C O R R E C T E D V E R S I O N

STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

LEGISLATION COMMITTEE

Inquiry into the performance of the Australian Health Practitioner Regulation Agency

Melbourne — 21 August 2013

Members

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Professor P. Dewan.

The CHAIR — Good evening. I declare open the public hearing of the Legal and Social Issues Legislation Committee. Tonight's hearing is in relation to the inquiry into the performance of the Australian Health Practitioner Regulation Agency. I welcome Professor Paddy Dewan. Thank you for appearing this evening and for your written submission.

All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Legislative Council standing orders. All evidence is being recorded, and you will be provided with proof versions of the transcript in due course. Transcripts will ultimately be made public and posted on the committee's website. I now invite you to proceed with a brief opening statement, if you wish, which will be followed by member's questions. We have allocated 45 minutes for your presentation.

I also thank you for resubmitting your submission with redactions. I also caution you in relation to the evidence that you provide to the committee this evening in relation to naming anybody. We look forward to hearing from you, and thank you again for being before us.

Prof. DEWAN — Thank you very much for taking my evidence and for giving me the opportunity to present this evening. There is obviously a significant public interest in the work of the committee and in the information I am presenting to you. To perhaps give you a little bit of background, I have produced a series of slides, which you have copies of, I gather, and what I have listed there are the topics of Semmelweis, Australian scenarios, Springborg, 98 cases plus 2, AHPRA, VCAT and then ultimately what you are looking for, which is solutions, and that is what I hope to help you find.

Semmelweis is important in that he was an obstetrician who in the 19th century said that obstetricians should wash their hands. He was drummed out of the corps because it was considered that he was calling them dirty rather than identifying that people need to wash their hands before they do deliveries to stop puerperal sepsis. The two slides that show the graphs indicate that he made a difference to the infection rate that was being created by obstetricians. He brought it down to the rate that the midwives were producing. The difference was that the obstetricians were doing autopsies.

He actually went mad and died in an insane asylum because people did not listen to the fact that you should wash hands. They drummed him out of the corps. It was not until Louis Pasteur came up with the germs theory and puerperal sepsis the organism was identified in 1884 that he was obviously vindicated.

In Australia we have had the benefit of having Stephen Bolsin, who is an anaesthetist in Geelong, write a paper about the scenarios that have occurred related to whistleblowing that he had been through in the UK about cardiac surgery; about the Canberra Hospital about neurosurgery, and the whistleblower was a staff specialist; the nurses at the Camden hospital and the associated hospital in New South Wales that ended up identifying systemic problems there; and an administrator at King Edward hospital in Western Australia.

In Queensland, we all know of the saga of Jayant Patel, which is still unfolding. He was appointed in 2003. In June 2010 he was convicted of manslaughter, of which he has subsequently been acquitted and all matters are obviously in the public domain, and there has been a lot of legal argument and a lot of cost. Medicine is not being judged by medical standards but in the legal arena, which is causing great cost and potentially great harm to the patients in that scenario, because they are being exposed to further risk on top of the medical problem that they have had in the past. The background problem that relates to the question of 'Is AHPRA appropriately serving the Victorian public?' is the fact that due diligence was not done about his dismissal from being able to practice prior to him coming to Australia. There is a sense of due diligence and processes that might be in place.

We then have the circumstance in Victoria that was alluded to in the other meetings I have seen here of the 55 women who have contracted hepatitis. That is effectively because the Victorian medical board did not have the tools to be able to protect the doctor, let alone the 55 women. The story is on the slide there, which gives some of the details in the time frame. The first patient was infected in 2008.

In Queensland there has been an inquiry that has been orchestrated through the health minister which has seen a review of 596 cases and found that 60 per cent had not been handled properly. That is in Queensland, which is using a similar model to that which has been used in Victoria. So it is not whether AHPRA is appropriately serving the Victorian public; it is whether the model that is in place for handling complaints is actually appropriate, and Queensland tells us that it is not. I think we need the same investigation here.

Just to prove the point, 98 case scenarios were submitted by me in August 2004. There was in fact a falsification of a document related to those cases by the CEO of the medical board. They were only willing to look at individual cases. There were 25 cases against one surgeon, and it was, 'We are not able to collect those cases to look at them collectively'.

One of those cases is in the next slide, which is of a boy who had a prenatal diagnosis, and there is a picture there of an X-ray taken at 90 days, which was the repeat of an X-ray, which is very arguably not needed. The story is able to be seen through the connection that I have given on the link, and during the process of that — and I have had the documents given to me by the mother today — there were seven Victorian medical board staff involved in a process that took from March of 2006 to early 2008 to reach the point of saying, 'There is no case'. That included a statement in defence by the surgeon, who has also been disaffected by this process, that the stent — the piece of plastic left in — can be left in for months. The fact is that it was in the wrong spot, and it was not taken out in a timely fashion as the surgeon had claimed. Note in the next slide that the 55 women started to get hepatitis in 2008. I had already drawn to the Ombudsman's attention that the 98 cases had not been handled properly, in effect because the medical board has not had the tools.

There was then a case I operated on in 2004, and I was found guilty in 2009 of a single case where I was ordered to retrain. The medical board, through the legal services, pursued the intention of my deregistration through a VCAT appeal, so the Supreme Court then accused VCAT of being like 13th chime of the crazy clock, and that is not all they said that was disparaging about the VCAT process. VCAT was then persistently asked to deregister me, and yet all they said eight years later, after the operation — the point is it has taken eight years to get to the point where the only impost upon me is that I have to do an audit, which should be the obligation of every medical practitioner. Eight years and however many hundreds of thousands of dollars were spent on insisting that I do what every doctor should do and, in effect, to stop me from being able to practice in the way that I should because of the blackening of my name with the public and with the medical profession.

The next slide looks better on the slides because it shows you the simple concept that goes with the surgery that was done in 2004. The following slide shows you that there were 15 cases presented at a meeting by a surgeon in 2009 who had had very similar surgery. So 2009, very similar surgery on 15 cases, reported out of Sydney, but I was found guilty of unprofessional conduct for having operated on one case in Victoria. Clearly the process of evaluation of that case was flawed.

In 2011 I operated on another boy with a similar condition, like the 15 cases in Sydney. The family gave evidence at VCAT of the great outcome from that surgery, and yet I was found guilty at the second lot of VCAT hearings, because there are no rules of evidence and it is a legal argument; it is not a medical argument about what the standard should be. So I have to do an audit. That was ordered in December of last year to start earlier this year. I have had no follow-up from AHPRA or the medical board about whether I am complying with that. The issue is I am complying with it, but AHPRA and the medical board do not know whether I am complying with it; that is the point that I make. Even my personal experience says that I could be very dangerous, as I have been accused, and they are not watching. Fifty-five women got hepatitis.

Another case that just indicates that there is inadequate control of the processes through AHPRA and the medical board is that I have subsequently had a notification against me in August 2012 — it is the time frame and the process that indicate that we do not have good barriers around the processes that are being used. I was notified in September 2012 and ordered to attend an immediate action committee meeting where a panel member who found me guilty previously was the chair of the panel that was going to decide whether I lose my registration — conflict of interest. That is the sort of standard that is being set in the judgements.

We had the father present, we had a letter from the surgeon at the children's hospital who was going to do that surgery in March, and yet there has been no further effective action taken about that notification of me being a danger to the Australian public for 12 months. For 12 months, according to the letter of notification, I have been a danger to the Australian public. I would protest that that is grossly untrue, but if the system is seeing that that might be true and not handling it, then that means that the system is broken. So clearly AHPRA and VCAT need to have some changes.

The presentations I have seen that really do show the core of the problem to this committee have been those of Julie Phillips, no. 28; Jenny Morris, no. 31; presentation nos 47 and 53. I gather there has been a further submission which I would like to mention, and that is from Helen Stanley-Clarke. Her story is also on the link

that you see there. The community from Stawell who were presented, and then there are a number of doctors who are happy to be mentioned, one of whom has made a submission — David Lindsay. Leong Fook Ng has made a submission which is yet to be put on the website. Helen Tsigounis is happy to be mentioned. Mr Ong Ooi, a general surgeon, has asked me to include his name in the list of surgeons who would say that the medical board processes are not in favour of the community.

The solutions — —

The CHAIR — Could I just stop you there, Dr Dewan, and clarify a point. You have mentioned a number of submissions that we have received. Just for your information, they have not yet been accepted by the committee. We have accepted a number that have been highlighted there, but a number that have not been highlighted, as you have mentioned, have not yet been accepted by the committee. I just need to make that point to you.

Prof. DEWAN — Okay. Thank you very much. The people who have made those submissions have asked me to mention their submissions this evening, if that is okay, but I understand the point that you make.

The CHAIR — We may have received them after the closing date, and therefore the committee has not accepted those submissions, but they may be accepted as correspondence. That will be a determination of the committee. But thank you for drawing it to our attention in any case.

Prof. DEWAN — The name at the end of the list on that slide is Malcolm Traill. He has a very lengthy contribution on a website, but the important point of his website really is about the appointment of panels both at the medical board level and the VCAT level, the process whereby they are elected, their terms of office and the terms of review of their performance. That is the point I make by putting his name down there.

Regarding the solutions, I think the main solution is to default to mediation. Great harm has been caused to the professions, and great harm has been caused to the community through the stress involved in the current processes. There is no accountability of the judges, and at each level in the adjudication of adverse events right down to the hospital level there does not seem to be accountability. There is no accountability process for the complainant either; it would seem that you can make a complaint and there is no comeback to those people who make a complaint. That is not legitimate. There is no real accountability of the witnesses. Despite the fact that we should be judging on medical evidence, there are hired guns for which there is no accountability, and that is not good for health care.

There are no appropriate rules of evidence in VCAT let alone at the other levels, and I think we have to have appropriate rules of evidence even down to the hospital level but particularly at the board levels so that when judgements are made they do not prejudice the judgement at a higher level because they have appropriate rules of evidence. And certainly with transparency, there is a very deep lack of transparency at the moment in the whole process of evaluating whether a clinical outcome is appropriate.

In order to be able to understand it I think there needs to be a mechanism that goes even beyond what has happened in Queensland. I think there needs to be an investigation of the legal costs involved and an evaluation of the costs for each of the outcomes — the outcomes for the patients once a complaint has been made and dealt with, and the outcomes for the professionals. The impression is that a lot of professionals are lost to their profession because there is a complaint that they have to endure where they may not necessarily have done anything particularly wrong. We need to look at the process steps in the reports for AHPRA. It talks about 'most' doctors being notified when there has been a notification. Why most? If you look at the last report, it says 'most cases' in three places; it refers to 'legal' in 29 places. We need to have records of the variations in the difference in processes between similar cases as well, and that includes the cases where there are complaints against AHPRA staff.

The CHAIR — Please continue. I am just getting some clarification in relation to the list of submissions you provided to us, and I will run through those with you.

Prof. DEWAN — There is a sense of a re-engineering of what AHPRA is at the moment. It would seem that an accountability of the boards to a minister is lacking. State boards that are accountable to a state minister, as was previously the case, seem to have potential safety for the boards, for the patients and for the practitioners, but there seems to be a failure of separation of powers at the moment in that we have accreditation, registration

and regulation under the one banner. Perhaps accreditation should be in the hands of a medical council that is independent of AHPRA and that registration be national and handled by an organisation that is like AHPRA is in part at the moment. But the regulation and the follow-through of the punishment should be at a different level with perhaps even an independent orchestration of the punishment of those practitioners who may have erred.

There are community groups that are looking for change, and I have given you a slide of one of those community groups that has tried to come together to help patients understand how they might more easily come to understand their health and the solutions to their medical problems. Thank you.

The CHAIR — Thank you very much for your presentation. Could I just clarify for you that we have received a submission from Mr David Lindsay, and that is on the committee's website. We have received a submission from Helen Stanley-Clarke and Leong Ng, but the committee has not yet considered them, and they will be considered in due course. But we have not received submissions from Helen Tsigounis, Ong Ooi, DS, Dr A. K. or Malcolm Traill. That is just for your information.

Again I thank you for your presentation. I would like to go to the area where you spoke about the auditing process that you have to undertake. I think you said that you self-audit. Is that correct?

Prof. DEWAN — Correct, yes.

The CHAIR — Could you please explain that auditing process to the committee — when it started and what you need to do — just to give us a further understanding of the issue you raise about the auditing process?

Prof. DEWAN — I think it is a very good example. Some of the presentations you have had from patients identify that it seems to be made up as you go. The board has had a very difficult situation. They have taken a ruling from VCAT and then it is, 'Now deal with it'. There are no guidelines for them, so they have said, 'An audit is what has been ordered. Go and do it'. But then there are situations where hospitals are told that my patients are being audited.

The CHAIR — So does VCAT order the audit and not AHPRA?

Prof. DEWAN — Yes. This is part of the — —

The CHAIR — The ruling process at VCAT?

Prof. DEWAN — AHPRA and VCAT now are in one way one and the same thing in that an appeal will go to VCAT. Now I think in fact the new iteration, since my initial circumstance, is that a case that is deemed to require a major inquiry goes to VCAT, so it is conducted in the legal environment of VCAT rather than in the medical environment of the medical board. It was still legalistic at the medical board previously, and probably is still, but now it goes into a purely legal environment, having legal argument about medical facts — where you have limited opinions that are searched out, and that is a flaw in itself. So a solution to evaluating a case is hot-tubbing. David, you are obviously aware of that as a lawyer.

Mr O'BRIEN — I am aware of that term, yes.

Prof. DEWAN — It is where you get the experts together and you work out what the balance of evidence is. That would seem to be a solution in the medical environment.

Mr O'BRIEN — Are you advocating that, or are you saying that it is part of the problem?

Prof. DEWAN — I am advocating it as a potential solution that needs to be explored for its flaws, but the current circumstance of having legal argument where each side seeks out its own experts to try to win against the other is not in anybody's interests. It does not encourage the doctor to continue to practice afterwards if he or she is not guilty. If I was guilty of something, it took eight years to prove it. It took eight years to potentially stop me. That is the legal process.

Mrs PEULICH — Just a quick point of clarification. When you refer to the hired guns, are you talking about the experts who are hired by the respective sides?

Prof. DEWAN — Yes, correct.

The CHAIR — Mr O'Brien, before I move to other committee members, if I could just get some clarification — I will move to other members because they will have questions — have you got a question on something that has been raised?

Mr O'BRIEN — Just on the nature of the submission. VCAT has, at least in the jurisdictions that I practised in up until 2010, the ability to hot-tub or, sorry, have joint expert evidence, and I believe we passed legislation that extended that ability to the courts or confirmed it in the courts for practice in court cases. Are you aware whether VCAT did not adopt the practice of joint experts giving evidence or hot-tubbing, or are you saying they need to do it more?

Prof. DEWAN — If they have the ability, it is underutilised. It certainly was not something that was made available. Mediation was only made available when there was a significant challenge — and again, it is my specific example, but it paints the picture, I think, of what is a not uncommon experience. The hot-tubbing was something that was not made available to us. Mediation was only made available — —

Mr O'BRIEN — Sorry to be difficult. Just to clear up the dates: to my knowledge it came in in about 2008 or 2009 in other practices for precisely the reasons you say — to try to get experts to have a more unified position and eliminate areas of disagreement and get to the heart of the issues and also to have the ability for the experts to ask each other questions rather than the lawyers doing all that work. When precisely do you think it was?

Prof. DEWAN — The case concluded in December 2012

Mrs PEULICH — Does that have a cost factor?

Prof. DEWAN — The process as it unfolded in my example was an extremely expensive exercise for the community that gave no benefit to the community. Hot-tubbing might have required some evidence to be put together, but I think the cost would have been significantly lower.

Mrs PEULICH — But it falls to different parties.

Prof. DEWAN — It falls back to the community ultimately in the cost of medicine to the community.

The CHAIR — Just on the auditing process, before I move to Ms Hartland, when you do report, how often or on what basis does VCAT order you to report? Regularity is what I am trying to get an understanding of.

Prof. DEWAN — It is on a six monthly basis, and there have been — for instance, the hospitals were only notified in March that I was undergoing an audit after the decision in December, so there is a significant delay in processing; a failure to protect the public. I am reporting on a six monthly basis, but what I need to report and who looks at it — so I have collected the data on my activities, and I have had imposed on me that I have a satisfaction form filled in by the patients. But what if the patients do not fill it out, if it is an impost upon the patient? There is no benchmarking about that type of phenomenology.

Effectively the medical board were making it up as they went is what I would say, and that is not a criticism of them. They have not got the tools to do it. They get a ruling from VCAT for which they have got no infrastructure and no knowledge of how to orchestrate it, and then they will go off, 'Well, what do we do now? We had better write to the hospitals and tell them he has to do an audit'. And the hospitals go, 'What about the privacy of our patients?'. So you have that type of thing going on instead of, 'What will we do if a surgeon has to be audited — that we are orchestrating? Here are the rules of engagement'. There is none of that sort of thing.

The CHAIR — Thank you, but just to get to that point in the notification, you said the ruling was made in December and the hospital was not notified until March.

Prof. DEWAN — In March.

The CHAIR — That is a three-month gap in which potentially somebody could have put patients at risk; is that your view?

Prof. DEWAN — Correct. And the appointment of the specialists who were to supervise my audit did not happen for months as well.

The CHAIR — When did that happen?

Prof. DEWAN — I think the notification to the hospitals happened as soon as they had eventually appointed people to do the supervision. So I was having a meeting with one of my supervisors before he had even been officially appointed by the medical board so that I could comply with VCAT?

Ms HARTLAND — Can we go back a step; I am a little confused about exactly how this works. So VCAT says that you have to be supervised. You go through a supervision process. You are collecting the data, but you are saying you are not actually sure that anybody is looking at that data that you are collecting?

Prof. DEWAN — I have had no constructive guidance. In a well-oiled process I would have thought that there was a predetermination of how it would unfold: the surgeon gets told to have an audit; these are the steps that we go through; here are the people who are assigned to orchestrate that; let us make sure that a practitioner is guided in the process. So somebody comes with me and says, 'Have you set up a spreadsheet? Do you know which data we want to have a look at? This is where you're going to need to report it subsequently'. I have had no contact to give me any guidance, and I have not had the contact that would suggest that the public is being protected, which is supposedly what they are doing.

Ms HARTLAND — So when you are collecting the data, who do you give that data to? Do you give that to VCAT?

Prof. DEWAN — No, to the medical board.

Ms HARTLAND — Right, and there is no contact back from the medical board as to whether this is satisfactory?

Prof. DEWAN — I have not had any. I have collected the data. I have emailed the data to my supervisor to say: 'It's coming up time; can you have a look at this?', to find a sense of annoyance that such minor cases are being imposed upon a senior person to supervise another very well respected except-for-the-whistleblower-phenomenon circumstance.

Mrs PEULICH — If all you are telling us is accurate and factual, it is a bloody debacle.

Prof. DEWAN — I have come to understand this through contact from a number of different people and from taking the trouble to read contributions in different directions, like Helen Stanley-Clarke's. Her story is quite similar to that of Jenny Morris, whose presentation I was able to be here for the other day; and that is a very impressive contribution. It lays out that there are a lot of steps along the way where the boards — and obviously the medical board and the other boards are probably similarly affected — have not been given the tools to be able to do the job of guiding the professionals and protecting the patient.

When you look at what has been done in Queensland, where 596 cases have been reviewed and 60 per cent of them have been found wanting, where this one case of my 98 has taken — there are seven different Victorian medical board people involved with contact people for the family. Their first letter goes out in March, and they find out in 2008, 'Well, no, we've dismissed that'. There is no mechanism of looking at the contribution from the surgeon who did not do a good enough job, but he was not guided by the medical board to be able to look at that in a constructive way. It was my opinion versus his and then, 'Well, we can't see a difference'.

Mrs PEULICH — So governance, the separation of powers and due process are really your key — —

Prof. DEWAN — Correct, yes. Particularly the separation of powers I think is one that something can be done about. We saw ophthalmology and optometry discussed around this table the other day, where if you take two professional groups who are in conflict about their roles and then you just take a contribution from one and the other and you do not have a mechanism for being able to judge it appropriately, and you do not take enough submissions, you have AHPRA, who is taking that sort of judgement and then taking individual complaints, like the vexatious complaint against me recently, and then just going, 'We don't know how to handle either of these', would be a reasonable response, because they do not seem to have the tools. I would argue that when you look at the reports, they drill down to number crunching, not looking at the issues, not looking at the real core of the underlying issues.

Mr O'BRIEN — Thank you, Professor Dewan. Just looking at the future, if you like, in terms of your recommendations, one mechanism we have of assessing that is in a sense a comparison with the past — the previous state-based systems. I know you have broken down the three areas — accreditation, registration and regulation — which is helpful, but by specific reference to the system that operated, what recommendations do you have about the strengths and weaknesses of the national system and where you think Victoria should head?

Prof. DEWAN — Certainly with registration I can see that there is an advantage to being able to go onto a single website and see what the current status is for a practitioner. I think that is a very useful thing to be able to do, and a centralised police check process — a working-with-children check — if that sort of thing can be centralised into the registration.

Mr O'BRIEN — Can I just get you to pause there — sorry — before we will deal with registration. Is there any advantage, do you think, in the previous state-based model or a federated model where you actually need to register in each state and that provides checks and balances that might be a red flag system, if you like, for a doctor moving around?

Prof. DEWAN — I think if you had the tools within the single national organisation, you could probably cover that base. I know that is a suggestion, you register once and then you can kind of hide what you are doing, whereas if you are having to move from state to state because people are catching up with you, then maybe it can be a mechanism. But I would have thought there were different ways — particularly not mandatory reporting. I think that creates vindictiveness. Creating a culture of accountability and a culture of no blame; I think that is where that solution comes from, where people are happy to mention that there has been a problem, like the nurses who were working in the Croydon clinic. How did he get away with it? Because people were afraid to say something. People have seen what has happened to Paddy Dewan, and they ain't going to squeak, mate.

Mr O'BRIEN — I just want to be clear on what you are advocating. Are you saying there is a problem with the culture of no blame, or are you saying we need to move to a culture of no blame?

Prof. DEWAN — We need to move to a culture of no blame. We need to promote that culture. Open disclosure is a throwaway line at the moment, with lots of words written about it, but it is not something that exists out in the workplace. The no-blame mentality is something that is a throwaway line about which there is a lot written at important committees, but it is not out there in the workplace. People are afraid to talk about complications. People are afraid to mention there has been a problem. So it is promoting that as a culture — the no blame, the open disclosure — and really working at that being part of what we do in health care. I think the clunkiness of the different states of registration — I think you could probably do with just a national registration authority.

Mr O'BRIEN — I cut in on you on registration, so if you could continue with the other aspects of accreditation.

Prof. DEWAN — Accreditation is about you as a professional being recognised to be able to work within a scope of practice, and within the scopes of practice there is not just what one professional might do, like orthopaedic surgery and podiatric surgery are overlapping; between the ophthalmologist and the optometrist there is overlap. So a body that allows for an assessment of the skill that people need to have to be able to provide that service rather than a label you need to wear to be able to sign off on that Medicare number is an approach I would like to see — that you set a standard of practice, and therefore people fall within that standard of practice. It is like general surgery and paediatric surgery; a paediatric surgeon should not only be able to operate on patients up to the age of 16 and a general surgeon only able to operate down to the age of 16. It should be: how good are you at that operation where you are good at it because you have this exposure to those patients? It is that approach, that accreditation of skill, not accreditation of a piece of paper.

Mr O'BRIEN — The last aspect was the regulatory aspect. You talk about accountability of in a sense everyone. I suppose that accepts the fallibility of everyone, be it a complainant, a practitioner, a regulator, a judge or a witness. How do you reconcile that with your no-blame culture? Is it the case that there is no blame whilst the event is occurring, but when you then look at systemic problems or the need to litigate, as you do occasionally, or whatever you have to do to get to the bottom of an event a few years on, you then adopt a more traditional court-style accountability so that reputations — —

Prof. DEWAN — In the appointing of positions to AHPRA and the medical board, for instance, it is my understanding that the legislation as it is written at the moment means that there is no limitation on the time of appointment of board appointees. I have to check the legislation, but there has certainly been the appointment of a national board chair from a previous state board chair position. If you look at the names of people, if you look at the groups that are involved in the committees from which VCAT medical panel members are selected, if you look at the people who were on the medical boards and then you look at those who are called to give evidence at the medical board for the medical board, then you will see a commonality of names where there is not a sense of limitation of the time in which they are able to do that. If you feel you might be judged by the other group of people, that is a sort of accountability where it is a balancing of the power in effect. It is not people being appointed in perpetuity to positions.

With the accountability of those who are making complaints, in essence it is about looking at it sensitively and constructively and not in a blame-type way. It seems that the documents that come back to the notifiers now are problematic. They are threatening and they are challenging, and I think that creates this tension and antagonism of attack and counter-attack. I do not think we want to have a legal process at the end if we want mechanisms that allow people to feel safe and protected but as if their performance is being watched. It is the performance being watched accountability.

The CHAIR — Can I take you back to a point about Queensland that you raised in your presentation? In your submission you refer to the Springborg policy reforms. Can you make a comment on the appointment of a health ombudsman to deal with complaints in Queensland?

Prof. DEWAN — Yes. In her presentation Jenny Morris was saying that the health services commissioner in Victoria is the solution: do away with the medical board and go to the health services commission because it has mediation. I do not see that as the solution. In fact in the documents that I presented previously I suggested that you have a health services commission to look at health services, and you have boards to look at the professional conduct. You should have mediation as the pinnacle of each of those organisations, not swap one for the other. I think you still need the health services commission to look at issues related to the way services are constructed rather than the way professionals are behaving.

The CHAIR — Thank you for that clarification. If there are no further questions, on behalf of the committee I thank you for your appearance this evening, for providing your evidence and for subsequent submissions. It has been very helpful. We appreciate your time this evening. Thank you very much.

Prof. DEWAN — Thank you.

Committee adjourned.