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Professor Ron Paterson
Chaperone Review
c/- National Health Practitioner Ombudsman and Privacy Commissioner
GPO Box 2630
Melbourne, Victoria 3001

Dear Professor Paterson

I am writing in response to the call for submissions in relation to the 10 August 2016 announcement by the Australian Health Practitioner Regulation Agency and the Medical Board of Australia of an independent review of the use of chaperones to protect patients.

I note that you, as reviewer, are asked to consider "*whether, and if so in what circumstances, it is appropriate to impose a chaperone condition on the registration of a health practitioner to protect patients while allegations of sexual misconduct are investigated*".

While not wishing to comment at length on the particular circumstances that gave rise to the review, it strikes me that the *Terms of Reference* have approached this issue from entirely the wrong perspective. If there has been regulatory failure in one egregious instance, I would have thought the more sensible approach would have been to examine the circumstances of that failure carefully, to identify the key failings and then look to see whether there were other similar circumstances suggestive of systemic failure.

To the outsider, the matter that gave rise to this review may not – if at all – point to an issue with the suitability or otherwise of chaperone conditions in cases of sexual misconduct but, rather, may be indicative of a failure to:

1. determine the most appropriate chaperone conditions for the circumstances
2. actively monitor the practitioner's compliance with the chaperone conditions
3. actively investigate any additional information / complaints regarding the practitioner that might be suggestive of non-compliance with the chaperone conditions, or further issues of conduct that might lead to a decision to suspend the practitioner.

I note that, in monitoring the performance of AHPRA and the Boards in Queensland, I have found systemic failures to monitor compliance with conditions (please see my Case Review - Managing practitioner compliance with conditions of registration on my website). In this instance I found that AHPRA had evidence of breaches of chaperone conditions on more than a dozen occasions and that:

1. Had AHPRA had analysed the self-reported data as it became available, AHPRA could have identified the breaches of chaperone conditions and the Queensland Board of the Medical Board

of Australia could have taken action within two months (rather than the ten months it took for the first evidence to go before the QBMBA).

2. No sanctions were imposed by the QBMBA, despite evidence of substantial non-compliance with conditions by the practitioner across a considerable period of time.
3. Despite evidence of the practitioner's non-compliance with the conditions imposed on his registration on at least 191 occasions across a two year period, it required evidence of forgery for the practitioner's registration to be suspended.

As a result of my investigation, I made ten key recommendations to enhance AHPRA's monitoring of practitioners' compliance with conditions imposed on their registration by the QBMBA:

1. AHPRA to develop and document a clear, detailed compliance monitoring plan for each practitioner that has conditions imposed on his/her registration. Where practicable, this plan should be progressed in parallel with the development of the conditions to be applied to the practitioner's registration.
2. AHPRA to provide the practitioner with a documented compliance plan at the commencement of monitoring that includes specific information on the matters to be monitored and the frequency of monitoring.
3. AHPRA to work with Medicare to establish processes that provide AHPRA with more timely access to data for compliance monitoring purposes.
4. AHPRA to develop and adopt a clear, risk-based compliance monitoring framework that provides a consistent set of principles and directions.
5. AHPRA to ensure its compliance monitoring framework provides that:
    a. self-reported data is assessed at intervals that allow for the early identification of noncompliance
    b. independent data for verification of the accuracy of self-reported data is obtained and assessed at intervals that allow for early identification of non-compliance.
6. AHPRA to review their processes for counting and categorising breaches of conditions to ensure more accurate measurement and reporting of the extent and nature of any non-compliance.
7. AHPRA to adopt a clear, transparent pyramid approach to regulating compliance that clearly outlines the hierarchy of responses from least restrictive to most restrictive for particular categories of non-compliance.
8. AHPRA to outline in their hierarchy of responses clear sanctions for the late submission and non-submission of self-reported compliance data by practitioners.
9. AHPRA and the QBMBA, including its committees, to consider changes to their decision making processes to streamline decision making, including establishing timelines.
10. AHPRA and the QBMBA to ensure that decisions to take no further action in response to non-compliance with conditions are accompanied by clear documented reasons for the decision and a plan to manage any outstanding risk associated with continuing non-compliance.

Were these recommendations to be appropriately resourced using a risk management framework, AHPRA would not only improve its performance in monitoring conditions generally but would, of course, be better placed to identify issues quickly and to intervene appropriately to ensure that the health and safety of the public are protected.

Moreover, as chaperone conditions are usually only imposed on practitioners in matters that are considered serious, it is not unreasonable to assume that a higher level of compliance monitoring needs to occur to mitigate risk and to protect the health and safety of the public to ensure that any breaches can be identified as soon as possible. A risk-based approach should seek to identify the minimal standard of regulatory action considered acceptable to monitor compliance (for example, does every Medicare record of a patient consultation by the practitioner need to be cross-checked with the practitioner's chaperone log and appointment schedule or only a sample - 10%, 20%, 50%, etc.?)

I acknowledge that this approach requires dedicated resources (and time) to acquire and review all relevant documents (retrospective monitoring) and to respond to new complaints about potential breaches (reactive monitoring). Here the risk to the health and safety of the public – or the risk of non-compliance - is high, compliance monitoring must include strategies such as pre-text opportunities, site visits etc. to ensure effective compliance with the conditions and therefore assure public protection can occur.

In summary, while there are strategies to improve the effectiveness of chaperone conditions (and these should be adopted using a risk based model), I am concerned that the review is ill-designed to determine whether there is a fundamental (and insuperable) problem with the use of chaperone conditions. I note that there appears to be no literature review or data review associated with the Terms of Reference that might point those wishing to make a submission to the Australian or international experience of the efficacy of chaperone conditions.

In my view, it would have been preferable to commence with a review of the cases where chaperone conditions have been monitored and additional information has come to light that has lead the Medical Board to move from chaperone conditions to suspension of the practitioner. A review of these cases would undoubtedly shed some light on the magnitude of the risk(s) that had been initially assessed in relation to the practitioner and on the appropriateness of the chaperone conditions in the first instance. This would have ben of great assistance to those providing a submission as it would have provided the necessary context that submissions could address.

In my view, without a thorough analysis of those cases where chaperone conditions have failed to meet their objective, it is not possible to determine whether those failures are due to the issues I have noted above (poorly focussed chaperone conditions, failure to monitor, failure to investigate) or, rather, are linked to some intrinsic inappropriateness of chaperone conditions in all - or some - classes of sexual misconduct. I think this is important work that ought to have been conducted prior to any consideration of the utility (or otherwise) of chaperone conditions.

Given the lack of comparative data and analysis, my response to the matters raised by the Terms of Reference are uninformed by this contextual material:

a. *whether chaperone conditions are an effective measure to protect patients* – Yes, when appropriately targeted to the risk, appropriately monitored and where non-compliance is identified quickly and dealt with effectively

b. *whether chaperone conditions are appropriate given the importance of trust and informed consent in the professional relationship between patients and their health practitioners* – Yes, as the circumstances that give rise to chaperone conditions are many and varied, and the imposition of appropriate conditions with sufficient information to patients is not an insuperable barrier to maintaining trust in the therapeutic relationship.

c. *in what circumstances chaperone conditions are not appropriate* – In circumstances where an appropriate risk assessment identifies that chaperone conditions will not mitigate the risk

associated with the conduct (based on issues such as the seriousness of the conduct, whether the conduct was predatory and/or part of a broader pattern of behaviour, where there is previous history by the practitioner of a disregard for conditions, etc).

d. *if chaperone conditions are appropriate in some circumstances, what steps need to be taken to ensure patients are protected (including effective monitoring of chaperone conditions to ensure compliance) and are adequately informed* – As noted above, a monitoring regime that regularly and frequently (and the circumstances / risk will dictate the frequency) determines that there is effective compliance, with clear and stated paths of escalation where non-compliance occurs, and one which deals effectively with the risks arising from non-compliance).

e. *the approach of Board committees in assessing the need for immediate action and use of chaperone conditions,* – As immediate action is a statutory path where there is a multitude of guidance from Tribunals and Courts, Boards should of course take a lawful approach to the issue of determining whether they hold a reasonable belief, and in assessing the nature of the serious risk and the way in which it is necessary to act. The appropriateness of any conditions (chaperone or otherwise) will always depend on identifying and obtaining sufficient information to gauge the risk and on reassessment as new information comes to light.

f. *the national Chaperone protocol and current practice, including processes for monitoring and compliance, notice to employers and places of practice, provision of information to patients, information sharing with other agencies, and escalation processes in the case of a suspected breach*– See my comments on my Case Review - Managing practitioner compliance with conditions of registration above.

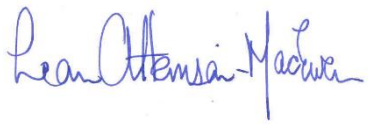
2. *recommend any other regulatory measures to protect patients while allegations of sexual misconduct are investigated* -– At this stage, without analysis of the Australian and international experience, I can make no determination about any recommendations that might be appropriate.

3. *recommend whether any change is needed to the Regulatory Principles for the National Scheme,* – See my comments on my Case Review - Managing practitioner compliance with conditions of registration above.

4. *recommend what (if any) legislative reform should be considered by Ministers to protect patients while allegations of sexual misconduct are investigated.* – At this stage, without analysis of the Australian and international experience, I can make no determination about any recommendations that might be appropriate.

More than happy to discuss these issues with you further.

Yours sincerely



Leon Atkinson-MacEwen
Health Ombudsman