioners in plain language. National boards would be authorised to refer matters for alternative dispute resolution. Any adverse findings and disciplinary decisions are to include the time frame for inclusion of the decision or finding on the registrants record, and those decisions are to be supported by strengthened monitoring of practitioners, including adequacy of supervision. The national law would be amended so that notifiers personally impacted by practitioner conduct could be informed in confidence by the national board about the process decision and rationale for the decision regarding their case. National boards and AHPRA

are to review correspondence standards with notifiers to ensure improved clarity, sensitivity and communication. And health complaints entities would be required to file complaints so that practitioners could be searched according to their AHPRA registration number to allow authorised persons to access data for research into the predictability of professional misconduct.

So, there are a bunch of recommendations there, which really go to transparency of processes. And then recommendation 28 recommended that AHPRA conduct specific education and training programs for investigators that should be designed in consultation with national boards, tribunals and panel members, and that was about developing consistent and appropriate investigative standards and approaches.

Senator DASTYARI: There are quite a few components to recommendation 9. Have they all been implemented?

Dr Southern: There would be a combination of administrative and process changes that could be made and also legislative changes that need to be made to the national law. Some of the administrative and process changes would have been able to be made quickly, but the ones involving changes to the national law are still working through drafting processes and have not yet been introduced into parliaments.

Senator DASTYARI: I do not know whether you have this in front of you at this point in time or whether you can take it on notice, but is there a table that goes through recommendation 9 and recommendation 28 that outlines the different components of it and the status that all parts are up to?

Dr Southern: We could certainly provide that on notice.

Senator DASTYARI: I am trying to get my head around what you are saying; it seems fairly complex. It sounds like you are saying that parts of it that are administrative in nature have been implemented and the parts that are legislative have not. Or are there administrative parts that have not been implemented yet as well?

Dr Southern: I think there would be a combination of those things which have been implemented, and which were able to be implemented quite quickly, and those which perhaps are still being worked through. I am not sure if colleagues from AHPRA are able to give a bit of an update on that. I know that they provide regular reports through the Australian Health Ministers' Advisory Committee to COAG health ministers on progress against the recommendations. So there is regular reporting on that, but perhaps Ms Ayscough is able to shed a little more light on that.

Dr Flynn: In general, and I will ask Ms Ayscough to comment, I think that most of those recommendations have been actioned, but it would be easy for us to provide on notice a report against the table of the recommendations.

CHAIR: That would be great.

Senator DASTYARI: Okay. When you say that most of them have been actioned—again, I just want to get my head around this one point. I understand what you are saying: there are some that were legislative in nature, and ultimately that comes from your evidence that they are the ones that seem not to be actioned. But are there administrative ones that have not, as well as legislative ones? I could not quite understand—I am sorry; it might be a bad line. I thought you were saying there were both administrative and legislative ones that are still being worked through. Or are there just legislative ones that are being worked through?

Ms Ayscough: I think it is appropriate if we provide a complete status update on the recommendations on notice. Some of the administrative recommendations certainly have had action taken, but in many ways they are continuous quality improvement activities, so whether we can complete them at any point in time is not entirely certain. But we have provided some examples of the outcomes of the action on some of these recommendations with our submission—for example, the processes by which we share information about complaints between AHPRA and the health complaints entities. We have done a lot of work with health complaints entities around the country to settle a tool, a matrix, to help us to make early decisions about which the right agency is to deal with a matter from the beginning. That level of certainty is something that certainly was made clear to the independent reviewer—something that both practitioners and notifiers were seeking from the complaints management system.

We have further examples of those kinds of activities—introduction of new guidance tools and improvements, as Dr Flynn referenced, not only in our communications with practitioners but also with those who make notifications to us so that the information is more useful to them and in plain language and at a frequency that they would expect.

Senator DASTYARI: Okay. You will take on notice, obviously, the specific status of the files. Your general overview is that some of the items, as you understand them—and, again, you will confirm this in the table—

require legislative changes. I am recalling all of yours that went through. At this point they have not been presented to the parliament yet. Is that your understanding?

Dr Southern: Yes, that is correct. And because of the way the national law operates the amendments are initially introduced in the Queensland parliament and then are picked up by the other states and territories in a kind of referral process. So the first step is their introduction in Queensland. My understanding is that the drafting instructions and the process for developing and settling that legislation is certainly now well underway.

Senator DASTYARI: Sorry; this is going to show my lack of understanding. If it were my understanding of New South Wales politics it would be a completely different question. Who drafts the Queensland parliament's legislation? Does the Commonwealth draft it for the Queensland Department of Health, or do they draft it? Again, this is probably a very simple question that I am making incredibly complex.

Dr Southern: It is quite a complex system. The drafting instructions are issued to the Queensland Parliamentary Counsel but there are, if you like, consultation mechanisms and governance mechanisms which sit behind it to allow for consultation and agreement across the jurisdictions before those instructions are issued and the drafting commences.

Senator DASTYARI: Thank you for that. It was a really good overview. I do not want to take up too much of the committee's time, and you can take this on notice if you like. Could I ask you for a bit more detail about the process for the drafting of these types of recommendations and the interaction between the Queensland parliament and the Commonwealth department. I am sure there will be something you will be able to supply quite easily—send us a link or whatever—because I am sure it is explained very well somewhere. Would it be okay if you took that on notice?

Dr Southern: Certainly. I would just make the point that the national law is all state and territory based legislation. There is not a piece of Commonwealth legislation that has been enacted as well.

CHAIR: I am having flashbacks here to when we were talking about 'always' in the first place.

Senator DASTYARI: I have just a couple of things I would like to go through fairly quickly. Again, I am very conscious of the time and other senators. You are obviously well aware of *Lost in the labyrinth*, which was the report done by the House health committee that looked at issues about overseas trained doctors like Dr Emery; is that correct?

Dr Southern: Yes.

Senator DASTYARI: So obviously you know what we are talking about, yes?

Dr Southern: Yes.

Senator DASTYARI: There were 45 recommendations from that House committee report. Are you able to tell us the status of the government's response to the report and how many of the 45 recommendations have been implemented or are being implemented?

Dr Southern: The status of the government response to the report was tracking along reasonably well, but then we had the caretaker period and the election. I think we are back to the point where we have to re-present the report to the minister for finalisation.

Mr Hallinan: The government's response at the moment is in a process of consultation across states, territories and relevant other parties, because that report covers a lot of territory outside of the Department of Health. It should be in the final stages of production in the coming months, but we are waiting on a couple of responses for it.

Senator DASTYARI: Okay. Without prejudice, the government has not yet responded. This is where it gets a bit funny. We often have the situation where the government response takes longer than the period in which recommendations are being addressed or undertaken, which it does not necessarily prohibit. I have seen this happen with other kinds of reports, where a committee will make, say, 25 recommendations and, in the time it takes the government to respond, they have already implemented five or 10 of them just because they are good ideas or decisions. It can be easier sometimes for a department to implement something than to wait for the government to respond in full. Has that happened in this case?

Dr Flynn: Many of the recommendations of the *Lost in the labyrinth* report were directed towards the processes for assessment of international medical graduates, which collectively are a responsibility of the Medical Board, the Australian Medical Council and some of the specialist colleges. A great deal of work has been done in the last three or four years to streamline those processes, and there are reports of progress against those recommendations which the Medical Board has provided over time. Again, we could provide some background to you. The bottom line is that there is much more transparent reporting of those processes and they are more timely.

There are, in fact, fewer overseas trained doctors in Australia now than there were at the time of the *Lost in the labyrinth* report, largely because the number of local graduates has increased enormously in the last few years, so there are fewer area-of-need positions. But the Medical Board reports on—

Senator DASTYARI: Can you take on notice: how many of the 45 recommendations that were recommended by the *Lost in the labyrinth* report relate directly to the Department of Health and how many of them sit in different areas? Without prejudicing the government response to the committee report as a whole, how do those recommendations sit with what the government is already doing or has already done in those different areas?

CHAIR: Is that something you can do prior to the response?

Dr Southern: I would think so. As Dr Flynn said, a number of the recommendations went directly to the activities of the board rather than the departments and have already been implemented, so I think we can pull that together fairly quickly.

Senator DASTYARI: You can help us understand. I have got your report. The report does not make it clear—it is not really the report's role—what part of the recommendations would suit you to implement. They just make recommendations, as reports should. They do not necessarily break it down—such as, this is actually with these people. It makes it a lot harder for us to chase up what has happened. It will help us if we work out where these recommendations actually fit.

According to the communique from the COAG health ministers meeting last month, on 7 October 2016:

Health ministers agreed to refer concerns regarding professional behaviour to AHMAC.

You obviously would have been have involved at some level with the preparation of that communique?

Dr Southern: I was a couple of steps removed but, yes, Senator. I am sorry, I could not quite hear the piece that you quoted.

Senator XENOPHON: Are you playing guitar in the background, Senator Dastyari?

Senator DASTYARI: One of the quotes from the communique is, and I will read directly from the communique here:

Health ministers agreed to refer concerns regarding professional behaviour to AHMAC.

Is that something you are aware of?

Dr Southern: Yes.

Senator DASTYARI: The communique is not going through [inaudible] that have been referred. Can you expand on what exactly those concerns were and whether they are relevant to this inquiry.

Dr Southern: We do not have a lot of detail. Neither I nor Mr Hallinan was present at the health ministers' discussion. From memory, this particular item was brought forward by one of the other jurisdictions. So I have not got a great deal of detail with me about the particular nature of the complaints that were discussed, but I can take on notice to provide more information about that and, indeed, whether it crosses over with the terms of reference of this committee.

Senator DASTYARI: If you deal with anything that does cross over with the terms of this inquiry, can you perhaps give us a bit more detail on this incident and what exactly will be [inaudible]? Have we got a time frame for when you will report to the health ministers? Is it relevant? Those words are just a bit vague, and I understand a communique is something you have got a hundred people involved in. Can you give more details on the concerns. What exactly will the advisory council do? How will it respond? When will it report to the health ministers? If it is more of a discussion than it appears to be, based on that quote from the communique, when did the COAG health council last discuss issues relevant to this inquiry and is it on the agenda to discuss these matters? That line implies to me that they have discussed these matters, and that is why it says that, but in case I have misunderstood what that quote means, perhaps you can explain: is it on the agenda for the next one or are there any plans to discuss these issues?

Dr Southern: Certainly. I guess in terms of a process for dealing with this particular issue going forward, AHMAC would usually, and I expect will in this case, refer a matter like this to the health workforce principal committee, which sits underneath AHMAC and of which AHPRA is a member. The discussions would proceed from there. One of the things that will be part of that discussion will be whether the particular issue that ministers had raised falls within the current tranche of reforms that are being undertaken in response to the review of the NRAS. As we noted about recommendations 9 and 28, there is a program of work to respond more broadly to the recommendations. One of the considerations will be whether something is already underway to deal with the issues that were raised, or whether it is in addition to that. They will be the sorts of considerations that will be undertaken.

Senator DASTYARI: Chair, I just want to point out that I can hear some music in the background. I just want to make it very clear that it is not me.

CHAIR: We can all hear it.

Senator DUNIAM: It sounded like your style!

CHAIR: We have not been able to identify the source of said music, so we do not know where it is coming from.

Senator DASTYARI: Basically the music is not mine, but I would like it to be.

CHAIR: Does that mean you have finished your questions?

Senator DASTYARI: I have finished. I know the committee has taken a lot on notice. You did mention this at the start of the day, but what is the date we set for responses to questions on notice?

CHAIR: We will have to work that out.

Senator DASTYARI: I know a lot have been taken on notice, and I apologise to whomever is going to read this transcript and have to answer all of those questions, but thank you.

Senator GRIFF: I have some AHPRA questions. On page 4 of the submission, you state:

Not all allegations of bullying and harassment … are appropriate for action … as the threshold for regulatory action may not be met.

What is the threshold?

Ms Ayscough: The primary threshold really is that the allegation needs to speak to a risk to public safety because the primary objective of the national law is around the protection of the public.

Senator GRIFF: So that is primary?

Ms Ayscough: Yes, it is, but that objective guides all of the decision-making under the national law. The role of the boards and AHPRA and of the scheme is to in fact provide for the protection of the public.

Senator GRIFF: So that is effectively the threshold. We have also had a number of anecdotal reports of surgeons working in private hospitals who, because of their inability to regulate and manage their anger, have physically assaulted nursing staff and even prosthesis company reps. When this happens, it appears that many private hospitals quietly refuse ongoing accreditation for that surgeon. The surgeon then moves onto another hospital and then potentially onto another hospital. Does AHPRA have any standard for mandatory notification when a hospital declines to renew or cancels accreditation for reasons other than retirement?

Senator XENOPHON: Or lets it lapse?

Dr Flynn: The mandatory notification requirements that are placed on employers or other health practitioners are explicit in the national law and they are in relation to a serious risk to public health and safety.

Senator GRIFF: So basically if no-one tells you anything, you are not going to know. I appreciate that that is pretty obvious, but the fact that there is not a requirement for the institution to advise you would obviously have an impact.

Dr Flynn: There are requirements if they believe that the behaviour constitutes a serious risk to public health and safety. If it does not constitute a serious risk to public health and safety, then effectively there are other bodies that ought to be dealing with it.

Senator GRIFF: We have received a submission from the Medical Students' Association. What mechanism of complaint do they have, and who can they approach in particular if they have been sexually harassed?

Dr Flynn: I think that the work that the College of Surgeons did articulated very clearly that these behaviours are crimes, they are against the law, and there are avenues that complainants should go to for appropriate redress. So discrimination, bullying and sexual harassment are crimes, and that is not—we are not a criminal body. It is not our remit, and in most cases the boards and AHPRA are not the first places where those matters should be addressed. They should be addressed through the appropriate employer or university or through antidiscrimination legislation in each jurisdiction. Students, however, find it very hard to come forward with complaints because they are worried about adverse impact on their progress and future careers. We do have a big role in influencing the culture of our professions and the healthcare sector widely in saying that these behaviours are unacceptable and that we cannot continue to stand by and watch bullying, harassment and discrimination occur.

Senator XENOPHON: Dr Flynn, further to this line of questioning, are you saying that bullying and harassment are criminal matters?

Dr Flynn: It is against the law.

Senator XENOPHON: It is against the law and therefore there is a criminal standard of proof of beyond reasonable doubt. Is that what you are saying?

Dr Flynn: I am not a lawyer. I understand that you are. Miss Ayscough is. But to answer the question about what is the appropriate forum for breaches of the law to be heard in, essentially we are not the first port of call for illegal behaviour.

Senator XENOPHON: But on the issue with bullying and harassment, there was a survey carried out by the Royal Australasian College of Surgeons which was quite staggering.

Dr Flynn: That showed that 49 per cent of surgeons, surgical trainees and international medical graduates had experienced bullying, harassment or discrimination.

Senator XENOPHON: And what you are saying to that 49 per cent of the 3,500 respondents to that survey is that they have got to go through a different process, not to APRA. They have to go through a process with the police to get redress. Is that what you are saying?

Dr Flynn: No, it is not entirely what I am saying.

Senator XENOPHON: Tell me what you are saying.

Dr Flynn: When somebody makes an allegation to APRA that they have, for instance, been criminally sexually assaulted, that matter should go to the police and it is appropriate that there be a police investigation in the first case. If somebody is making an allegation they have been bullied in the workplace then employment law gives them more redress then we can provide. We can ultimately take disciplinary action against a practitioner but we cannot provide compensation.

Senator XENOPHON: Can we go back a step. You say there is employment law. But if you are a medical student—we spoke to a medical student association earlier—there is no employer-employee relationship in that case, is there?

Dr Flynn: No, but the university has a duty of care to its students and has processes—

Senator XENOPHON: That is not employment law though, is it?

Dr Flynn: No.

Senator XENOPHON: So do you expect the university to enforce that?

Dr Flynn: We enforce standards of professional behaviour. If a complaint came to us, we would investigate it. However, my view is that the boards are not the appropriate first point of call for most matters in relation to bullying, which ought to be dealt with locally and investigated locally. Most problems should be solved close to the source of they can. It is only if those processes reveal a bigger problem or somebody has got a repeated pattern of behaviour—

Senator XENOPHON: Can we just dissect that. You are saying that there is a distinction between sexual assault and sexual harassment at law and there are different laws that apply.

Dr Flynn: Yes.

Senator XENOPHON: So are you saying in the event of bullying or harassment that unless it is repeated behaviour APRA does not need to know about it?

Dr Flynn: I am saying that I do not believe that the board and APRA are the appropriate first point of call for most complaints about bullying and harassment.

Senator XENOPHON: But you did say in evidence a moment ago that in the event of a pattern of behaviour of repeated complaints, it may be appropriate for the board or for APRA to look at that. Was that correct?

Dr Flynn: Indeed.

Senator XENOPHON: But if you do not want to know about it in the first place, how do you find out about those behaviours? If you say 'we do not want to know about this unless it is repeated' then how on earth would APRA or the board find out about repeated behaviour? It is a catch 22, is it not?

Dr Flynn: I appreciate the point that you are making. What I am trying to say is—

Senator XENOPHON: It is not an unreasonable point.

Dr Flynn: No, it is not an unreasonable point. What I am saying is I do not think that all of the people who experience behaviours in workplace or learning situations that they believe are bullying or harassment should come to us because mostly things are better dealt with at the local level. However, when there is a serious problem that does raise issues about somebody's professional conduct or that may pose a risk to the public then it is appropriate.

Senator XENOPHON: But when do we know it is a serious problem? You could have half a dozen instances of bullying or harassment that presumably you would not want to know about because you have said yourself that there is an issue of a repeated pattern or a repeated behaviour, but you could have a pretty egregious case of harassment or bullying which in just one instance could call into question the professional competence of the medical practitioner, could it not?

Dr Flynn: You could, senator.

Senator XENOPHON: But you have just said that you do not really know about those individual instances, did you not?

Dr Flynn: I did not say I did not want to know about them. I said I did not think we were the appropriate first point of call.

Senator XENOPHON: Sorry, I do not want to misrepresent your position. 'Not the appropriate first port of call' means, by implication, it is more appropriate that that complaint go somewhere else?

Dr Flynn: That is what I said.

Senator XENOPHON: I just wanted to make sure that was clear. So, in respect of that, it seems to me that there is no filtering mechanism to determine whether one instance of bullying or harassment could go to issues of professional competence. For instance, I have heard stories of surgeons throwing an instrument in an operating theatre in a fit of rage. If I were under general anaesthetic, I would like to think the surgeon who was operating on me would be fairly even tempered and not lose it that way.

Dr Flynn: Those behaviours are not acceptable and they need to be dealt with. Perhaps—

Senator XENOPHON: Sorry, Dr Flynn, you have just said that they are not matters that ought to go to the Medical Board or AHPRA at first instance. Is that right?

Dr Flynn: I have said that, yes. I believe they should be—

Senator XENOPHON: Where should they go to?

Dr Flynn: They should be dealt with in the institution where the behaviour occurs.

Senator XENOPHON: And if the institution, for whatever reason, does not want to deal with it, what happens then?

Dr Flynn: I do not think they have a choice in terms of their responsibilities in terms of clinical governance. Perhaps Professor Casey could talk about that, given that she works in a large public health service. They do need to deal with them, and if the surgeon is unresponsive then that is one of the threshold issues where it may be necessary to report the surgeon to AHPRA.

Senator XENOPHON: You understand, though, that if a junior medical practitioner, a medical student, a nurse or a theatre nurse raises issues about a medical practitioner's conduct or a surgeon's conduct, for instance, it could put them in a very awful—

Dr Flynn: Absolutely.

Senator XENOPHON: I have not finished my questioning. It could put them in a terribly compromising position with respect to their careers. Correct?

Dr Flynn: That is what they fear, yes.

Senator XENOPHON: And that is not an unreasonable fear, is it not?

Dr Flynn: I agree.

Senator XENOPHON: If you acknowledge that fear, do you therefore acknowledge that there is going to be a significant underreporting of unacceptable behaviour?

Dr Flynn: Yes.

Senator XENOPHON: And doesn't that mean that, if there is that systemic underreporting, if you like, of bad behaviour, the complaints you do get are probably the tip of the iceberg?

Dr Flynn: Yes.

Senator XENOPHON: But even though those complaints are the tip of the iceberg, you are saying they should not come to AHPRA or the Medical Board in the first instance?

Dr Flynn: That is my belief.

Senator XENOPHON: Do you think your belief is unreasonable, given the sort of evidence that this inquiry has heard and the submissions made to this inquiry?

Dr Flynn: I have stated to you my personal opinion, which I formed in the work that I did with the College of Surgeons in relation to where was the most appropriate place for these behaviours to be dealt with.

Senator XENOPHON: We have just gone through it logically. You admit that this is the tip of the iceberg. Most people do not make a complaint because they are terrified about the consequences to them.

Dr Flynn: I agree, Senator Xenophon, and I do not believe that it is any easier for them to make a complaint to AHPRA and the board than it is to make a complaint in their local workplace.

Senator XENOPHON: Not with the attitude that you have just exhibited to this committee. You are basically saying: 'We don't want to know about it.' That is what you are saying.

Dr Flynn: I disagree.

Senator XENOPHON: What are you saying then?

Dr Flynn: I am saying we have a responsibility to set standards that are expected of the registered professions, and where there is a risk to public safety we have responsibility to take action.

Senator XENOPHON: If a surgeon is behaving in a way where they throw instruments across a room in an operating theatre—stories that we hear from time to time—you don't think that raises issues of public safety?

Dr Flynn: That behaviour is not acceptable and does raise issues of public safety.

Senator XENOPHON: So at what point does the Medical Board or AHPRA want to know about these issues? Are you saying that people should only go to AHPRA or the Medical Board if other avenues of redress fail?

Dr Flynn: No.

Senator XENOPHON: So when should somebody should go to AHPRA or the Medical Board?

Dr Flynn: Somebody can come to AHPRA or the Medical Board at any time when they are concerned about the behaviour or conduct of a registered health practitioner.

Senator XENOPHON: And as to AHPRA's attitude—I may ask Ms Ayscough: do you then normally suggest they go somewhere else? Do they go internally, as Dr Flynn said, if it is an employer-employee relationship—go to the hospital, for instance? I mean, how would you deal with it?

Ms Ayscough: If a person raises their concerns with AHPRA prior to lodging a notification and asks, 'Is this the appropriate forum?' then we will canvass with the person the other avenues for dealing with these sorts of issues, which are: in the workplace, generally in the state regulatory agencies that are established to deal with workplace issues, and we are clear to discuss with the person seeking our advice that our key role is looking at issues of public safety and not necessarily at what are, in fact, workplace issues that could and should be managed closer to the local area.

Senator XENOPHON: But would there be a point where the behaviour crosses over into public safety? How do you determine that? What sort of risk matrix do you establish?

Ms Ayscough: We are talking about two different things. The response I just provided was in the event that a person seeks advice from us, prior to making a notification, trying to determine whether it is the right avenue that they have come to. If we receive a notification from a person that alleges bullying and harassment then we apply the risk matrix that we apply to all notifications, which is to look at those questions of implications of risk to public safety. We have provided in our submission—where we refer to the number of notifications, on page 6 of 25 of our submission—as best as we can isolate them, the notifications that identified bullying and harassment as the primary issue, and you will see there that both the number of matters was very small and the range of behaviour that was complained about was quite disparate, some of which suggests a risk to public safety and some of which amounts more to an employment situation that could and should be managed at the local level.

Senator XENOPHON: But doesn't the College of Surgeons' own survey indicate a widespread culture of bullying and harassment within the profession?

Ms Ayscough: Well, that is as I understand the results of the survey, yes.

Senator XENOPHON: Can I just ask you: where is Mr Fletcher?

Ms Ayscough: Mr Fletcher is overseas and has sent his apologies to the committee.

Senator XENOPHON: I have spoken to Mr Fletcher about this. Had he already arranged a trip before the date for this committee was set or not?

Ms Ayscough: Yes, that is correct. His plans had been in place for some months.

Senator XENOPHON: That is fine, and it is not a criticism. I just wanted to clear that up. Ms Ayscough, when AHPRA was set up, it was suggested that registration costs would go down and that it would be a more efficient system. According to one submission, they have more than doubled since the establishment of AHPRA. Is that correct or not?

Dr Flynn: If I could comment, the profession about which people are concerned is medicine.

Senator XENOPHON: Sorry; I should have made that clear.

Dr Flynn: The fee for registration for medicine before the national scheme varied from, I think, about $150 in the Northern Territory, heavily subsidised by the Northern Territory government, to about $400 or so in Victoria and I am not sure which other jurisdictions. The fee currently is $725 in all jurisdictions. Prior to the national scheme, a number of jurisdictions received some government subsidy either directly or in-kind through services. There are no such subsidies now. The scheme is entirely self-funding. So it was not true that it would be cheaper. The board has set an initial fee, which I think was $650; it has increased it by CPI every year since then, until this year where the fees have been held steady.

Senator XENOPHON: Thank you for clarifying that. Can I just go to the issue of the 2011 Senate inquiry into AHPRA where the committee commented:

The committee is concerned about inconsistency in the application of complaint processes, the prescriptiveness of the application form and the way in which vexatious complaints are handled. The committee considers that further development of the complaints process is urgently required.

And the committee actually recommended that:

… complaints processing within AHPRA be reviewed to ensure more accurate reporting of notifications and to reduce the impact of vexatious complaints on health practitioners.

That was five years ago. What steps, if any, has AHPRA taken to deal with those issues, including: how is the complaint process handled now, compared to 2011, and how do you reduce the impact of vexatious complaints, including suggestions that have been made that there ought to be a good-faith declaration about a complaint?

Ms Ayscough: Five years is a very long time, and there have been numerous activities undertaken in reviewing our approach to the management of notifications over that period of time. I could put them perhaps in a few categories, one of which is about information. I think you referenced complicated information and the difficult form. We have spent quite a lot of time reviewing the information that we publish about the complaints and notification system. I think it has probably become apparent today that the national scheme is quite complex in its construction, and we have had significant efforts, really, to publish plain language information that allows members of the public and practitioners alike to understand how the processes work.

We have continued to refine the form that we use for people to capture information about notifications, recognising that the national law allows people to make their notification either on the form or by contacting us, and we can assist them with making the notification and we do. We reference, I think, also in our submission the fact that we are in the process of developing a portal, as the entry to the notification system, which will allow people to provide us the relevant information. It will guide them through the information they need to provide. That initiative also includes a requirement for a person to tell us, as they submit their notification, that the information they have provided is true to the best of their knowledge and belief.

Senator XENOPHON: Can we just go to one aspect of the process? A caution from AHPRA is non-appellable. Is that right?

Ms Ayscough: That is correct. So if a board decides—

Senator XENOPHON: Even though that could be a stain on the medical practitioner's or health practitioner's reputation?

Ms Ayscough: Under the national law, the board has available to it a number of regulatory responses. They really are considered to be in an escalating scale of seriousness, to respond to the different levels of regulatory risk, and a caution is a response that is at the very low end of the regulatory response. The national law provides that most of the restrictions on a practitioner's or responses to a practitioner's registration are published—

Senator XENOPHON: Sorry; I do not want to interrupt your flow, but can we just pause there. A caution must be notified to an employer—is that not the case?

Ms Ayscough: The outcomes of notifications are to be notified to employers.

Senator XENOPHON: That can have quite profound effects—quite serious effects—for a person who has been cautioned, yet they have no rights of appeal. Is that a fair summary of the facts?

Ms Ayscough: It is correct that the national law does not provide a right of appeal against a decision to impose a caution. However, cautions are generally not published to the national register—

Senator XENOPHON: But it goes to the employer?

Ms Ayscough: Yes. Employers are required to understand the responses to notifications.

Senator XENOPHON: But the person that has got the caution against them cannot appeal against that?

Ms Ayscough: That is correct. The national law does not provide a right of appeal for that decision.

Senator XENOPHON: And do AHPRA or the medical board have any views about the procedural fairness of that?

Ms Ayscough: I would not like to venture an opinion about that.

Dr Flynn: A caution is not imposed unless a practitioner has been given notice of the board's intention to impose a caution and given an opportunity to make a submission in relation to it. So the practitioner does have an opportunity to make a submission, but that is not the same as an appeal; I accept that.

Senator XENOPHON: Sure. And the board may have made an error—a jurisdictional error; an error of fact—or not considered appropriate evidence—

Dr Flynn: All of those things—

Senator XENOPHON: all of those things, but there is no appeal? Do you have a view as to whether there ought to be an appeal process for a caution, Dr Flynn?

Dr Flynn: I can understand that practitioners' confidence in a scheme depends on their belief that it is fair, and it would certainly not be a problem to the board if there were capacity for an appeal against a caution. A practitioner, however, may still feel, because they need to inform their employer that they have been subject to the notification, that that actually in itself is inappropriate. But that is the reality: they need to inform their employer one way or the other whether the notification is—

Senator XENOPHON: Sure. I will just wrap up, because of time. In terms of a vexatious complaint, something that the Senate committee back in 2011 reflected on and made recommendations on, we have heard from the College of Anaesthetists. They made a very interesting submission. At the bottom of page 3, they talked about one anaesthetist complaining about another and knocking one out from practicing and how that could have profound implications in a country town, for instance—in a regional community. I thought that was quite revealing. They said:

> ANZCA is unaware of any specific examples of individuals or institutions using the threat of reporting to AHPRA vexatiously to intimidate registrants. However there is some anecdotal evidence that suggests allegations against private specialists are being used to exclude them from being credentialed in private institutions. This has the impact of restricting their ability to practice which in small towns could be quite devastating.

That is quite an open submission.

I have to squeeze in a couple more questions so could you take on notice: how do you deal with those sorts of matters? How do you adequately deal with the consequences of vexatious complaints and whether it is appropriate? There needs to be a good faith declaration at the very least, to say, 'What I am saying is truthful', so, if it is found that you have falsely or recklessly made a statement, that ought to be taken into account.

I want to go to one of the witnesses earlier today, an orthopaedic surgeon, Dr Gary Fettke, who gave evidence publicly so I do not feel constrained in raising the issues that he raised. Dr Fettke made allegations—and, perhaps, you do not have to comment on Dr Fettke but about the general principles. He said he was refused access to the documents under freedom of information legislation because it might reveal the workings of AHPRA or it was deemed by AHPRA to be confidential. As a general principle if there are issues there of natural justice—and I think Dr Fettke's allegations are that he would give advice to his patients as an orthopaedic surgeon dealing with cases of lower limb amputations for people with diabetes and problems of obesity. He has gone through a pretty traumatic time for the last few years. What is your approach to FOI in those circumstances? It seems that there has been a lot of resistance by AHPRA to release documents which on the face of it seem not unreasonable to release.

Ms Ayscough: It probably will not surprise you that I cannot comment specifically on Dr Fettke's case, but I can start to say that—

Senator XENOPHON: And I do not expect you to at this point.

Ms Ayscough: But I can say that we are bound, as you would imagine, under the freedom of information legislation. There are exemptions provided for in the legislation. We have published to our website—

Senator XENOPHON: Are these under sections 24 and 40?

Ms Ayscough: There are a range of exemptions—potentially exempt documents—under the Freedom of Information Act under various sections: internal working documents, for example, under section 36; documents that relate to the personal affairs of another person, which often is relevant when we are talking about documents generated through the complaints process, section 41.

So we have a freedom of information policy which is published on our website. Our policy and the legislation also allows for review of FOI decisions in the event that we refuse to release documents, and a review by the National Health Practitioner Ombudsman and Privacy Commissioner. And, in the event that the applicant remains dissatisfied with the outcome, there is a right of appeal to the administrative tribunal in the local jurisdiction. We also publish on our website a disclosure log, which makes publicly available the decisions that we have made under freedom of information and the information we have released.

Senator XENOPHON: So, in terms of Dr Fettke's matter, that is still before AHPRA—you can say that much, can't you?

Ms Ayscough: I can say that we would not comment on Dr Fettke's matter because it may interfere with current proceedings.

Senator XENOPHON: There is one matter you may be able to comment on: Dr Emery, who appeared on the ABC's *Lateline* some time ago—his matter has been brought up. Can you comment on the fact that it was finally resolved, with no adverse findings against Dr Emery, and it took some two years and three months for that process to take place?

Ms Ayscough: I have not prepared the information on the duration of the matters relating to Dr Emery, but I can certainly confirm that information back to the committee.

Senator XENOPHON: Is it fair to say that Dr Emery's matter has been disposed of in a way without any adverse findings against Dr Emery?

Ms Ayscough: Again, I have not prepared on the specific case of Dr Emery, so I am happy to come back to you on that.

Senator XENOPHON: Could you please take that on notice. I note that Dr Emery is now overseas and has moved back to Europe to practice there. Does it concern you, in general terms, that a matter might take over two years to resolve?

Ms Ayscough: I have mentioned already in evidence to this committee that we recognise that we have had issues with the time frames for investigations, and we certainly acknowledge the impact that extended investigations have on both the notifier and the practitioner. We have had a number of process improvements to work on the time frames, and we generally aim to conclude investigations within six months. But we acknowledge also in our published information that some notifications are complex and, depending on which of the activities are required under the national law to completely investigate a matter, they may take longer than that ideal time frame.

Senator XENOPHON: I will wrap up now. Going back to the FOIs, can your decisions on FOI be appealed to the Information Commissioner or to the AAT?

Ms Ayscough: Yes. The FOI decisions are open to review by the National Health Practitioner Ombudsman and Privacy Commissioner, and, in the event that a person is unhappy, still, with the outcome of the review from the ombudsman, they have a right of appeal to the administrative tribunals in the states and territories.

CHAIR: Senator Xenophon, we are running out of time. Senator Duniam—who, by the way, is on his mobile, because we are having technical problems—has a question and I have a couple myself.

Senator XENOPHON: Sorry. I will defer to Senator Duniam. I am done.

CHAIR: Senator Duniam, I am going to hold the phone up to the microphone; hopefully, everyone can hear you.

Senator DUNIAM: Thank you very much, Chair, and apologies for the technical problems. It was an adventure, I can tell you, while I was offline. The one question I had goes back to the qualifications of investigators. I wonder whether you might be able, on notice, to furnish the committee with the selection criteria by which the recruitment decisions are made around the investigators, if that is at all possible, please?

Ms Ayscough: Certainly. Yes. We advertise those roles frequently, so we will be happy to provide the role description and selection criteria.

CHAIR: I have a couple of questions. I suspect there will be more on notice as well. And we are going to try and get Dr Fletcher on as well at some stage. In terms of the length of time for complaints to be resolved, you said the median time has come down to 135 days. What is the longest? We are getting complaints of a number of years. So what is the longest? They are the ones, obviously, we are going to hear about a lot.

Ms Ayscough: Yes, as you say, I would need to take that on notice. I do not have the details of the longest investigation currently open.

CHAIR: Could you take on notice, then, the longest, but also how many are taking over the median?

Senator XENOPHON: Where there is an investigation that has been found not to be of substance, and the complainant, who has been exonerated, for want of a better word, has raised issues about the vexatious nature of the complaint, do you then, at that point, look at it to see whether the complaint was in any way vexatious, where there were things misleading or false or misrepresentations put to the Medical Board or AHPRA in respect of that complaint?

Ms Ayscough: If that allegation really amounts to a notification about another practitioner, then we would look at that through the same process as we look at all notifications about professional conduct.

CHAIR: Sorry. Does that mean that if they had been using the system vexatiously you would look at that? Is that what I take from your response?

Ms Ayscough: I am saying that if a practitioner who had been the subject of a notification then makes a complaint to us about the conduct of another practitioner, then we would look at that.

CHAIR: What happens if the system has been used vexatiously? If I have taken out a complaint against a competitor, which is the comment we have heard today—because of a commercial opportunity or whatever—and that is found to be not substantiated, you do not then look at the fact that somebody has made a vexatious claim?

Ms Ayscough: I think what I would say is that these types of issues are rarely as clear as that, and often complaints that are made which may have an element of either professional or commercial interest also give rise to questions around the public interest and public risk which require consideration by the boards, and that is the way we deal with them. There is the capacity for a board to make a decision when first assessing a notification that the notification is frivolous, vexatious or not properly made out, and the board might decide at that very early stage that they will take no further action on it.

CHAIR: I will just need to go back, because there are lots of facts and figures in your submission. You give us detail on the breakdown of some of the claims, but I do not think you have given us figures on how many dealt with at that early stage.

Ms Ayscough: No. And that is because what we do say is that it is extremely difficult—in fact, virtually impossible—for us to provide specific data on that. The grounds in section 151(1A), which refer to the 'frivolous, vexatious and other', are one of the grounds on which a board might decide to take no further action. And we do not routinely capture data on which parts, which elements, of that test have been satisfied, leading the board to make the decision to take no further action.

CHAIR: Okay. Thank you.

Senator XENOPHON: Chair, perhaps I could put a question on notice. One is from our colleague Senator Peter Whish-Wilson. I understand that Dr Fettke had received a final letter from AHPRA wanting to proceed with a caution effective immediately. They have said it was non-appealable. The letter was dated today and the email arrived at 1.43 pm. I just wanted to put that on the record. Can you comment on that at all?

Ms Ayscough: No, I cannot comment on that.

Senator XENOPHON: The final issue is: would AHPRA consider mediation as a first step instead of the current adversarial submission system? Is it within your purview to consider that under the current legislation, under the national law?

Ms Ayscough: We have considered that question before and I think it is relevant to point out that AHPRA and the national boards are part of the overall complaints management system, and there is also in each state and territory a health complaints entity. The health complaints entities do have the capacity to mediate or conciliate on complaints.

Senator XENOPHON: But you do not? Does AHPRA have that ability?

Ms Ayscough: It is not currently one of the processes that is outlined in the national law for managing a complaint or notification.

Senator XENOPHON: If the national law is silent on it, does that mean you can still do it?

Dr Flynn: If I might comment: Ms Ayscough referred to earlier, and in the recommendations from the independent review there was, a set of recommendations about the way AHPRA works with the health complaints entities in each state and territory. Essentially, what we have done is clarify that relationship so that matter that are suitable for mediation are dealt with by the health complaints entity, which then takes their mediation process forward. If it is a matter that relates to the threshold we were talking about, about public risk, then the board investigates it. In that case, we do not believe it is suitable for mediation, because it is a matter that has raised an issue about risk to the public.

Senator XENOPHON: You do not normally mediate anyway. That is not the practice of AHPRA at the moment.

Dr Flynn: Correct. Matters that are to be mediated are handed to the health complaints entity. So when the complaints come in, somebody from the health complaints entity office and somebody from the AHPRA office in each state and territory sits down and looks at them and determines which body is the appropriate one to deal with it, according to a defined decision matrix.

CHAIR: Okay. We have gone over time. Thank you for your evidence today and for your submissions. We will be back in contact with time lines for answers to question on notice. I thank all the witnesses.

Committee adjourned at 16:34