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30 September 2016

Professor Ron Paterson
Chaperone Review
C/- National Health Practitioner Ombudsman and Privacy Commissioner
GPO Box 2630
Melbourne VIC 3001

By email: ChaperoneReview@nhpopc.gov.au

Dear Professor,

Re: **Independent review of chaperones to protect patients**

The Australian Dental Association (ADA) is pleased to be able to respond to this review. The ADA is the peak national body representing dentistry in Australia. The majority of our dentist members work across approximately 7,500 small private practices providing around 85% of the dental health care services in Australia.

In reviewing this matter the invitation to respond to the Review was circulated by the ADA to all branches of the ADA and to affiliate groups of the Association. These include the various specialist bodies that are affiliated through a common membership. It is in response to their feedback that this brief submission has been prepared. When referring to "the ADA" in this response this should be read as being a response based on feedback from these groups.

The ADA notes the issues being addressed in the review but will confine itself to only some areas of the Terms of Reference.

TERMS OF REFERENCE:

a) whether chaperone conditions are an effective measure to protect patients

In general terms the ADA is satisfied with the current protocols for the utilisation of chaperones. It recognises, accepts and endorses the necessity for protocols to be implemented to safeguard patients. The concept of the imposition of a chaperone is seen as an effective measure to protect patients.

b) whether chaperone conditions are appropriate given the importance of trust and informed consent in the professional relationship between patients and their health practitioners

c) in what circumstances chaperone conditions are not appropriate

In reviewing the protocol, the issue of the "appropriateness" of the protocols has been placed in question by the ADA. While recognising the importance of the safety of the patient, many comments have been received suggesting that the protocol needs to also be looked at from the perspective of the practitioner.

Most placements of a chaperone will follow complaints having been made against a practitioner from a patient or member of the public. Placement of a chaperone, while not evidencing guilt on the part of the practitioner, will demonstrate to most patients that something untoward (probably of a sexual nature) has been alleged against the practitioner. The ramifications of this upon the practitioner could be devastating. During the chaperoning period the practitioner will risk losing the respect and trust of their employer, colleagues, employees and patients.

In most cases dentists enjoy the luxury of the company of a chaperone throughout their practising day. Most dentists work very closely with their dental assistant and other staff members. While this may be the case, it is recognised that this does not mean the dental profession is beyond reproach but it certainly indicates that the risk of misconduct is substantially reduced. The relationship that exists between practitioner and assistant will vary from situation to situation. In some cases it may not empower the dental assistant/staff member to take any stand in relation to any perceived misconduct. However, it is felt that in many cases the provision of chaperone requirements utilising the practitioner's dental assistant or suitable staff member may suffice. Utilisation of an appropriate staff member or members of the practitioner or practice will afford the same protection of the patient as would another AHPRA approved chaperone yet it would not carry the stigma that might attach to a more public outside appointment of a chaperone.

Recommendation 1:

Greater opportunity should therefore be afforded the practitioner to utilise a suitable staff member or members as the appointed chaperone. AHPRA should create a protocol that enables it to assess the suitability of the assistant/staff member(s) as chaperones. If the assistant/staff member(s) satisfy the criteria developed then the appointment of that assistant/staff member(s) as chaperones should occur.

Currently, the AHPRA Chaperone Protocol requires that, where a practitioner has a chaperoning requirement, an A3-size sign, derived from an AHPRA template, must be posted in the practice waiting area and be clearly visible. The ADA questions if that sort of demonstrable action is just.

ADA suggests (and it is a common theme from our contributors) that such action should only occur where at least some independently substantiated evidence of improper conduct has been established. It must not occur following only receipt of allegations. Notwithstanding the importance of the safety of the patient, a practitioner must not be seen to be "guilty" without some sort of inquiry having been conducted. It is a basic premise of the law in Australia that an accused is presumed innocent until proven otherwise. There is no reason why health practitioners should have some different standard imposed upon them. All too often the public would perceive the placement of a chaperone as evidence of "where there is smoke there is fire" and that the practitioner is guilty of improper conduct before this has been established.

What is suggested, is that adjudication of a complaint of misconduct that may result in the placement of a chaperone be something dealt with swiftly and must result in the improper conduct being established on the balance of probabilities in this preliminary investigation. Statistics suggest that between 2011 and 2015 there were less than 30 panel decisions involving practitioners where inappropriate sexual comments or behaviour was the subject of the notification. 11 of these resulted in 'no case to answer.' Investigations conducted seem on average to have taken over 6 months to complete.¹

It is unfair to infer guilt based on an allegation only and some form of due process must be adhered to before protective and public action is taken. Requiring a preliminary investigation to establish the bona fides of a complaint based on the civil onus of proof of balance of probability would afford the practitioner and patient

¹ See <http://www.ahpra.gov.au/Publications/Panel-Decisions.aspx>

the opportunity to have the complaint undergo a preliminary investigation. Protective action by the placement of a chaperone could follow substantiation of the patient's claim on the balance of probability. If the evidence did not substantiate the allegation to that level of proof, no action should be taken. If the onus of the balance of probability is established the protocol for utilisation of a chaperone could be implemented. Whether further punitive action follows would depend on the outcome of the latter comprehensive investigation-no doubt based on a finding "beyond reasonable doubt" as required by the criminal onus of proof.

Once established in a preliminary investigation on the balance of probabilities, AHPRA must then be obligated to expedite the conduct of a full inquiry into the allegations. Currently, the majority of investigations into notifications about practitioners are taking more than six months to complete.² This is too long to impose interim chaperoning requirements on a practitioner, who may very well be exonerated. Imposing chaperoning requirements on an accused practitioner for this duration denies them access to natural justice, where the accused is presumed innocent until proven guilty.

Recommendation 2:

Before the imposition of a chaperone by AHPRA an expedited review of the preliminary allegations against the practitioner be undertaken. This is to involve questioning of both parties (patient and practitioner) and any witnesses as to the allegations.

No steps are to be taken on the appointment of a chaperone until the allegations made against the practitioner in this preliminary hearing are satisfied on the balance of probabilities.

The protocol then requires the practitioner to "inform each and every patient in that class of the necessity for a chaperone to be present and directly observing any contact between you and the patient at all times." Noting that there is already a requirement for a sign to be placed in the surgery waiting area advising patients of the requirement for a chaperone to be present, this additional requirement seems unnecessary and will only further adversely impact on the respect and trust of the practitioner. One or either form of notification should suffice.

Recommendation 3:

That the practitioner have the option of either placing the A3 sign advising of the appointment of a chaperone in the surgery waiting room OR complying with the requirement that each patient be informed of the necessity for a chaperone be present.

Another concern voiced by our contributors to this review is that the protocol that practitioners, that have imposed on them a chaperone restriction, are required to either directly or through AHPRA notify Medicare Australia and private health insurers of the restrictions imposed upon the practitioner. To obligate a practitioner to notify these entities in relation to something that is only an allegation and has not been proven is totally unacceptable. The ADA has already raised the adverse inferences that patients will draw from the appointment of a chaperone. To add to this the need to advise unrelated third parties such as Medicare and private health insurers is totally unnecessary. There is nothing to be gained by either Medicare or private health insurers having notice of the imposition of a chaperone protocol. These entities do not require protection. If as a consequence of some misconduct by the practitioner, it is later established that improper or unnecessary treatment has been provided both Medicare and private health insurers will have maintained their rights of recovery from the practitioner.

² AHPRA performance report, Victoria Jan – Mar 2016, Table 18: Investigations Completed by Time Frame, available at <http://www.ahpra.gov.au/documents/default.aspx?record=WD16%2f20940&dbid=AP&checksum=LnDhQiCsXvxzO%2fHXU6F2Rw%3d%3d>

Recommendation 4:

The requirement imposed in the protocol requiring Medicare and private health insurers be informed of the imposition of a chaperone be removed.

Finally the ADA would like to suggest that perhaps AHPRA may like to consider the creation of guidelines as to what does and does not constitute appropriate behaviours for practitioners.

Recommendation 5:

AHPRA consider the enhancement of the current Code of Conduct Guidelines to include more educative material on how practitioners should interact with patients to ensure their conduct is at all times "appropriate".

The ADA wishes to thank AHPRA for the opportunity to respond to this review.

Should you require further comment regarding this submission, please contact Mr Robert Boyd-Boland at

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Yours sincerely,



Dr Rick Olive AM RFD
President