LA TROBE UNIVERSITY

The use of Alternative Dispute Resolution in Australia and New Zealand by Health Practitioner Registering Bodies

Report and Recommendations for Victoria

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Centre for Public Health Law

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2 EXECUTIVE SUMMARY

2.1 Background

In June 2003, the Victorian Department of Human Services commissioned the Centre for Public Health Law, at the School of Public Health La Trobe University, to conduct a research project examining the use of Alternative Dispute Resolution (ADR) techniques within regulatory schemes registering health professionals. The project has three main objectives:

- to understand how ADR techniques are used within health regulatory authorities internationally;
- to identify the extent to which ADR techniques have been adopted by health practitioner regulatory authorities in Australia and New Zealand, and
- to make recommendations concerning the potential for ADR techniques to be incorporated into Victorian health practitioner registration board complaints and disciplinary processes.

The project comprises two parts:

- a critical review of the literature on the use of ADR by regulatory authorities both in Australia and in key jurisdictions internationally, and
- a survey of Australian and New Zealand health practitioner registration bodies on the use of ADR.

The literature review, results of the survey and recommendations on the project are presented in this report.

The following discussion summarises the context of the project, survey methodology and results, and the project's key recommendations.

2.2 Context

There are twelve health practitioner registration boards in Victoria.[1] All are charged with the responsibility protecting the public by providing for the registration of health practitioners, and conducting investigations into the professional conduct and fitness to practice of registered practitioners. In the

[1] Victorian Department of Human Services, Regulation of the Health Professions in Victoria – A Discussion Paper, State of Victoria 2003. Pages 17-18

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case of many of the boards, this gives rise to a very time consuming and resource intensive workload. In the interviews conducted for this report, it was clear that all boards would be likely to embrace new case management options which had the potential to simplify, and shorten the investigation and hearings process, so long as exercising the options did not compromise fairness, consistency or transparency.

Alternative Dispute Resolution (ADR) has been successfully used in many legal and quasi legal contexts to bring the parties to a result without the need for the intervention of a court which can be a longer and more expensive process. It may be that the use of ADR has a part to play in giving more case management options to the boards in the conduct of investigations into the professional conduct of registered practitioners. It may also have application later in the process of investigation, for example in the conduct of formal or informal hearings.

2.3 Definition of ADR

The term "ADR" or "Alternative Dispute Resolution" has different meanings in different contexts. The literature review did not reveal an accepted definition of the term, but rather suggested that it is commonly used as an umbrella term for practices that go beyond the resolution of specific disputes between parties. ADR may not refer to a specific process, but rather to a shared set of methods, goals assumptions or values.

In the context of conducting the literature review and the survey in preparation of this report, it was important to use a very broad definition of ADR as it was desirable to consider all practices of health practitioner registration boards in this area to allow the clearest picture of current practice and to enable the most practicable recommendations. For the purposes of this report, the following is regarded as the definition of ADR:

- Referral by a board or board delegate to an external mediator or conciliator.
- Mediation or conciliation functions which are or could be carried out by a board or delegate.
- Functions which have a similar effect to those caused by ADR, and which are or could be performed by boards or their delegates, but which are not currently referred to in the legislation governing the boards.
- Case management procedures which are or could be performed by boards or their delegates, but which are not currently referred to in the legislation governing the boards.

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2.4 Considerations in the application of ADR by health practitioner registration boards

It is certainly the case that some health practitioner registration boards have enormous workloads in conducting investigations into the professional conduct of registered practitioners. Both the budgets of boards and the goodwill and commitment of members are stretched by the demands of large numbers of complaints investigations. Registered practitioners and complainants also find their involvement in the process stressful. The difficulties of the experience are exacerbated when the investigation is protracted. It is time to consider whether ADR may assist. ADR has begun to be extensively used elsewhere in the legal system. However, there are a number of unique factors about the role of health practitioner registration boards. Making investigations and hearings quicker and cheaper is a very important and worthy goal; however, boards have a statutory role to protect the public. Boards must be seen to behave consistently, fairly and transparently and to act in the public interest. The use of less formal processes runs the risk of being neither fair, consistent nor transparent. Complainants and members of the public must not be given the impression that a deal has been done 'behind closed doors'. Any additional case management processes included in health practitioner registration acts must balance the need for expeditious and cost effective processes with the need for an investigations process into professional conduct of registered practitioners which gives a fair voice to complainants, and is consistent transparent and fair, and in the public interest.

2.5 Data collection methods

Semi-structured interviews were conducted with members of health registering and health complaints bodies in Victoria to investigate the adoption of ADR techniques by such bodies and members views on ADR use. Questionnaires were used to survey the adoption of ADR techniques and views of ADR use among health registering bodies in Australia and New Zealand. A number of participants who did not have time to respond to the questionnaire answered key questions via e-mail, telephone and letters. Data was analysed using a qualitative research approach.

2.6 Participants

In Victoria, 13 authorities participated in the interviews, including 12 Health Practitioner Registration Boards and the Office of the Health Services Commissioner (OHSC). A total of 28 interviews were conducted. These interviewed included the Health Services Commissioner and Presidents, Chief

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Executive Officers, Registrars, Legal Practitioner members and Managers of the participating bodies.

Forty-two questionnaires were sent to health regulating authorities in Australia and New Zealand. Twenty participated in the survey, comprising 12 who responded through the questionnaire, three by e-mail, three by telephone and two by letter.

2.7 Results

The survey found that most participants viewed ADR techniques as useful, flexible and desirable, as a good alternative to the existing complex, expensive and intimidating system of dispute resolution, and saw it as a beneficial mechanism for handling consumer complainants as well as those involving practitioners. Many participants perceived ADR as a commonsense part of good management.

Several bodies in Victoria, other states and New Zealand have applied ADR techniques, most without reference to legislation. Those techniques may or may not be regarded as ADR by the individual Boards, depending on individual perception of ADR's definition.

ADR techniques have been used largely in the initial stage in complaint management prior to Boards embarking on an informal or formal hearing. Types of ADR techniques used include:

- various forms and levels of contacts with parties involved in a complaint;
- attention given to complaints before consideration by the board;
- 'performance pathway' – an alternative to professional conduct or professional health pathways;
- a vetting process to assess proper management of a complaint and the resources it requires.

At the investigative stage and prior to a Board's decision about a complaint, the following have been used:

- undertakings,
- warning letters, and
- a Board's delegate communicating with the parties involved.

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After a decision to go to a hearing has been made, pre-trial meetings and some forms of plea-bargaining, submissions, and notice to admit, have been used. Therapeutic jurisprudence principles have been adopted by one Board to maximise the quality of the outcomes of complaint handling as far as future practice by the practitioner is concerned.

Among Australian and New Zealand boards, 'without prejudice' meetings, submissions, undertakings, counselling and practitioner support have also been applied.

There was a view expressed that ADR techniques are suitable for: complaints that do not warrant formal investigation or hearings; complaints where removal of the practitioner's registration is not an expected outcome; or where rehabilitation or counselling of the professional is a desired outcome. Examples of these complaints are:

- communication and manner problems;
- personality clashes;
- some health issues, and
- small management matters.

Complaints about gross professional misconduct, breaching of legislation, sexual misconduct or manipulation of power for sexual gratification, clinical incompetence or the health concerns of the practitioner are not suitable for ADR.

Boards must have sufficient information about a complaint in order to justify the application of ADR.

ADR use has provided, or is perceived to provide positive outcomes such as improving Board's efficiency, enhancing communication for all parties, empowering consumers, and avoiding trauma in formal procedures. Anticipated risks include those of the public losing confidence in Boards, the practitioner not gaining insights for overcoming professional standard problems, ADR's confrontational nature and consumer complainants still being dissatisfied after ADR. These views reflected many of the findings of the literature review.

If Boards are to use ADR, participants suggested that ADR processes must be fair, transparent, consistent, have a mechanism to prevent overuse, have a pathway after ADR, and have a means for informing all parties. There is a shared concern that in using ADR, Boards do not compromise their legislative obligation to investigate disputes.

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In terms of interaction with other health complaints bodies, for example the OHSC in Victoria, participants reported a good working relationship. All participants expressed concern about a duplication of ADR use by both Boards and other health complaints bodies. It was suggested that Boards would need legislative power to perform ADR. Working together was also suggested. Although OHSC personnel supported the use of ADR by Boards, they also stated that the OHSC would welcome the increase in workload that would result if Boards were to refer more complaints to that body. However, OHSC personnel also expressed some caution about the use of ADR by Boards, believing that the public might perceive Boards as protecting their own professional members when performing ADR. Most participants felt that OHSC had the best expertise to deal with ADR.

A number of professional associations have complaints management processes. In general**,** Victorian Boards have a good relationship with the respective associations. There is mutual concern about associations protecting their members. In particular, there is concern that serious matters, which have implications for public safety, might be dealt with by professional associations without the knowledge of the relevant Board.

Views on the need for legislative reform to adopt ADR are divided. On one side, participants felt that the Boards already had many ADR techniques available for use, and that such techniques were currently used at the Board's discretion. According to this view, legislative change was unnecessary because the Boards' essential duty is to protect the public. Concern was expressed that to formalise ADR would reduce the existing flexibility, and lead to inappropriate use. On the other side, participants felt that ADR use by Boards should be legislatively recognised so as to give Boards compliance powers, and to provide transparent and consistent guidelines for ADR use by all Boards.

Four main themes including the Boards' integrity, the consumer's voice, justice for the professionals, flexibility in the current system, and uncertainty about ADR definitions have been found to be important factors in how a Board perceives ADR use and legislative reform to embody ADR use.

2.8 Recommendations

As a result of the literature review, survey and analysis of results, the following recommendations are made:

Recommendation 1: The term 'Alternative Dispute Resolution' is not used in relation to additional case management powers for health practitioner

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registration boards. This is to avoid confusion raised by different meanings of the term in common usage and to avoid confusion about the role of boards and the role of the Health Services Commissioner in this area. The term "case management processes" is preferred.

Recommendation 2: Health practitioner registration acts be amended to include a broader range of case management processes for the use of boards at the conclusion of the preliminary investigation process and for the use of panels during the formal hearing process.

Recommendation 3: The Health Services Commissioner, acting within her powers under the Health *Services (Conciliation and Review) Act* 1987 is acknowledged as the most appropriate person to conduct conciliation and like processes. Boards which consider complaints as suitable for conciliation should refer these cases to the Health Services Commissioner under the existing pathway in the health practitioner registration acts and the *Health Services (Conciliation and Review) Act* 1987.

Recommendation 4: Health practitioner registration acts are amended to make available new case management processes to boards carrying out preliminary investigations and to panels appointed by boards to carry out formal hearings. The new case management processes will be:

At the close of the preliminary investigation, it will be open to the investigator to recommend to the Board, and open to the Board to accept one of the following recommendations:

1. If the Board is satisfied that having had regard to the need to protect the public, and the need for fairness to the complainant and to the registered practitioner, that it is appropriate to issue a warning letter to the registered practitioner in the prescribed form which notes the behaviour complained of and draws the practitioners attention to certain relevant statutory obligations of practitioners under the relevant health practitioner registration act, the Board may determine that such a letter be sent. The prescribed form of the letter will include a statement that this letter does not constitute a finding of unprofessional conduct. A copy of the letter is then placed on the practitioners file. It would be required that a copy of the letter was also sent to the complainant.
2. If the Board is satisfied that having had regard to the need to protect the public, and the need for fairness to the complainant and to the registered practitioner, that it is appropriate and if the practitioner is prepared to agree, that an undertaking is drawn up in the prescribed form which notes the behaviour complained of and includes an undertaking that the practitioner will not engage in the behaviour complained of. The prescribed form will include the statement that this undertaking is not an admission of unprofessional conduct or a finding of unprofessional conduct. The signed undertaking is then placed on the registered practitioners file and a copy given to the registered practitioner. It would be required that a copy of the undertaking was also sent to the complainant.

When a panel is appointed to conduct a formal hearing into the professional conduct of a registered practitioner, the board will have the following additional power:

1. If the board is satisfied that the case management of the hearing would be assisted by the appointment of a case manager, it would be open to the board to appoint a case manager from the board, other than a board member who is an appointed panel member for that formal hearing or another suitably qualified person. The case manager would be able to conduct pre hearing meetings in which the case managers purpose would be to seek to narrow the matters in dispute. Case management meetings would be conducted on a 'without prejudice' basis. The conduct of the case management meetings would be at the case mangers discretion, but could include the seeking and exchange of witness statements. The case manager could also ask questions of parties and expert witnesses to establish areas of agreement and to narrow issues in dispute.
2. If a panel conducting a formal hearing into the professional conduct of a registered practitioner makes a finding of unprofessional conduct of a serious nature and the case manager considers it may assist the board in making a determination, the case manger may conduct a pre determination meeting to assist the registered practitioner in considering the development of a written or oral submission on any determination the panel may make. It would be the purpose of the case manger to narrow issues in dispute and to encourage the registered practitioner to make a submission which would assist the panel in reaching a determination.

Recommendation 5: After a formal hearing, if a panel makes a finding of unprofessional conduct of a serious nature, panels are empowered to invite the complainant or person or persons affected by the unprofessional conduct to submit an unprofessional conduct impact statement to be considered by the Board in reaching a determination.

Recommendation 6: Once a case manager is appointed, the case manager may not have discussions, written communications, electronic communications or communications of any other kind with any members of the panel appointed to conduct the formal hearing. The case manager would inform him or herself about the progress of a formal hearing by reading the documents relevant to the case in the possession of the board, attending the formal hearing or reading the transcript of the proceedings. Any order to hold a closed hearing must exempt the case manger.

Recommendation 7: The amending legislation must state that these case management processes are not intended to be exhaustive. The amendments are not intended to alter the existing powers and discretions of boards and panels to institute case management processes.

Recommendation 8: Boards should be educated in the use of a variety of case management processes and better understand the role of the Health Services Commissioner in conducting conciliation. The Department of Human Services may consider making a contribution to a fund to encourage the health practitioner registration boards to join together, using a contribution formula which is based on the number of registrants of each contributing board, to fund a tender to develop case management guidelines for the use of all boards which explore both the use of legislative processes and pathways and other case management processes which are open under the legislation, but not specified in the legislation.

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REPORT

3 INTRODUCTION

In June 2003, the Victorian Department of Human Services commissioned the Centre for Public Health Law, at the School of Public Health, La Trobe University to undertake a research project examining the use of Alternative Dispute Resolution (ADR) techniques within regulatory schemes that register health professionals. This report is the product of that project.

There are twelve health practitioner registration boards in Victoria.[2] All are charged with the responsibility protecting the public by providing for the registration of health practitioners, and conducting investigations into the professional conduct and fitness to practice of registered practitioners. In the case of many of the boards, this gives rise to a very time consuming and resource intensive workload. In the interviews conducted for this report, it was clear that all boards would be likely to embrace new case management options which had the potential to simplify, and shorten the investigation and hearings process, so long as exercising the options did not compromise fairness, consistency or transparency.

Alternative Dispute Resolution (ADR) has been successfully used in many legal and quasi legal contexts to bring the parties to a result without the need for the intervention of a court which can be a longer and more expensive process. It may be that the use of ADR has a part to play in giving more case management options to the boards in the conduct of investigations into the professional conduct of registered practitioners. It may also have application later in the process of investigation, for example in the conduct of formal or informal hearings.

3.1 The project's objectives

The project has three main objectives:

1. To understand how ADR techniques are used within regulatory authorities internationally.

[2] Victorian Department of Human Services, Regulation of the Health Professions in Victoria – A Discussion Paper, State of Victoria 2003. Pages 17-18

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2. To identify the extent to which ADR techniques have been adopted by health practitioner regulatory authorities in Australia and New Zealand.
3. To make recommendations concerning the potential for ADR techniques to be incorporated into Victorian health practitioner registration board complaints and disciplinary processes.

Three core activities were undertaken to fulfil the project's objectives. They included:

Core activity one – conduct a critical review of literature on the use of ADR by regulatory authorities both in Australia and in key jurisdictions internationally.

Core activity two – survey Australian and New Zealand health practitioner registration bodies on the use of ADR.

Core activity three – prepare a report and recommendations on the potential for using ADR by Victorian health practitioner registration bodies.

3.2 Definition of ADR applied in this report

The terms "ADR" or "Alternative Dispute Resolution" have different meanings in different contexts. The literature review did not reveal an accepted definition of the term, but rather suggested that it is commonly used as an umbrella term for practices that go beyond the resolution of specific disputes between parties. ADR may not refer to a specific process, but rather to a shared set of methods, goals assumptions or values.

In the context of conducting the literature review and the survey in preparation of this report, it was important to use a very broad definition of ADR as it was desirable to consider all practices of health practitioner registration boards in this area to allow the clearest picture of current practice and to enable the most practicable recommendations. For the purposes of this report, the following is regarded as the definition of ADR:

- Referral by a board or board delegate to an external mediator or conciliator.
- Mediation or conciliation functions which are or could be carried out by a board or delegate.
- Functions which have a similar effect to those caused by ADR, and which are or could be performed by boards or their delegates, but which are not currently referred to in the legislation governing the boards.

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- Case management procedures which are or could be performed by boards or their delegates, but which are not currently referred to in the legislation governing the boards.

4 LITERATURE REVIEW

4.1.1 Introduction

The Victorian Department of Human Services (DHS) is currently in the process of reviewing all health practitioner legislation in Victoria. Currently there are 12 Victorian Acts of Parliament which establish registration Boards to register health practitioners and regulate their practice [3] . The Boards are responsible for maintaining the high standards of education and practice of health professionals as well as for providing a mechanism to deal with complaints made by health consumers against individual practitioners (DHS, 2003; 9).
Health professional regulatory legislation commenced in Australia at the beginning of the twentieth century. The rationale for all such regulation is the protection of the public interest, rather than as a forum for dispute resolution. A major challenge with the regulation of health professions in Victoria has been the need to ensure that the legislative framework within which registration boards operate is effective, flexible and responsive to emerging challenges. The aim of the current review is to determine the need for reform of board powers and any further regulation if necessary to ensure that health practitioner registration boards are able to competently protect the public; promote consumer and community confidence in their operation ; and to ensure mechanisms that oversee practitioner and health system quality. A number of guiding principles to any reform will ensure that registration board processes remain accountable; transparent; fair; effective; flexible and consistent.

4.1.2 Current Victorian Model of Legislation

The present Victorian model of health practitioner registration was introduced in 1993-94 with the passage of the *Nurses Act* and *Medical Practice Act*. Since then, the Victorian Parliament has passed eight new Acts and introduced a series of reforms to the current health regulatory framework.
Under the Victorian model, there are standard provisions in all registration Acts (except the Health Act and the Pharmacists Act which is currently under review) which establish common powers for registration boards to register practitioners, establish standards, receive and investigate complaints, conduct

[3] These Acts include the Chinese Medicine Registration Act 2002 , Chiropractors Registration Act 1996, Dental Practice Act 1999, Medical Practice Act 1994, Nurses Act 1993, Pharmacists Act 1974, Physiotherapists Reg Act 1998, Podiatrists Reg Act 1997, Psychologists Registration Act 2000,
Optometrists Reg Act 1996, Osteopaths Reg Act 1996, Health Act 1958 Health (Medical Radiation Technologists) Regulations 1997.

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hearings and apply sanctions where necessary. More than three quarters of the provisions in each Act can be considered ‘template’ or ‘model’ are common across all registration Acts excepting those covering pharmacists and medical radiation technologists (DHS, 2003:46). Recent legislation that regulates optometrists and dental care providers including the Dental Practice Act and Optometrists Registration Act depart from the standard Victorian model.

4.1.3 Complaints and Professional Conduct

One of the key responsibilities of professional boards is that of investigating complaints about practitioners. An effective complaints handling and disciplinary structure can be used to monitor and enforce practice and ethical standards in the profession and help to reduce the incidence of consumer dissatisfaction.[4]Under the current Victorian model, registration boards are empowered to receive a complaint regarding registered practitioners, decide whether and how the complaint will be investigated and by whom, determine the course of action arising from the investigation, including which complaints will proceed to either informal or formal hearings and who will be appointed to the hearing panel and make a number of findings or determinations which vary according to the seriousness of the Act. The Act sets out provisions regarding these hearings but does not prescribe how they are to be conducted (DHS, 2003:90).

However, concerns have increasingly been raised by disgruntled members of the public regarding their experiences with registration boards complaints handling and disciplinary processes [5]. DHS periodically receives complaints from the public regarding the lack of transparency in decision making which impacts on the perceived fairness and integrity of the complaints process; the need for greater involvement of and support to complainants and the timely resolution of complaints.

Concerns have been raised by registration boards themselves who suggest that there is not sufficient flexibility in the legislation, especially when dealing with less serious complaints which could be resolved more quickly and efficiently possibly through the use of an alternative and less formalised process (DHS,2003;110).

4.1.4 Aim of Literature Review

The aim of this literature review was to examine the use of less formalised alternative dispute resolution processes currently in use by regulatory boards both in Australia, New Zealand and in key jurisdictions internationally including the United Kingdom, United States and Canada. The findings of this review are intended to inform the development of a survey tool to be

[4] NSW Health, Report of the Review of the Optometrists Act, Final Draft Report, December, 1999

[5] The AHMAC Quality in Australian Health Care Study highlighted consumer concerns in this area and lead to the recommendation that a review of professional boards be undertaken (Protecting the Public Interest- A Review of the Northern Territory Professional Boards p 51).

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presented to registration boards in Australia and New Zealand to identify how alternative dispute resolution techniques are, if at all, currently being put into practice.

4.1.5 Search Strategy

The literature search used a combination of strategies including searching of computerised data bases, website and library catalogues.
Data bases accessed included CINAHL, PUBMED, AUSTHEALTH (including Health and Society), AMI (Australian Medical Index),MEDLINE, AUSTROM (including AGIS and APAIS), AUSTLII ,OVID and WebSPIRS. Latrobe University Campus Data bases such as health sciences and pharmacy were also searched.
Search items used included 'alternative dispute resolution', 'health regulatory boards', 'complaints', 'disciplinary hearings', 'health complaint handling', 'regulatory bodies', 'mediation', 'conciliation', and 'grievance procedures'.
Certain on-line and library journals were also searched including Medical Journal of Australia, British Medical Journal, Canadian Medical Journal, Journal of Dispute Resolution, Australasian Dispute Resolution Journal, Mediation Quarterly and Negotiation Journal.
Extensive searches across the World Wide Web were also carried out using search engines such as Google, Alta Vista and Netscape. These were the most helpful in revealing links to sites of Australian and New Zealand and international regulatory boards and access to report documentation not accessible through other library data bases. Health Organisation data bases searched included Department of Health (UK). Health Regulatory Boards (US and Canada) and the various boards throughout Australia and New Zealand.

In order to obtain information about the processes of health regulatory boards, contact was made either by phone or email with individuals within government bodies, universities and dispute resolution agencies. This revealed many of the key resources accessed however very little information specific to procedures used by regulatory boards had been documented.

Review of comparable legislation and discussion with a number of registration boards revealed a lack of flexibility in processes, especially when dealing with complaints about monetary costs and quality of services and in less serious instances where an apology was required or misunderstanding occurred between the parties that could have been resolved quickly and efficiently.

Other organisations as well as Australian health regulatory boards and health complaints commissions included NADRAC; VCAT, Victorian Dispute Resolution Centre, International Centre for Conflict Resolution at the University of Melbourne, Equal Opportunity Commission, Health Issues Centre, Institute of Arbitrators and Mediators, Plumbing Industry Commission, Law Institute and Victorian Workcover Authority.

Little if any literature pertaining to this review was able to be accessed outside of reports and reviews on health legislation conducted and prepared by Government health and legislative agencies. Most material relating to the use

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of alternative dispute resolution in health complaint processes in Australia related was to the discussion of the use of conciliation in dispute resolution by Health Complaints Commissioners, and the use and role of mediation conducted by lawyers in medical negligence litigation.

4.1.6 Definition of 'Alternative Dispute Resolution'

Alternative Dispute Resolution or ADR, encompasses a range of approaches designed to seek less formal means of resolution of disputes, and to attempt to contain the costs of matters proceeding through the formal court system.

The rise of the ADR movement in Australia is a reflection of increasing consumer rights consciousness in various areas of society including health care and the questioning of traditional forms of conflict management in a justice system which was considered over-burdened, costly and inaccessible. ADR services are used extensively at local, State and national levels in various jurisdictions to help a broad range of matters from neighbourhood disputes through to industrial disputes.

ADR is perceived to provide a range of procedural advantages over formal processes including being less costly, and quicker than traditional adversary processes; more flexible in that it allows the accommodation of non-legal principles and adaptation to the needs and culture of participants; non-confrontational, and offers participants the ability to be heard and feel heard as well as being involved in developing outcomes. It focuses on communication between parties and its methods and philosophies are more concerned with the 'human side of dispute settlement [6].

According to Condliffe (2002), benchmarks for good ADR practice include :

Accessibility – processes are readily available by promoting knowledge of their existence, are easy to use and there are no cost barriers;
Independence – that the decision making process is independent form those funding it;
Fairness – that decisions are fair and seen to be observing the principles of procedural fairness;
Accountability – accountable to the public;
Efficiency – complaints are kept a track of so they are dealt with by the appropriate forum and performance is regularly reviewed;
Effectiveness – appropriate and comprehensive terms of reference and periodic independent reviews of performance [7]

3.1 Definitions of ADR Processes

ADR is commonly used as an umbrella term for practices that go beyond the resolution of specific disputes between parties. ADR may not necessarily refer

[6] Boulle, Laurence (1996). *Mediation : Principles, Process, Practice.* Butterworths, Sydney p 96
[7] Department of Industry, Science and Tourism, Benchmarks for Industry Based Consumer Dispute Resolution Schemes 1997

to a specific process but rather to a shared set of methods, goals, assumptions or values.

Definitions of ADR vary considerably and may conflict depending on ideology, styles and practice, the scheme being considered, who the ADR provider is and the nature of the dispute. According to Sourdin (2000), significant definitional variations of ADR occur in different States of Australia in relation to the range and variation of some processes currently in use. Some of the problems of definition are as a result of the contrasts between 'private mediation' and the various forms of 'institutionalised mediation' which are connected to the courts and are defined by Statute (Boulle,1996:4).

In 1995, the Commonwealth Attorney-General launched the National Alternative Dispute Resolution Advisory Council (NADRAC) as an independent group of experts advising the government on matters pertaining to ADR. In 1997, a NADRAC discussion paper suggested the relevance and importance of consistent terminology in ADR jurisdictions to ensure accurate and consistent information about the processes. This was despite concerns that strict legal definitions would lead to a loss of flexibility and discourage lateral thinking (NADRAC, 1997:5).

The most common forms of ADR in use include mediation, conciliation, arbitration dispute counselling and facilitation [8] (Hannaford, 2001).

4.1.7 Mediation

Mediation is a decision-making process in which the parties to a dispute, with the assistance of a neutral third party (the mediator), meet to identify the disputed issues, help develop options, consider alternatives and attempt to reach an outcome to which both parties will assent. Mediation is a voluntary process where the participants choose to attend, making a free and informed choice to enter and if preferred, leave the process if desired. The mediator has no power to impose a decision on the parties and acts in an advisory role in regard to the content of the dispute and may advise on the process of resolution.

If the process and the outcome is to be fair, all parties must have the willingness and capacity to negotiate and there must be a rough parity of power between the parties. Mediation does not determine who is wrong or who is right but focuses on what has happened in the dispute or complaint purely as the basis for negotiating for the future. Mediation may be undertaken voluntarily, subject to an existing contract or court order. (NADRAC, 1997;6).

Mediation aims to maximise the parties' interests and this may be done by taking into account remedies and concerns not recognised by the Courts. The process is not bound by rules of substantive or procedural law and is often

[8] Dispute counselling is a process which is increasingly being used by government and ADR organisations to assist parties in determining the appropriate process to handle the dispute. The counsellor may investigate the dispute. Arbitration most closely resembles litigation where parties to a dispute present arguments and evidence to a neutral third party(arbitrator) who makes a determination (Sourdin,2003).

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referred to as 'interest' rather than 'rights' based. Mediators adopt a problem-solving rather than adversarial and confrontational approach to conflict, even though mediation often occurs with reference to arguments constructed for use in an adversarial setting.

4.1.8 Conciliation

Conciliation is an informal voluntary meeting chaired by a neutral third party (conciliator), usually in a neutral venue. It differs from mediation in that the conciliator may have an advisory role on the content of the dispute or the outcome of its resolution. The conciliator is not an advocate but may advise or determine the process whereby resolution is attempted and give expert advice on likely settlement terms and actively encourage participants to reach an agreement. (NADRAC, 1997;6) A majority of complaints in conciliation involve some form of compensation or claim for refund of fees.

Bryson (1990:136) refers to a conciliator as a mediator within a legal framework- an advocate for the law, whilst remaining impartial to the parties. Conciliation encourages non-adversarial, consensual approach to negotiation (and/or resolution) in the spirit of mediation as well as 'meeting the needs of a justice system which aims to protect legal rights'. Furthermore, Bryson comments that a conciliator can play a fundamentally educative role by providing relevant information regarding issues of law by informing parties as to what is required of them in terms of the process and the law, by calling upon appropriate bodies who can give advice, by assisting with negotiating positions, strategies and settlement options. In this regard, conciliation may be more beneficial in redressing the power imbalances so often apparent between doctor and patient.

Conciliators have wider powers than mediators and can make recommendations for settlement and directions for a limited period. Matters favouring conciliation involve expert or legal issues, where a party to a dispute is a government entity or an insurer or whether parties have a desire to keep the matter private or confidential (Sourdin, 2002).
According to Wilson et al (in smith), it can be regarded as a legitimate alternative to litigation.

4.1.9 Mediation in Health Disputes

ADR in the form of conciliation and mediation in health disputes attempts to bring closure to patients by providing a forum where complainants and respondents can be brought face to face to discuss key issues and achieve resolution.

According to Marcus (1995), some commentators contend that the best way to achieve truth, justice and balance in health disputes is through the adversarial process. Others believe the process of delivery of health care is best accomplished through careful deliberation, good listening, understanding and mutually beneficial collaboration. It is considered that the process of mediation offers a constructive framework for resolving health care disputes

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by methods which can be adapted to facilitate the process of convening parties in a dignified manner where control of the outcome remains with the parties.

According to Kellet, (1987;125), as a dispute resolution process, litigation fails to address the 'emotional' injuries of the complainant and inflicts emotional injuries on the doctor. He suggested that what was necessary in health disputes was a process that could help parties understand the underlying conflict, diffuse their anger and repair their relationship with an emphasis on the future.

Reeves (1994) suggested that mediation allows the parties to negotiate a face to face meeting, discuss their differences, explore their interests and form a solution to the issues in a structured yet flexible form.

According to the literature, mediation in health disputes have to date occurred predominantly in cases of medical negligence where a less interventionist adversarial approach to dispute resolution has proven more beneficial than the traditional sphere of courtroom settlements (Hughes, 1997). Whilst it had to be acknowledged that there are many medical negligence matters which will ultimately end up in court, studies have shown that many people use litigation as a last resort. This is after they have felt frustrated seeking an explanation, apology and assurances that the mistake will not be repeated by the health practitioner and agencies involved. Mediation and conciliation offer an important forum in which to bring parties together to address complainant's concerns by clarifying key issues in a way that a court system can not.[9]

There is extensive international literature looking at the role and features of ADR, specifically mediation, in medical indemnity cases but little if anything exists regarding the use of ADR in regulatory board processes.

4.1.10 Conciliation in Health Disputes

In Australia and New Zealand within the past two decades there has been the emergence
of various independent statutory authority health complaints investigative bodies. In all States and Territories, such organisations make provision for conciliation of disputes between consumers and health care providers as an alternative to litigation. The function of conciliators in all jurisdictions is to arrange for informal discussions between consumers and providers, assist in the conduct of those discussions, and, if possible, assist parties to reach an agreement.

According to Thomas (2002), in his overview of health complaints mechanisms in Australia[10], this was not so much as a result of a culture of complaint as a culture of heightened medical accountability following a series

[9] Parliament of NSW, Report of the Committee on Health Care complaints Commission, March 2002.

[10] Thomas, D (Ed) Medicine Called to Account : Health Complaints Mechanisms in Australia. School of Public Health Law and Community Medicine, University of NSW

of public medical disasters. According to Daniel (1994; 198) the perceived failure to enforce proper discipline made medical registration boards the chief targets for attack over medical accountability. This was in part due to expectations of complainants not being met by regulatory boards which were considered inaccessible and ' more intent on safeguarding the respectability of the profession than its standards of practice' (Thomas,2002;4).

These organisations have two functions. Firstly ,they are empowered to receive complaints from consumers about adverse experiences in the course of treatment either at the hands of individual health care practitioners or institutions ; and secondly to attempt to satisfy complainants through a process of mediation or conciliation or by taking direct legal action against healthcare providers. Thomas (2002) suggests that on the one hand health complaints mechanisms are 'designed to sharpen and enforce the accountability of medical professionals ', but also have the improvement of health services as their major raison d'etre. (2002:5)

According to Newby (2002) however, there is a failure to appreciate the different operational requirements of these two objectives with a provision of conciliation as an ADR process and by legislation that it be a private and confidential process, but also in their 'watchdog' role that they are mandated to assess evidence of systemic or professional inadequacy and technically should not be able to use information gleaned from individual cases.

Structured around this 'conciliation' approach, the rationale is that where medical errors or grounds for complaint occur, the best process of dealing with them is through non-legal conflict resolution processes by way of face to face meetings with or without a third party present. In this context, the ability to talk out issues is the initiating factor in moving the two parties closer to resolution of the 'dispute' and a restoration of 'trust' in the relationship. Using this approach, adversarial situations are avoided and resolution or redress with an emphasis on speed and low cost is a way of maintaining relationships and re-establishing trust (Allsop and Mulcahy , 1996).

4.1.11 Potential Advantages of ADR

ADR (specifically mediation) is considered a better forum for dealing with emotions and the constructive expression of anger. It is a private and confidential process which by its very nature has the potential to encourage trust, honesty and open communication and participation in the process. It also has the potential, if handled by appropriately trained individuals to reduce antagonism and repair personal and professional relationships, especially looking forward to any ongoing future involvement.[11]

Mediation is not concerned with right and wrong, but only with a workable future agreement. Like conciliation, mediation is an educative process where each party is able to learn about each others wants and interests, attempting

[11] Royal Society of Edinburgh (2001) Mediating Patient and Health Services Disputes in Scotland. *Scotland's Wellbeing Public Policy* Seminar Program Report 1, page 11.

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to bring out the similarities in people and issues rather than focussing on the differences. Mediation is said to address the real causes of a dispute and encourages compliance in that parties are more likely to adhere to an agreement they have helped to mould.

ADR is flexible in that it is not restricted to rules or courtroom procedure and there is scope for more creative solutions including explanations, expressions of regret or apology without parties being held to have admitted liability. In health and medical cases this is particularly appropriate for future and on-going care arrangements. It encourages participation and control over the process. Due to its informality, it tends to be less threatening and less intimidating. The agreement reached reflects the interests of the parties involves and does not reflect that of the mediator

4.1.12 Potential Criticisms and Limitations of ADR

A significant issue is whether and in which situations ADR processes should be used. It has been suggested that certain disputes should never be referred to ADR processes and that mediation or conciliation may not be suitable for all conflicts and all parties.

This can occur when a party is put at risk, or the safety of the individual is in doubt as a result of a significant power imbalance between parties as in most mediations and conciliations there is no decision maker or adjudicator. Where power imbalances are not sufficiently addressed, one party may dominate the outcome to the extent that the needs and interests of the other are not met. Power is not quantifiable and a source of power in society may be acquired through identity, education, wealth and social networks, for which mediators or conciliators are unable to compensate

In cases where there is a need for public sanctioning of conduct or where repetitive violations of statutes and regulations need to be dealt with collectively and uniformly, a closed and private process of mediation is clearly not appropriate[12]. It raises concerns that being closed and confidential, the process may fail to provide necessary safeguards and thus be contrary to the notions of fairness and transparency. Whilst the legal system has many shortcomings, it is open to scrutiny from which public debate can ensue the private settlement of disputes can disguise social problems as personal disputes, isolating them from the inherent inequalities of society.

Hofrichter (1982) argued that mediation with its emphasis on individual conflict may undermine the process of community and Scutt (1988) suggested that mediation did not ensure justice because every dispute has a social context and the power imbalances present in society will be present in mediation

In the event of the mediation producing an unfair result, a disputant may subsequently go to litigation thereby increasing both the cost and time taken

[12] Scottish Health Service, 2002. ‘ *The Use of Mediation in Patient/Health Services Disputes’*.

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to resolve the dispute. .An additional layer of quasi-bureaucracy such as mediation may in such cases be seen to elongate an already lengthy process.

Where a party to a mediation or conciliation is suffering from impaired mental capacity through drugs, alcohol, psychiatric disorder or emotional disturbance it may results in an inability for an individual to negotiate in their best interests. Pressure may be brought to bear on these vulnerable parties and any agreement made may create injustice by failing to take into account the interests of a vulnerable third party or matters of public interest.

There is a danger that a willingness to mediate is an indication of acceptance by both parties of wrongdoing; a likelihood of there being a monetary outcome, or easy and quick fix solution. Prior to mediation participants must be made aware of their legal rights and whether the process is able to deliver the outcome which is sought.

Of particular concern are practitioners about whom multiple complaints are received. It is in the public interest that these practitioners are brought to the attention of registration boards rather than attempt to mediate the matter, thereby sweeping it under the carpet (Wilson, 1999).

Sexual misconduct by the health provider is probably the most serious of all complaints received by health complaints bodies. Complaints about sexual misconduct it has been recognised, are referred directly to the relevant registration boards so the professional conduct of the practitioner can be investigated (Wilson, 1999).

Cases which lack settlement potential such as those where there is a desire to set a precedent; those where the claim value is high and those where there is insufficient information on which to base settlement negotiations are not suitable for mediation.

4.1.13 Health Registration Boards

In contrast, the disciplinary complaint system focuses on the regulation of individual health care professionals through professional registration boards. Once the health professional is registered with a board, public protection is met by a reactive system, dependent on people making complaints which trigger mechanisms to identify what is considered to be professional conduct or acceptable practice as considered by the professional group (Dix, 1998)

There is an emphasis on procedures for investigation and potentially adjudication because the purpose of the process is to establish individual responsibility, fault and culpability. It is a formal structured process that immediately establishes an adversarial relationship between the board and the health professional. In such circumstances, the original concern for public protection can be lost in a contest between legal representatives and the technicalities of law. The findings of fault will carry punishment which

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therefore makes these procedures complex, legalistic, time consuming and costly (Allsop & Mulcahy, 1996).

According to proponents of this ‘prosecutorial’ approach, it is argued that while restoration of trust through conciliation may be desirable on a personal level, it obscures what may in fact is required in terms of legal process and penalties for wrongdoing (Thomas 2002). This process is private and even if justice is done, it may not be seen to be done and will be masked in terms of systemic issues.

There is a tendency in recent medical practitioner legislation to distinguish between complaints and concerns about the physical and mental health of medical practitioners to the extent that physical or mental health compromises their ability to practise medicine and matters warranting disciplinary action.. Impairment is one of the grounds on which a complaint may be made against a medical practitioner under the NSW Act.[13]

The impairment provisions of the NSW and Victorian Medical Practice Acts establish an alternative non-disciplinary approach to deal with concerns about the impact of ill-health on the ability to practice medicine. These provisions differ from standard disciplinary complaints in that they are attempting to reach a voluntary agreement with medical practitioners in a treatment rather than disciplinary response. The Western Australian Review of the Medical Practice Act also considered a dividing line was necessary between impairment and disciplinary grounds. [14] This review will not consider impairment processes as alternative dispute resolution processes .

4.1.14 Victorian Model of Health Regulation Boards

In Victoria, model or ‘template’ provisions exist in most registration acts (except the Pharmacists Act and the Health Act) with the aim of achieving consistency in the regulation of health professionals in this State. Each Act establishes common powers for registration boards to register practitioners, establish standards, approve training courses, and receive and investigate complaints, conduct hearings and apply sanctions where necessary.
A key feature of the Victorian model is that board powers are limited to determining whether the practitioner has engaged in unprofessional conduct. This view is not necessarily shared by many disgruntled complainants who believe that boards exist to resolve grievances and punish practitioners. .A standard definition of ‘unprofessional conduct ’is adopted in all Victorian registration acts

4.1.15 Complaints disciplinary processes

[13] Section 39, Medical Practice Act 1992.
[14] Review of the Medical Act WA – Report to the Minister , p 146.

Under the current model, registration boards are empowered to receive complaints [15]regarding practitioners who are registered with the boards; initiate a preliminary investigation into a registered practitioner's professional conduct and/or ability to practise; conduct an informal or formal hearing if necessary; and if necessary, make one of a number of findings and determinations which vary according to the seriousness of the practitioner's conduct.

In Victoria, the full board must make all decisions in relation to the receipt and investigation of all notifications including whether to conduct a preliminary investigation and any actions arising from these and appoint the hearing panel. This contrasts with jurisdictions in other States which have legislated for a subcommittee structure with statutory powers to enable decision making in relation to various board functions including , registration of practitioners and assessment of complaints which enables streamlining of the Board process .

The first registration Acts to be reviewed under the Victorian model were the *Nurses* Act and the *Medical Practice Act 1994.* These have since been the subject of further review and National Competition Policy assessment, with the most recent amendment made to the *Medical Practice Act* via the *Health Practitioner Acts (Further Amendments)Act 2002.*The *Medical Practice Act* is the most recently updated Act and will serve here as a model .

4.1.16 Receipt of Notifications (Complaints)

Under the current Medical Practice Act 1994, either the Health Services Commissioner (HSC)[16] or the relevant registration board can receive and investigate a complaint concerning a registered practitioner. The *Health Services (Conciliation and Review) Act* 1987 sets out the framework that governs the relationship between the HSC and registration boards.

Pursuant to Section 23 of the *Medical Practice Act 1994*, the Board must investigate a notification to determine whether it is considered to be frivolous or vexatious or whether it is to be dealt with by the Health Services Commissioner. In practice, a delegate of the HSC regularly liaises with each board to table all complaints and those apparently relating to unprofessional conduct are generally referred to the relevant board for investigation unless the consumer wished to pursue a conciliated settlement via the HSC.
In some instances, a complainant will be referred back to the HSC for conciliation following a board investigation and disciplinary process. A opportunity for conciliation is already in place from this perspective.

[15] The Medical Practice Act 1994 as amended in 2002 now refers to complaints as 'notifications' to highlight the fact that complaints not only come from consumers of health services, but also other agencies such as the police, Victorian Workcover Authority and Drugs and Poisons Unit of DHS.
[16] The Health Services (Conciliation and Review Act) 1987 establishes the office of the Health Services Commissioner as an independent mechanism for conciliation complaints.

Although there is a common statutory framework for all but one of these registration boards, each has interpreted the legislation to develop its own internal processes and approaches to complaints handling. Currently in some boards, informal use of processes such as early discussions whether by phone contact or meeting with both the professional and notifier to clarify issues of the complaint which could be interpreted as a form of negotiation do occur, but at present there are no processes in place which enable such early intervention.

4.1.17 Preliminary Investigation

Part 3 of the *Medical Practice Act 1994* details the responsibilities, process and powers of the Board in respect of fulfilling the requirement for preliminary investigations and sanctions imposed. This section does not define how an investigation is to be conducted and scope may exist for introduction of processes which potentially allow in specific cases, quick resolution of notifications without going through lengthy formal processes.

All members of the Board are appointed to one of two Professional Conduct Committees (PCC) to determine outcomes of investigations. A Sponsoring Board Member (a member delegated to work directly with the investigator), a member of one PCC and a board investigating officer are assigned each notification after it has been through a 'vetting' or 'screening committee' process to determine whether the notification is vexatious or frivolous, whether it is the domain of the Health Services Commissioner or whether it is more appropriate for another organisation to handle. This process also determines which path the notification must follow once accepted by the Board whether it be Professional Conduct, Performance Pathway or Health. This assists in determining early in the process which notifications are suitable for lengthy investigation and which may be resolved by time efficient contact with the notifier especially in less than serious matters where an apology or clarification of a matter is required.

A complaint to a health practitioner registration board may result in one of four outcomes:

1. The complaint is judged to be frivolous or vexatious and is not investigated.
2. The complaint is investigated and determined by the Board to require no further action following this investigation.
3. Following preliminary investigation, an informal hearing panel is established to hear the matter and make findings and determinations .
4. Following preliminary investigation, a formal hearing panel is established to hear the matter and make findings and determinations.

The Act sets out which functions registration boards may delegate and to whom, who may be appointed to hearing panels and what powers the boards and their delegates have in conducting disciplinary and hearings functions.

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There are general provisions regarding the conduct of informal and formal hearings, but the Acts do not prescribe how proceedings are to be conducted.

4.1.18 Informal Hearings

Informal hearings are convened by the Board where the evidence suggests that a medical practitioner may have engaged in 'unprofessional conduct **not** of a serious nature' which is the most serious finding that an informal hearing can impose. An informal hearing usually consists of three board members, hearings are closed and practitioners are not entitled to be legally represented. A panel can not suspend or cancel a practitioner's medical registration. A panel of up to three Board members generally interviews both the medical practitioner and the notifier and must reach a consensus on whether or not the allegation constitutes unprofessional conduct. Being relatively informal, hearings of this nature could in fact represent an opportunity for the use of some form of ADR by the board to deal with relatively less serious matters.

4.1.19 Formal hearings

When the Board considers that a medical practitioner might have engaged in 'unprofessional conduct of a serious nature' the matter is referred to a formal hearing . This has the potential to lead to cancellation of a practitioner's medical registration. The proceedings at formal hearings are not dissimilar to those of a court and the medical practitioner is entitled to have legal representation while the Board engages counsel to assist the Panel. Witnesses are called, examined and cross examined. Matters usually dealt with by way of a formal hearing include allegations of gross incompetence, serious boundary and sexual violations, findings of guilt of an indictable offence and improper use or supply of drugs of addiction. If found guilty, the Board has a range of options owing to it including suspension or cancellation of registration. Each formal hearing is heard by a minimum of three panel members, one of whom must be legally qualified.

4.1.20 Health Assessment and Monitoring

Amendments to the Medical Practice Act 1994 have provided the board with a role in investigating the health of registered medical practitioners and students if poor physical or mental health is believed to be impacting on their ability to have patient contact or have patient contact. The Board has a Health Committee (5 members) which assists it to monitor impaired medical practitioners and students. Each member sponsors a number of medical practitioners being investigated and the committee makes recommendations to the Board on what conditions should be imposed.

4.1.21 Professional Performance

Amendments to the Medical Practice Act now enable the Board to deal with medical practitioners whose performance is consistently less than satisfactory.

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4.1.22 Current Use of Alternative Dispute Resolution in Victorian

In Victoria, where conciliation or mediation of a complaint against a health provider and some form of resolution is sought, the notifier (complainant) must seek the intervention of the Health Services Commissioner rather than the registration board.

In Victoria, the Office of the Health Services Commissioner, established by the *Health Services (Conciliation and Review Act) 1987 (Vic)* is a statutory authority akin to a health ombudsman which has jurisdiction over all health service providers. It is an independent, accessible body established to receive and resolve complaints about health service providers with a view to improving the quality of those services. (Wilson, 1999).
The Commissioner and staff deal with complaints in a structured process of four stages :

1. Direct response by provider to client;
2. Preliminary investigation;
3. Conciliation;
4. Formal investigation.

Complaints move from one stage to the next when necessary and a high proportion of complaints are resolved in the early stages (HSLA, 1994). Complaints which are not settled in the early stages following point of service resolution, or because the provider will not co-operate or because the user will not accept the explanation may be assessed and assigned to an investigator. Usually, an apology, explanation or refund will resolve the matter. Those not resolved, and if considered suitable for conciliation are referred to trained neutral conciliators who can conduct the process. They can provide information to the parties about the law of negligence, legal process, and the role of lawyers and the courts. Conciliation is an informal voluntary process and parties can withdraw at any time. The conciliation process is confidential and privileged and information produced can't be used in later court proceedings (Wilson,Jackson and Punshon, 1998).

Currently most registration authorities carry out both registration and disciplinary functions. There are a number of shortcomings with such an arrangement. Undertaking both functions may be seen as creating conflict of interest since the public may perceive the body that registered a practitioner to have a vested interest in protecting that practitioner in the event of a complaint. Justice must not only be done but must be seen to be done.

4.1.23 New South Wales

Complaints about health practitioners in NSW are dealt with by a co-regulatory model involving registration boards in conjunction with Health Care Complaints Commission, (HCCC) the independent health care complaints authority.

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In NSW there are 13[17] registered professional groups each governed by its own piece of legislation and Board. The NSW Department of Health maintains direct involvement in the activities of 9 of these boards through the provision of administration and financial support services administered through the Health Professionals Registration Board.

Complaints about individual registered practitioners can be made to either the HCC or the relevant registration board. When a complaint is made to a registration board, consultation must take place between the HCCC and the relevant board in accordance with the provisions of the HCCC Act 1993.

If either form the view that there are grounds for disciplinary action, the HCCC must investigate the complaint. At the conclusion of the investigation, the HCCC must consult with the relevant board as to what action should be taken including the prosecution of the complaint before a disciplinary body. Boards have a subordinate role to the HCCC and are unable to conduct an investigation during that of the HCCC.

The Board can, following consultation, refer the complaint to a Tribunal (serious complaints) or Professional Standards Committee (PSC) for less serious complaints. These processes are designed to increase public accountability of the disciplinary process and minimise possible legal error and breaches of natural justice.[18]

The Medical Practice Act 1992, the Nurses Act 1991 and the Psychologists Act 2001 contain a two-tiered disciplinary structure involving a PSC and a Tribunal although details and arrangements differ slightly.

A PSC provides for complaints of 'unsatisfactory professional conduct' [19]and comprises of a committee of three including a lay person appointed to run an inquiry regarding a less serious matter. It is closed to the public and run with as little formality as possible. Legal representation is not allowed. A PSC is similar to an informal hearing process in Victoria in that it does not have the power to suspend or deregister a practitioner but can recommend this to the board.

Those complaints if substantiated, that would lead to suspension or de-registration are referred to a Tribunal which deals with matters of 'professional misconduct'. They comprise four members including a legal member and a lay person and are comparable to a formal hearing of the Victorian board.

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[17] In NSW, registered professional groups include chiropractors, dentists, dental technicians, optometrists, osteopaths, doctors, nurses, optical dispensers, pharmacists, physiotherapists, podiatrists, prosthetists and psychologists.

[18] NSW Health, 1999. Review of the Dentists Act : Issues Paper. p 49

[19] NSW Medical Board Guide to the Medical Practice Act 1992. Accessed at www.medeserv.com.au/nswmb.legamend.htm

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When the HCCC decides not to investigate, the HCCC may refer complainants to conciliation conducted by the Health Conciliation Registry[20] or by referring complaints suitable for mediation or negotiation to the Patient Support Office.

The consent of the respective parties is required before conciliation can proceed. Participation in this process is voluntary. If the HCCC decides not to investigate the complaint, Boards can deal with it themselves.

4.1.24 Less Serious Complaints Handling

Under the NSW model, statutory powers exist for registration boards to delegate certain administrative functions to staff and sub-committees of the boards including those of registrations, complaint assessment and disciplinary committees which, in Victoria, reside with the entire board

In the case of less serious complaints, many health registration acts in NSW have a complaint management and investigation committee modelled on the Dental Care Assessment Committee established under the Dentists Act 1989. This is now duplicated in various other legislation including the newly proclaimed but not yet operational Optometrists Act 2002.
The disciplinary structure relied on in the Dentists Act to deal with complaints is different to that in the Medical Practice Act and Nurses Act.

4.1.25 Dental Care Assessment Committee

The Dental Board accepts all complaints referred to it and in accordance with the HCCC Act 1993, consults with the Board on a monthly basis (S 31A)
Where a complaint is made directly to the Dental Board , the Act (section 34) provides the Board with a range of options including : referral of the matter to the HCCC for investigation; dealing with the complaint at an ordinary Board meeting; referral of the matter to a committee of the Board for investigation ; decline the complaint; a formal Board inquiry or refer the matter to the Dental Care Assessment Committee (DCAC) for investigation, resolution and or recommendation.[21] This committee provides the Board with a mechanism through which less serious complaints can be investigated and/or conciliated with the consent of the parties.

The DCAC was established to replace the “Dentists Charges Committee” under the previous Act. It is not considered part of the Board and its members are appointed by the Minister for three years. It is comprised of three dentists and a consumer representative with administration for the DCAC provided by Board staff (S 26).Names of potential committee members are provided to the Minister by the Board and the chair is appointed in consultation with the Board.

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[20] The Health Conciliation Registry conducts conciliation processes under the Health Care Complaints Act 1993. It is independent of all registration boards and the HCCC, being part of the Legal branch of the NSW Department of Health.
[21] NSW Health , 1999. Review of the Dentists Act : Issues Paper ; 46.

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Complaints provided to the Board must be substantiated by a statutory declaration and then assessed by a 'complaints' or 'vetting' committee to determine whether there is proof of professional misconduct .If there is no proof of professional misconduct, there is according to the board, no complaint. The DCAC can attempt to conciliate in clinical matters and can attempt to secure a refund for complainants. Where necessary, DCAC will arrange for an independent assessment of the complainant's condition and this is paid for by the Board.

Section 34 [22] refers to the determination by the Board as to the manner in which a complaint is to be handled. Pursuant to Section 42, the committee can make a recommendation that following its investigation, it may, if able to, can effect settlement by consent (of both parties) of a complaint; recommend a refund of money paid for the treatment, or that the patient withhold their fees; recommend payment of fees consequential to remedial treatment; recommend that the treatment or fees are reasonable; recommend that the patient pay the fee considered reasonable by the committee; recommend that the practitioner be cautioned or reprimanded or make a recommendation for the board to deal with it.

Where a matter can not be resolved by DCAC with the consent of the parties involved, or there are issues which DCAC considers should be brought to the notice of the Board, the committee can refer the matter back to the Board with a recommendation for action.

DCAC provides a forum for independent assessment of concerns raised by patients as to the standards of dental service provided to them and the fees charged for those services. It is enabled by legislation to obtain any reports it thinks necessary to carry out its function. Issues relating to fees for service refers to the commercial conduct of the provider rather than being an issue of public health and safety.

The DCAC operates to provide a means for the Board to make a more detailed assessment of the complaint before determining how to proceed. In this regard, the committee can refer a patient for an independent examination and obtain any evidence and professional reports and advice that it considers desirable. The Dental Board justifies the use of such a committee due to the complexity and number of complaints referred to them and the useful function it believes this process served for consumers.

In practice, this is an administrative process does not allow for any direct health provider/complainant face to face negotiation or discussion and all exchange of information is done by document exchange. It may expedite an investigation but in its present form may not be interpreted as a form of mediation or true conciliation. [23]

[22] Dentists Act NSW 1989
[23] Private discussion with Registrar of NSW Dental Board.

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Complaints regarding rudeness are not considered appropriate for this process as a one off encounter with a health professional may not necessarily reflect the desire for an ongoing professional relationship, a situation where conciliation or mediation is intended to prove more useful.

The DCAC is considered a quick and effective way of dealing with complaints relating to the less serious end of the misconduct scale. It is considered a prompt and efficient process and represents a less costly alternative to litigation and the burden of the complainant obtaining their own expert evidence.[24]

In the interests of accountability and transparency, the Report of the Review of the Dentists Act recommended that where DCAC came to view a matter potentially involving unsatisfactory professional conduct or professional misconduct, it should be entitled to make a recommendation that the matter be dealt with in the form of an inquiry by the Board.

Nearly all Acts in NSW now include this process of peer review which provides an alternative to going to court, therefore keeping costs down.

4.1.26 The Optometrists Act 2002 (NSW)

The Optometrists Act 2002 has not yet been proclaimed but will be the most up to date health practitioner registration Act in NSW. The Optometry Care Assessment Committee is intended to operate in the same way as the Dental Care Assessment Committee. The Committee is intended to be used by the Board as an expeditious and expert mechanism to inquire into complaints about optometry services which the HCCC does not intend to investigate and will generally be at the lesser end of the spectrum of seriousness.[25]

The Committee will be comprised of four members, an optometrist opted by the Board and two appointed by the Minister from a panel of practitioners put forward by the Board. In order to ensure that the committee is perceived to be independent and the process remain transparent, Board members will not be eligible to be appointed. The Committee will investigate complaints and make recommendations to the Board for their resolution and included as part of their powers of investigation will be to be able to require the practitioner to undergo skills testing to ensure the retention of appropriate standards of practice[26].

Section 39 (1)(c)of the Optometrists Act provides for how complaints are to be dealt with by referral of the complaint to the Optometry Care Assessment Committee under Division 3 of the Act and section 43 determines the kinds of complaints that can be referred to the Committee. The OCAC will be designed to operate as an investigative body and will be able to obtain reports and interview individuals.

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[24] NSW Health, Report of the Review of the Dentists Act. P 60.
[25] NSW Legislative Council, Optometrists Bill Hansard Extract – 12/6/02.
[26] Section 45 Optometrists Act 2002

The Committee is not intended to have the power to determine complaints but will be able to facilitate the patient and practitioner reaching an appropriate agreement between themselves. If an issue of unsatisfactory conduct is raised during investigation, the Board will be obliged to follow up their referral for disciplinary action.

4.1.27 Western Australia

In 2001, the State government of Western Australia drafted new health practitioner Acts based on the outcome of the review of Western Australian Health Practitioner Legislation.[27] The review was undertaken with the aims being to regulate harmful practices; establish a fair, flexible and effective disciplinary system and enhance the ability of registration boards to ensure registrants meet competency standards.

In Western Australia, there are currently 13 registration acts, all of which have individual boards. The template disciplinary procedures have evolved over time, and are intended to provide a system of disciplinary review and action which is accountable, procedurally fair and unbiased, efficient and which involves non-professionals and professionals.

The Osteopaths Act 1997 established template or model legislation for other health professional legislation in Western Australia and subsequent amendments to it introduced a more flexible arrangement for delegation of Board functions.

As a result of the review[28] of the template legislation, a 'complaints assessment committee' was established as a less formal way to manage complaints as well as to investigate and inquire into matters of practitioner impairment.

The review also determined that where conciliation was the appropriate course of action, then the matter was to be referred to the Office of Health Review pursuant to the Health Service(Conciliation and Review) 1995.

The Office of Health Review is an independent State government authority responsible directly to Parliament. Its role and jurisdiction is largely modelled on Victorian legislation. Formal powers are vested in the Director whose primary function is to receive, investigate and conciliate complaints, with a view to improving practice and procedures in the health care system to ensure poor practices are not repeated (Thomas, 2002).

There are currently no provisions in the health professional legislation that incorporate the use of mediation, conciliation or any alternative dispute resolution.

[27] The effects is that replacement legislation will be developed for chiropractors; dentists and dental prosthetists; nurses; occupational therapists; osteopaths (amendment only); physiotherapists, podiatrists and psychologists.

[28] Review of the Western Australian Health Practitioner Legislation, June 2001.

The Osteopaths Act 1997 provides for the establishment of a complaints assessment committee (CAC) to carry out the initial assessment of complaints. The CAC must comprise an osteopath, a lay person and any other person that the Osteopaths Board considers appropriate. In order to separate registration form disciplinary action, membership of the CAC does not have to be drawn from board membership[29].

Under S 51, the CAC has power to reject complaints if it is of the opinion that they are frivolous, vexatious or without substance. The CAC has the power to make recommendations to the Osteopaths board on how a particular complaint or disciplinary matter should be dealt with. The CAC also has power to attempt to conciliate a complaint, but only if requested to do so by the board pursuant to sections 63 and 64.

Pursuant to sections 57 and 58 of the Act, the Osteopaths Registration Board and the CAC have power to appoint investigators who must report to the board or CAC as directed.

A comprehensive review of the Medical Act 1894 was also undertaken and a review of the Pharmacy legislation is being conducted on a national basis. The recently released Review of the Medical Act 1894[30] recommended that there should be significant changes made to the disciplinary provisions of the Medical Practice Act, intended to enable the board to be more proactive. This included the introduction of an informal disciplinary process for dealing with matters which do not , or are unlikely to warrant consideration being given to suspension of registration or de-registration (ie less serious complaints).

According to the Medical Act Review, significantly more complaints about medical practitioners are made to the Office of Health Review than to the Medical Board. A major concern was the absence from the Act of a graduated response to matters requiring action by the Board which has been perceived as the Board being less than willing to deal with disciplinary matters of a less serious nature against medical practitioners.

In response, the Review proposed that the new Medical Act should provide for a two-tiered system involving retention of the current formal disciplinary process involving an inquiry by the Board and the introduction of a separate informal process for dealing with less serious matters. This is modelled on the NSW Professional Standards Committee and Medical Tribunal model.

The Review examined the provisions of the template legislation providing for the establishment of a ‘complaints assessment committee’ (CAC) by the Osteopaths Registration Board, and supported the inclusion of comparable provisions in the new Medical Act.[31]

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[29] Section 16 Osteopaths Act 1997 (WA)
[30] Government of Western Australia,1999. Report of a Review of the Medical Act1894 by a Working Party established by the Minister of Health.
[31] Medical Review Act – Report to the Minister for Health, p 154

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As in the template, it was proposed that the Medical Board, on advice from the CAC would take responsibility for deciding the course of action to be followed. The Board would not be bound by the CAC's decision but would ensure accountability for the decision taken.

The decision by the Board to refer the matter to either a Professional Standards Committee or to the Medical Tribunal would be determined by an assessment by the CAC and the Board as to whether the complaint was serious enough to warrant suspension or cancellation of Board registration. If the Board was of the opinion that move may be necessary, it would be required to refer the complaint or matter to the Medical Tribunal.

In its response to the Review, the Government of Western Australia agreed that the Medical Board of WA should retain primary responsibility for deciding on the action that should be taken in response to complaints following assessment and investigation, and recommended the establishment of various statutory committees for complaint handling and discipline. These included :

- a *complaints assessment committee* of the board to conduct preliminary inquiries into complaints and to advise the Board accordingly ;
- an *impaired registrants panel* of the Board to inquire into possible health concerns impacting on the practitioner's ability to practice;
- a *professional standards committee* of the Board to inquire into issues of competence and professional conduct;
- a separately constituted *medical tribunal* with primary jurisdiction to hear serious complaints or matters of concern where suspension or cancellation of registration may be warranted.

The Review recommended that the role of the Professional Standards Committee (PSC) would be to provide an informal mechanism for dealing with less serious complaints or concerns that a disciplinary matter has arisen. The Committee would be established and supported administratively by the Board and would consist of at least two medical practitioners, not necessarily members of the Board, and a person to represent the interests and perspective of the community.[32] It is recommended that medical and community members be appointed by the Minister from panels of possible participants who have expressed an interest and who have relevant experience and expertise to ensure transparency.

The PSC and Medical Tribunal would be independent but complimentary of one another and cases should be able to be referred to the Medical Tribunal where appropriate from the PSC. In keeping with the NSW model and consistent with an informal approach to dealing with less serious complaints, there will be no rights to legal representation .

The *Medical Act* 1894 did not provide for the use of alternative dispute resolution (mediation, conciliation) in handling complaints against medical

[32] Medical Review Act – Report to the Minister for Health p 157

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practitioners. The 1991-1993 Review recommended that a possible option available to a CAC (complaints screening committee) could be for referral for conciliation of the matter by the Office of Health Review and dealt with under the relevant Act.[33]

Pursuant to Division 5 of Part 5 of the *Osteopaths Act* 1997, the complaints assessment committee can become involved in the conciliation of disputes at the request of the Board.[34] In terms of conciliation, this refers to the CAC having power to arrange conferences between the parties or their representatives to be arranged and presided over by a conciliator; give advice and make recommendations to assist in reaching a settlement and have the parties, either separately or together, appear before the CAC.

A settlement reached by conciliation with the consent of both parties, is given effect by the Osteopaths Board and is considered to be final and binding. In cases where the conciliation is unsuccessful, or do not meet Board approval, the Board may proceed to an investigation or formal inquiry.

In no other jurisdiction, does the Medical Board attempt to conciliate disputes between complainants and practitioners, only that complaints are referred for conciliation to Health Services Commissioners who are empowered under legislation to do so. In most instances, those complaints warranting an attempt at conciliation would be referred to those bodies with expertise and experience in this form of negotiation. However, the Review decided that in order to retain flexibility in the Act, the option of conciliating complaints should not be closed off.

It seems essential that an awareness of the imperative of impartiality of the role of conciliator be reinforced in this situation, by not choosing Board members to be on the CAC.

The role of the Medical tribunal would be to hear and determine complaints of a serious nature against medical practitioners and the suitability of such complaints for mediation or conciliation is highly questionable.

4.1.28 Queensland

In 1993, the Health Practitioner Registration Acts (HPRA) Review was conducted by the Queensland Government and the Professional Standards Act and Registration Boards Acts were passed. This profoundly affected the functioning of the Queensland Health Rights Commission, the independent health watchdog and complaints body, because it removed the Commission's powers to investigate complaints against registered providers and placed them instead in the hands of the Queensland Health Practitioner registration Boards. The Office of Health Review is modelled on the Victorian Office of the Health Services Commissioner. Conciliation is enable under Part 6 of the

[33] Health Services (Conciliation and Review) Act 1995. S 53 which requires registration authorities to provide copies of complaints received to the Director and for consultation with the agreement of the complainant on suitability for conciliation.
[34] Section 63, Osteopaths Act 1997.

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legislation specific to the Office of Health review and specifies that all issues of public interest (including complaints of a sexual nature or other boundary violations) are to be identified and brought to the attention of the parties.

The Queensland *Health Practitioners (Professional Standards)* Act 1999 established the following committees with statutory functions :

- Professional Conduct Review panels (Similar to Victorian informal hearings)
- Health Assessment Committees to deal with impaired practitioners.

The Act contains all of the provisions relating to the conduct of disciplinary, impairment and professional standards matters relating to all registration boards. Section 14 of the Act sets out the functions of a 'professional conduct review panel' which includes conducting a hearing and making decisions relating to disciplinary matters other than those providing grounds for suspension or cancellation of registration. Routine disciplinary matters would be handled by way of an informal/collaborative and re-directive hearing process. A panel of three comprising two professionals and one lay person are nominated by the Minister from a list of potential panellists nominated by the Board. Section 136 states that a hearing committee must comply with natural justice and act as quickly as possible with as little formality and technicality to be consistent with a fair and proper consideration of the issues before it. Such a committee has the hallmarks of an informal mechanism with the potential for dealing with complaints not of a serious nature.

Under the Queensland *Health Practitioner Registration Boards (Administration) Act* 1999, an Office of Health Practitioner Registration Boards has been established to provide administrative and operational support to help the Boards carry out their functions. This is a statutory authority that is the combined secretariat for 11 Health Practitioner Boards.

Under the Queensland regulatory scheme, registration boards have retained the prime responsibility for investigation of complaints. Although the Professional Standards Act is designed to provide a common framework for regulating the registered health professions, the profession specific Acts still contain many provisions that are common across all of the Acts.

The Medical Board of Queensland under the recently proclaimed *Medical Practice Act* 2001 has a two-tiered structure in its jurisdiction to deal with certain complaints against medical practitioners. More serious complaints must be referred to the Medical Assessment Tribunal (MAT) which is similar to a court constituted by a Judge of the Supreme Court of Queensland who sits with two medical practitioners (appointed by the governor) who act as assessors. Their role is to advise the judge in determining matters of fact while all matters of law are usually determined by the judge.

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Queensland proposed the adoption of a generic three-tiered disciplinary structure for its health practitioner legislation [35] comprising:

- the Medical Board which would deal with matters that could simply be addressed through counselling or advice
- the Professional Standards Committee (PSC) which would deal with less serious disciplinary matters. Membership would be constituted from panels of registered professionals and consumers selected by the particular registration board and appointed on the nomination of the Minister of Health
- a Health Practitioner Tribunal (HPT) to deal with matters which may provide grounds for deregistering or suspension of a registered practitioner. The Health Practitioner would replace the Medical Assessment Tribunal and have jurisdiction across all regulated health professions.

4.1.29 New Zealand

The Health Practitioners Competence Assurance Act (HPCA) was passed by New Zealand Parliament in September 2003 and comes into operation in October 2003. It is intended to provide a framework for the regulation of health practitioners in order to protect the public from the risk of harm from the practice of the profession. Its objective is for the framework to cover a range of health professional occupations, repealing 11 occupational statutes.
The HPCA builds on the existing framework where all major concepts of the Medical Practice Act have been carried forward into the HPCA, adjusted to generic terms to apply across professions.

Part 4 of the HCPA proposes the establishment of a single tribunal, called the Health Practitioners Disciplinary Tribunal, to hear and determine charges brought against practitioners by the Health and Disability Commissioner or by a complaints investigation committee of the relevant registration board.

Where a complaint is made to a registering authority about a practitioner, that complaint must be referred to the Health and Disability Commissioner. The registering authority is precluded from taking any action until the Commissioner has either disposed of the case or has referred the matter back to the registering authority.

The N.Z.Health and Disability Commission was established in New Zealand in 1994 and was intended to promote and protect the rights of health and disabled consumers (Thomas, 2002;85).One of the objectives of the Health and Disability Commissioner Act 1994 is to facilitate the fair, simple, speedy and efficient resolution of complaints'. It also has a watchdog role to ensure public safety

4.1.30 Complaints Investigation Committee

[35] Queensland Health (1996) Review of medical and health Practitioner Registration Acts – Draft Policy paper, p 37.

When referred back to a registering authority from the Commission, the investigation process may be undertaken (under clause 68), by a professional standards committee of the authority , or by the establishment of a complaints investigation committee (previously referred to as a complaints assessment committee) comprising two practitioners and one lay person.

Under clause 77, the powers of a 'complaints investigation committee' would be to determine whether the registering authority should review the competence of the practitioner or of them to practice; whether a complaint should be subject to conciliation; the complaint should be considered by the Disciplinary tribunal or whether any further steps needed to be taken.

Conciliation in this context arises from a 'determination' of a committee pursuant to clause 77(3)(c). There is no indication in this Act as to the definition of 'conciliation', or who would offer the service or who indeed is entitled to receive it. Issues as to who covers the costs or what the committee should do if the parties are unable to agree on a conciliator are not available.

An investigation by the committee is conducted by receiving any information, especially oral evidence and statements and submissions from individuals associated with the practitioner including the complainant. The complainant may have a support person with them but that person may not speak at the hearing.

Clause 79 refers to the provisions governing settlement of a complaint by conciliation. to assist the practitioner and complainant resolve the complaint by agreement. If a complaints investigation committee has decided to submit a complaint to conciliation, the committee must attempt to assist the practitioner and the complainant to resolve the complaint.

If the complaint is resolved by agreement, the registration board is to be given written notice to this effect and if it is not resolved, it can be recommended that no further action be taken or that a charge be laid against the practitioner before the disciplinary tribunal. The committee also has the power to recommend that the practitioner competence, fitness to practice or scope of practice be reviewed or that the practitioner be counselled or the matter referred to the police. It is also proposed that the committee should be required to report to the registering authority at any time during the investigation if the committee is of the view that members of the public are or will be put at risk.

The New Zealand Law Society[36], in its response to the Submission of the Draft Paper have questioned the need for the change of name of the complaints assessment committee and of the need to appoint an investigator. Further, they suggest that the functions and powers conferred on the committee to determine whether conciliation has resolved a complaint closely resemble those of the Health Practitioner Disciplinary Tribunal. They suggest

[36] New Zealand Law Society, 2002. Submission on the Health Practitioner Competence Assurance Bill.

that the role of the committee should be limited to assessing the facts of the complaint determining if the complaint is frivolous or vexatious ,or is a professional disciplinary offence and whether conciliation is even appropriate to resolving the matter.

4.1.31 New York

The New York Board of Regents, established by the New York State Legislature is responsible for appointing a State Board for each licensed profession. The office is responsible for investigating and prosecuting professional misconduct for all the professions except medicine which is the responsibility of the Office of Professional Medical Conduct. As a lay governing body, the Board of Regents represents and safeguards the public by ensuring that licensed professionals in New York State provide competent and ethical services. Complaints are received from the general public, other licensed professionals, institutions and from other State and Federal agencies. All professional misconduct complaints are investigated by this office and if professional misconduct is substantiated, several results are possible ranging from letters advising of the need for corrective action to a fine or in the most serious cases, referral for formal charges.

The U.S. Pew Commission[37]reported on the need to improve professional regulatory role in meeting consumer expectations in health service delivery. This included the standardisation by regulatory boards of their programmes and performance objectives in areas such as investigation and discipline, information dissemination and continuing competence of health professionals.

In 1996, the management was requested to devise a reform plan that would make the Office more efficient and more effective and create a disciplinary system that was more responsive to enhancing public protection through the timely resolution of complaints of professional misconduct.[38] The Complaints Resolution Process (CRP) was first implemented that year as a pilot in the professions of dentistry, nursing, pharmacy and psychology and was later expanded to all professions. It led to 'marked process improvements in the resolution of complaints, improving efficiency, fairness and public protection'.

The CRP consists of two key elements, the 'Early Involvement' (EI) and the Informal Settlement Conference (ISC). The EI, occurring within 120 days of the receipt of the complaint, involves the investigator, prosecutor and the board member who evaluate the merits of the complaint and provide direction for case development. With agreement that the case go forward, an informal settlement conference is scheduled to resolve the allegations. Within six months of the receipt of the complaint, the subject and the attorney are invited to an ISC with the prosecutor and a member of the applicable State Board to discuss the case informally. This conference is facilitated by the Professional Conduct Officer and frequently leads to the resolution of the case without the

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[37] Pew Commission, 1998. Strengthening Consumer Protection : Priorities for Health Care Workforce Regulation.
[38]Office of the Professions, New York, Progress Report on Disciplinary Reforms, July 2000.

necessity of a formal hearing with the average time for resolution of all Regents Actions being reduced by nearly 30% since 1996.

The establishment of Informal Settlement Conferences (ISC) greatly reduced the number of cases requiring formal hearings and saved the board a significant amount of money. [39] The ISC provide a negotiating framework where all participants are present and are afforded the opportunity to discuss their respective positions with 'candour and clarity'. The result has been that formal hearings are used only after negotiations have been exhausted and serious factual disputes remain. According to an 'Update'[40] of the new process, the system was deemed to be working more quickly and more cheaply by reducing the number of administrative steps involved and improving the integrity of the disciplinary process.

4.1.32 Ontario, Canada

In Ontario, the health professions are regulated by the *Regulated Health Professions Act* 1991 (RHPA); the Health Professions Procedural Code; 21 Profession specific Acts; regulations under the *RHP* Act and the profession specific Acts; and the Ministry of Health Appeal and Review Board Act.

The RHPA which came into force in 1993, provides a common framework for regulation of those working in Ontario's 23 regulated health professions. The objectives of the Act include protecting the public form harm; promoting high quality care and to make regulated health professionals accountable to the public amongst others.

In its report of the review of the regulatory system 'Adjusting the Balance', the Ontario Health Professions Regulatory Advisory Council (HPRAC) noted ' the effectiveness of the college's complaints and discipline process is important to achieving the legislative objective of protecting the public from harm'.[41] The Review noted that many adjustments were needed to increase the effectiveness of the complaints and discipline process to increase the public confidence in it and these included the need for greater fairness, transparency of decision-making criteria in dealing with complaints, the use of alternative dispute resolution (ADR), and arriving at penalties when a member was found to be guilty of professional misconduct.[42]

The management of complaints and disciplinary processes by the Ontario Colleges is set out in the Health Professions Procedural Code (HPPC) under the Regulated Health Professions Act 1991. Each registration board (college) has:

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[39] In 1999, 88% of the most difficult cases were resolved at an Informal Settlement Conference as compared to pre-ISC when the vast majority of the unresolved cases were referred for formal hearings.
[40] New York State Education System, Office of the Professions. 'The Update', May/June 1998
[41] HPRAC, 2001. Review of the Regulated Health Professions Act, p 11.
[42] HPRAC, 2001. p 13.

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- Executive Committee - full Board powers; make interim suspension or practice limitations; can refer matters for investigation or impairment proceedings;
- Complaints/Screening Committee – investigate complaints; consider findings related to the complaint; make decisions for steps following investigation;
- Disciplinary Committee – powers to conduct hearings and impose sanctions on those found to have engaged in professional misconduct or found to be incompetent; can suspend or revoke registration;
- Fitness to Practise Committee – power to appoint a panel to hear matters related to health and impairment;
- Quality Assurance Committee can evaluate knowledge and skill of practitioners.

A three- member panel appointed by the College (equivalent to registration board) is responsible for handling complaints. Three members comprise these committees, one of which is a lay person. The Review[43] commented that lay members played an important role in avoiding the perception of bias in complaints committees. All formal complaints were to be investigated and disposed of within 21 days. If a College member is found guilty of professional misconduct , they may be referred to one of the Committees for appropriate action.

4.1.33 Use of ADR in Ontario

In the report 'Adjusting the Balance', the HPRAC reported on submissions received on the role of the Complaints Committee in Alternative Dispute Resolution (ADR)[44] programmes and its commensurate role in remediation. It was noted that 'early resolution of complaints through mediation offers the possibility of increasing both efficiency and complainant satisfaction in knowing the complaint has been dealt with in a timely manner. It was also noted that frivolous and vexatious complaints ought to be 'dismissed' earlier rather than later in the complaints process to achieve administrative efficiency and fairness to the respondent.'[45]

HPRAC acknowledged that colleges use ADR differently and have different names for the process. HPRAC recommended certain restrictions and guidelines on the use of ADR and recommended the following amendments to the HPPC :

- The establishment of guidelines for the use and limitations on the use of ADR;
- Restrictions on the use of ADR in particular in relation to complaints of professional misconduct of a sexual nature;

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[43] HPRAC, 2001 p 59

[44] ADR is allowed by s 4 and s4(1) of the Statutory Powers and Procedures Act, which applies to College proceedings.

[45] HPRAC,2001, p67.

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- In order to provide for accountability and protection from harm, all ADR settlements involving mediation should be made part of the register available to the public;
- Any ADR settlements reached prior to referral to discipline must be subject to approval by a panel of the Complaints Committee ;
- That categories of cases appropriate for ADR at the complaints stage should be articulated in the HPPC and should not involve behaviour deemed serious by the college and should be instances of minor misconduct that have not resulted in harm and are not indicative of more serious concerns about professional misconduct or a pattern of substandard practice;

Therefore ADR should be used only to deal with complaints of:

- poor communication, inaccurate or poor documentation and/or record keeping;
- rude behaviour not indicative of serious practice deficiencies; isolated standards of practice failures not resulting in serious harm;
- breach of confidentiality; conflicts of interest; and behaviours not indicative of a pattern of practice deficiencies;

That an express provision be that a panel of the Complaints Committee be allowed to refer the matter to a Quality Assurance Committee for assessment of competencies and determination of appropriate remediation programmes.[46]

HPRAC receives a number of submissions dealing with general process issues such as the amount of time the hearing process can take, the expense associated with hearings, and the use of ADR. One submission suggested that a fuller investigation of the decision-making process was required before it was possible to comment upon whether the RHPA had struck an appropriate balance between patients/clients, members and the college.[47]

In HPRAC's view, issues raised by the public refer specifically to whether the hearing process is fair and the use of ADR at the discipline stage of the process. In the discipline process, some colleges use the term ADR to apply to pre-hearing negotiations between the college and the member aimed at arriving at an agreement of facts or joint proposal for a penalty if the member agrees to a guilty finding. HPRAC acknowledges that there may be valid reasons for using ADR at this stage of the proceedings but that this could have a detrimental effect on the public's confidence in the college's discipline process and that accountability and transparency must be ensured. Therefore, it was further recommended that all ADR settlements be subject to review and approval by the panel of the Discipline Committee hearing the matter and that the settlement be published on the Register available to the public.[48] In addition, accountability would be enhanced trough a performance monitoring system.

HPRAC did not accept that awarding financial compensation to complainants was an appropriate function for regulatory bodies and that protection from the

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[46] HPRAC, p 68- 69.
[47] HPRAC, p 77
[48] HPRAC, p 78

public is its primary objective. As there is no equivalent to the Office of Health Services Commissioner in Canada, civil liability and court proceedings are the only options available in instances where complainants are seeking financial compensation. HPRAC recommended that compensation and professional accountability are two separate functions that should be kept distinct.

HPRAC were of the view that ADR should not be used in cases of serious physical sexual abuse because of the inherent power imbalance between the complainant and the respondent health professional, the reluctance of complainants to come forward and the sense of vulnerability and the potential for re-victimisation that can result. Physical sexual abuse does not represent a 'dispute' to be resolved but is serious misconduct that must be proven and addressed. It goes beyond a private dispute between the health professional and the patient and is a matter of public protection and therefore should not be resolved through ADR. [49]

4.1.34 Participative Resolution Programme

The Colleges of Nurses of Ontario[50] has a statutory responsibility as the nursing regulatory body to investigate all complaints received about nurses' practices and behaviour. The Participative Resolution Programme (PRP) is a non-adversarial alternative to the complaint investigation process which allows the complainant, the nurse and the College to work together to create mutually satisfactory solutions to a complaint and effectively protect the public interest. Many complaints about nursing conduct and practice are eligible except those involving abuse, fraud or criminal conduct.

Following screening for suitability for PRP by the College, discussions are held between the College, the complainant and nurse seeking mutual agreement to undertake the process. A CNO investigator facilitates the resolution and other staff may become involved as the proceedings continue especially in the case of the need for re-training.

Any party has the option of discontinuing the PRP at any time for any reason and if terminated , the complaint proceeds through the College complaint investigation process.

Final resolution requires the complainant and the nurse to agree that the PRP will bring closure to the matter and an agreement specifying agreed solutions and outcomes is signed and both parties are provided with a copy. The agreement together with the letter of complaint and any additional information must be reviewed and approved by the College Complaints Committee. The final agreement is not made available to the public nor is the information used in future College proceedings although it is considered in assessing whether the PRP is a viable option in future complaints made against a nurse.

[49] HPRAC, p 83-84.
[50] College of Nurses Ontario, 2003. Fact Sheet 'The Participative Resolution Program'. Accessed @ www.cno.org

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4.1.35 United Kingdom

In July 2000, the National Health Service[51] proposed the formation of a UK Council of Health Regulators to co-ordinate the various bodies which regulate individual health professionals. There are eight bodies regulating UK health care professionals.[52] Reforms conducted in several of the regulatory bodies have changed the way they govern themselves or manage complaints against their members. In addition, more bodies are establishing 'revalidation' systems to allow them to check the quality of members' practices.

The NHS has its own system for implementing clinical governance through monitoring and improving standards where there is a statutory obligation upon health service providers to assure the quality of clinical work in their hospital or primary care trust.

The evaluation of the NHS complaints procedure indicated that the process caused significant dissatisfaction for complainants and that the system needed to be more flexible and that more complaints needed to be able to be reviewed at the local level to reduce the need for them to escalate unnecessarily.[53]

The General Medical Council (GMC) is a statutory body independent of the NHS and of Government with responsibility for maintaining the medical register for the United Kingdom. It has statutory powers under the Medical Act 1983 to take action when concerns are raised about the performance, conduct or health of individual doctors of a level of seriousness which calls into question the doctor's fitness to remain practising. Lesser complaints are encouraged to be resolved locally in particular through NHS procedures. GMC processes are distinct from those of the NHS or other employers but is committed to work collaboratively with the NHS to ensure effective public protection.[54]

The keeping of the medical register will remain a central function of the GMC. Increasingly, concerns about a doctor's conduct, performance or health will be dealt with at the local level by a hospital, health authority or primary care trust. The new GMC will concentrate on the most serious cases and those where local action is insufficient to protect the public. Panels considering cases will have a number of options other than the removal of doctors from the register. There has been a radical overhaul of initial stages of case-handling to make them quick, effective and fair; confining formal conduct hearings for serious allegations and new procedures for dealing with cases which are not deemed

[51] NHS,2001. Modernising Regulation in the Health professions Consultation Document.
[52] The General Medical Council, Nursing and Midwifery Council, Health Professions Council (incorporating chiropodists, podiatrists, dieticians, clinical scientists, occupational therapists, radiographers etc), General Chiropractic Council, General Osteopathic Council, General Dental Council, General Optical Council, Royal Pharmaceutical Society of Great Britain. Each body sets standards, investigates allegations of unprofessional behaviour and has the power to strike health care professionals from its register.
[53] Department of Health, Reforming the NHS Complaints Procedures
[54] Acting Fairly to Protect Patients, GMC, March 2001, paragraph 16.

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to be so serious but might deserve a lesser sanction.[55] Not all changes to the GMC require amendment to the Medical Act.

During 2000, the GMC received 4,500 complaints many of which were more appropriate to the NHS complaints system as they raised matters which, although serious, did not call the doctor's registration into question.[56] Since that time, the GMC has acted quickly to encourage those complainants to contact local authorities.

Initial consideration of complaints involved three stages: a decision as to whether the complaint is trivial or inappropriate; screening for the next stage for either closure or referral to either an intermediate conduct committee (Preliminary Proceedings Committee) which then considered whether to refer the case to the Professional Conduct Committee or for an assessment of the doctor's performance. This model was criticised for being slow, cumbersome and lacking in transparency. Where a complaint is considered appropriate for action by the GMC, screening may have determined that the complaint required immediate action by the Interim Orders Committee (IOC); be referred to the Preliminary Proceedings Committee (PPC) Conduct; the Performance or Health Committee or the case is closed.

The Preliminary Proceedings Committee is a panel of medical and lay members who meet to consider whether a case should be referred to the Professional Conduct Committee (PCC) for a full public inquiry. If the PPC decided that a case raises serious professional misconduct, the case will proceed to the Professional Conduct Committee for a full public inquiry. The PPC can also refer a case to the health Committee.

In March 2001, the GMC published 'Acting Fairly to Protect Patients' which set out proposals for major reform. The new 'fitness to practice'[57] scheme aimed to :

- Streamline and speed up our processes
- Separate investigation and adjudication
- Achieve a holistic approach to fitness to practice bringing together conduct, performance and health.

It is intended that the Registrar should undertake the initial assessment of whether a complaint engages the fitness to practice procedures. Decisions about whether further action is necessary are the responsibility of the Investigations Committee. Cases referred to the Fitness to Practice panels, replacing the existing Professional Conduct, Health and Professional Performance Committees. The aim is for the process to be as streamlined and fair as possible.

[55] Reform of the General Medical Council, p9.

[56] GMC, 2001.Acting Fairly to Protect Patients: reform of the GMC's fitness to practise procedures. P 8

[57] GMC,2003. Fitness to Practise : Proposed New Rules and Guidance – consultation paper, p 3

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4.2 Summary of findings

This literature review has looked at the use of alternative dispute resolution (ADR) processes in complaints and disciplinary mechanisms of various health and regulatory boards both in the different States of Australia and in some overseas jurisdictions.

The incorporation of ADR into statutory processes in regulatory boards has been minimal especially in Australia and the literature evaluating and reviewing its use is virtually non-existent. It appears that the role played by the conciliation in dispute resolution in various Health Complaints bodies especially involving monetary compensation has been widely acknowledged by consumers and legislators. It must be kept in mind that the introduction of ADR into regulatory boards may serve only to confuse the roles of the respective organisations and blur the boundaries further and the gateway for use in disciplinary functions would have to be clarified. The adaptation of some of the principles of ADR processes such as mediation, negotiation and conciliation into regulatory disciplinary boards has only slowly begun to be incorporated into legislation such as in reforms to the Medical Act in Western Australia.

Some processes conducted by boards were becoming increasingly flexible and informal, with an acknowledgement for the need of transparency and flexibility as a response to concerns raised by the public and the Boards.

There appears to be no consistent definition of ADR with the most common process referred to being conciliation. The use of conciliation in the processes reviewed, appeared to reflect scope for informality, greater flexibility and more creative and proactive solutions.

There is always a concerns with ADR that opening up processes of discussion and communication may heighten expectations of complainants and that the gesture to mediate reflects an acceptance of guilt or wrongdoing by the other party. This may be a stumbling block to getting parties to agree to come together. In the case of regulatory boards, creating another potential layer of quasi-bureaucracy which may ultimately serve to or be seen to elongate an already lengthy process may prove detrimental especially in cases which lead on to litigation or further disciplinary action.

In Australia, those studies which have sought to determine whether ADR processes should be used have focussed on disputes which involve litigation. This is to some degree skewed reporting about the costs and benefits of ADR as the content of discussion reflects the need for reform to the court system. According to the Australian law reform Commission, there is a need for more research and evaluation as the limited data available is related to difficulty measuring the benefits of the processes .[58]

[58] ALRC, 1996, 96 ;43

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NADRAC's research and consultation indicates that while client satisfaction with ADR is generally high, there are some specific problems and risks. These include informed and effective participation by parties, the appropriateness of the dispute for ADR, accessibility and fairness in procedure, maintenance of confidentiality and termination of the ADR process. There is a need to establish an appropriate level of practitioner competence and ensure the quality of processes for both parties.

In practice, in both the design of the dispute resolution system and in the delivery by mediators and conciliators, a great number of choices must be made about process and procedure. Some of these may include the participation of legal representatives; private meetings with participants during the process; sole or co-mediation; professional knowledge of the area of dispute; separate and independent initial assessment of suitability of ADR for each party; what the goal of the process is; how to deal with emotional issues; whether the process should be single or multi-session; the formality of the process; the amount of disclosure required; the amount of data required; writing up of the agreement and of the decision reached; the stage at which the ADR is provided; any possible pressures brought to bear on parties to engage in the process; power differentials and how they will be dealt with; and the training and experience of mediators and conciliators.

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5 THE SURVEY

5.1 Qualitative research methods

Data collection for the survey employed qualitative research methodology. This is the most appropriate methodological approach because the survey aimed at gaining insightful information and exploring perspectives of members of the health registration bodies and health complaint bodies around ADR use. Qualitative research methods are particularly useful in understanding the richness of participants' experiences and perspectives. The advantage of qualitative research is its capacity to ask questions that cannot be asked using quantitative methods. (Howe, Degeling, Hall, 1990)

Two methods of data collection were employed: the semi-structured interview and an open-ended questionnaire.

5.1.1 The semi-structured interview

A semi-structured interview was conducted with the President and Registrar of all relevant Health Registration Boards in Victoria, and the Office of Health Service Commissioner. It was determined that legal members of the boards would also be interviewed, where possible, to obtain information from lawyers' perspectives.

Research questions in the questionnaire format were used as guidelines for the interview. Questions were asked in a different order according to the particular leads given by the interviewees. The purpose of this approach was to make the atmosphere of each interview relaxing and comfortable for all participants. Questions were illustrated with examples and prompts were used to draw out information in depth.

All interviews, but one, were conducted face to face, at the venue and time nominated by the interviewees. The interview not conducted face to face was carried out by teleconference because the respondent did not have an office in Melbourne. Two researchers, one with a legal and health regulation board background and the other with a health and social research background, conducted each interview. The interview took from 45 to 60 minutes. With each participant's consent, a tape recorder was used to record the interview. This provided details and accuracy of data not obtainable by taking notes, and allowed the interviewer to concentrate on listening and probing for further

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information. For the purpose of data analysis transcription of the tapes was carried out by a professional transcriber. Hand written notes were taken by one of the interviewers during every interview as a supporting record, and when tape recording was not permitted.

5.1.2 The Questionnaire

The questionnaire survey was aimed at all Health Registration Bodies outside Victoria, including those in New South Wales, Queensland, Northern Territory, Western Australia, South Australia, Tasmania and New Zealand. It consisted of all major questions broken into small, open-ended questions with prompts and ample space for written response. The questionnaire was posted to participants with an information pack and a self-addressed, stamped envelope for the return of responses. A timeline of two to four weeks was given as a guide for responding. An electronic copy of the questionnaire was sent to a number of participants who requested it and then responded electronically.

Telephone contacts were made with the questionnaire recipients who had not responded within the timeline. Some organisations were found to be willing to participate but without the time to complete the questionnaire. The project researchers therefore suggested a less time-consuming method of participation by e-mailing them the key questions about the survey. Where possible, general information on the use of, and views on ADR were obtained in these follow-up approaches, but a number of organisations indicated that they neither wanted to answer the questionnaire nor respond to the e-mail message.

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5.2 Research questions

The semi-structured interview and the questionnaire consisted of a number of open-ended questions based on the purposes of the project and recommendations from the literature review. They covered the following key areas:

1. Information about the organisation and the respondent/interviewee;
2. The formal procedure adopted by the organisation in dealing with complaints;
3. Perceptions of ADR in the organisation and the use of ADR in the existing processes of complaint management procedure adopted by the organisation;
4. Views on advantages and disadvantages, and risks and benefits arising from the use of ADR applicable to the organisation, the registered practitioner and the complainant;

5. ADR use and the effect it has/may have on the organisation's relationship with other health complaints bodies and professional associations;
6. Views on any need for legislative change to support the adoption of ADR, and the use of various ADR techniques that may have been used informally or may be used in the future by the organisation in the processes of complaints management, and
7. Final comments about ADR and the survey.

The semi-structured interview questions/questionnaire is attached at Appendix II.

5.3 Recruitment of participants

The semi-structured interview: A list of contact addresses was originally obtained from the Victorian Human Services Department, and extended through personal contacts. An initial contact was made through a letter inviting participation in the project, addressed to the President and Registrar of each organisation. Attached to the letter were project information sheets outlining: project objectives, method of participation and its voluntary nature, possible risks involved in participation, conduct and nature of the interview, and the manner in which project results would be disseminated to all respondents through a summarised, anonymous report.

The letter of invitation to participate in the project and the project information sheet appear at Appendices III and IV respectively.

As indicated in the letter of invitation, one of the project's researchers made follow-up contact with the potential respondents between one and two weeks after the letter of invitation was sent. This was to answer any questions they may have, confirm participation, and if possible, make an interview appointment. The appointments were made with the respondents at a time and venue suitable for them.

Thirteen organisations comprising 12 Victorian Health Registration Boards and the Office of Health Service Commissioner were involved in the semi-structured interviews. A total of 28 interviews were conducted, each with both interviewers present. Those interviewed included Presidents, Chief Executive Officers, Commissioner, Registrars, Managers and Legal Practitioner members of the participating organisations.

A list of Victorian respondents and interviewees is provided at Appendix V.

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The questionnaire: A list of contact addresses was originally obtained from the Victorian Human Services Department, and extended through the assistance provided by some of the organisations on the list, as well as by perusing their websites. A letter of invitation to participate in the project was addressed to the President and posted to 42 Health Registration Boards/Councils in Australia and New Zealand. Attached to the letter were project information sheets, a copy of the proposed questionnaire, and a self-addressed, stamped envelope for the return of the completed questionnaire.

The letter of invitation informed recipients that one of the project researchers would contact them by telephone as soon as possible to answer their queries, if any.

The 42 recipients of the questionnaire and the information package serviced 52 Health Registration Bodies, including 39 in Australia and 14 in New Zealand. Of these, seven responded by letter or e-mail stating that**,** as the ADR was not relevant to their organizations**,** they would not be participating in the project. Some provided brief information on ADR use and perspectives on ADR in their organisations.

In total, data were solicited from 20 respondents in Australia and New Zealand by means of questionnaire, e-mail messages and telephone calls. These comprised 12 who returned completed questionnaires[59], three out of 10 e-mail recipients who responded to the key questions, three who provided brief information by telephone and two who responded by letter.

A list of non-Victorian respondents from Australia and New Zealand is included at Appendix VI.

5.4 Data analysis

Data from interview transcripts, questionnaires, e-mail messages and telephone notes were analysed using thematic analysis, a qualitative research approach (Rice and Ezzy, 1999). It involved reading through the transcripts and coding or categorising data including phrases and descriptions and exchanges between the participants which appeared during the interviews that related to questions the project set out to investigate. Any one piece of data was often appropriate to more than one category; hence it was coded more than once. Patterns, themes and concepts were then identified and

[59] The response rate for the questionnaire survey is 28.6 per cent.

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explanations were made to broaden understanding of the topic under investigation.

The themes, patterns, categories, descriptive examples and quotations identified through the analysis became the basis for interpretation of the findings. Unexpected themes and patterns were taken into account, and were considered for their indications about the research questions.

5.5 Limitations

As the survey method is based on a qualitative methodology, it has a number of limitations. Qualitative research findings typically are limited to a specific time, place and situation (Patton, 1990). Generalisation cannot be made from findings of the interviews nor the questionnaire.

The open-ended questionnaire aimed at gaining subjective, in-depth responses and individual perspectives to a list of questions. The survey team was aware of the time required to answer the questionnaire and participants were advised that they had no obligation to respond to all the questions if they did not so wish. When the fieldwork began in late 2003 with the questionnaire being posted to respondents in December, some organizations were busy with end-of-year activities and unable to respond to the questionnaire by the timeline. Some only contributed information via follow-up telephone conversations or e-mail messages. Because of the questionnaire's low response rate and the fact that participants did not answer every question, the survey team decided not to make a comparative analysis of data across organizations.

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6 RESULTS

The presentation of the survey results is organised as follows:

1. Current complaints management processes in Australia and New Zealand;
2. ADR use in existing practice;
3. Views of registering bodies and health complaints bodies on ADR;
4. Types of complaints suitable and unsuitable for ADR;
5. Benefits and risks of ADR techniques;
6. Health Registration Bodies using ADR, and issues with the health complaints bodies;
7. Health Registration Bodies using ADR, and issues with the relevant professional organizations;
8. Views on legislative change necessary for the adoption of ADR for resolution of complaints about professional misconduct; and
9. Views on law recognition about specific issues

Where appropriate, findings from Victorian health registering bodies and those from other Australian and New Zealand organisations are distinguished in each topic. When it is more important to focus on patterns other than sources of data, results from all participants are presented together.

6.1 Current complaints management processes

This part outlines the complaints management process as it currently operates in Victoria. This information is a summary of descriptions provided by survey participants in response to a question about the complaint management process in operation in their boards. The processes and health regulation legislation for other States and New Zealand boards/ councils are outlined in the literature review.

6.1.1 The Victorian model

The legislation regulating health professionals in Victoria in the complaints arena has a number of common features that are summarised broadly below. For the purposes of this project these common features are referred to as the "Victorian model".

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- Boards provide assistance, via website, telephone and hard copy to complainants and potential complainants.
- A complaint about the conduct of a practitioner is received. Some boards require written non-anonymous complaints. Others have a view that all complaints, even if oral and anonymous, require attention. Such attention may be limited to a board considering further action inappropriate through lack of evidence.
- Discussions ensue with the OHSC about who should deal with the complaint.
- The matter is brought before the board for consideration of whether the complaint should undergo the process of formal investigation. This will be the case unless the board determines the complaint to be frivolous or vexatious, or unless the board of its own motion then determines that the complaint should be made subject to an informal or a formal hearing without the need for a formal investigation. The registration of a practitioner may be suspended at this stage.
- A report is presented to the board, which is then required to decide if the complaint is to referred for an informal or a formal hearing.
- Informal hearings are conducted without legal representation, allow the practitioner to attend and make submissions, are closed to the public, should proceed with the minimum of necessary formality and must apply the rules of natural justice. A panel may decide the matter should be dealt with by a formal hearing panel, may find that the practitioner has not engaged in unprofessional conduct or that the practitioner has engaged in unprofessional conduct not of a serious nature. The panel has the power to require a practitioner who has engaged in unprofessional conduct not of a serious nature to undergo counselling or further education or be cautioned or reprimanded.
- Formal hearings are conducted with the right to legal representation, allow the practitioner to attend and make submissions, are normally open to the public, should proceed with the minimum of necessary formality and must apply the rules of natural justice. A panel may find that the practitioner has not engaged in unprofessional conduct that the practitioner has engaged in unprofessional conduct not of a serious nature, or that the practitioner has engaged in unprofessional conduct of a serious nature. The panel has the power to require a practitioner who has engaged in unprofessional conduct of a serious nature to undergo counselling or further education, be cautioned or reprimanded, be fined, or have registration status affected by suspension, cancellation or the imposition of conditions.
- There is no provision in most legislation about the use of ADR, other than for liaison with the OHSC.
- The over-arching requirement is for the protection of the public.

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- Most boards do not have the power to recover costs from or award costs to a practitioner.

6.1.2 Variations in practice

There are variations in practice between the boards, and not all follow the Victorian model described above. These variations in part reflect the different structures and procedures the boards create to apply the legislation, and in part represent a search by some boards for an alternative way to resolve certain disputes. Some variations are:

- Different delegations for the purposes of the initial attention given to a complaint prior to first consideration by a board and for complaint management thereafter.
- An alternative to the professional conduct or practitioner health pathways, that alternative being the performance pathway (Medical Board) and the view that inappropriate conduct is not usually just a one-off mistake but reflective of an entrenched attitude or procedure.
- A vetting process to assess a complaint and the most appropriate pathway to adopt.
- The degree of contact with complainant and practitioner prior to first consideration by a board. Whether handled by correspondence or personal contact or both. At this stage some attention may be given to the possibility of resolution either by referral to the OHSC, or otherwise. Other resolution may involve discussions with each of the parties as a result of which the complaint, at least as far as the complainant is concerned, may be resolved. These resolutions may be reported to the board with a recommendation for no further action. Undertakings from practitioners and correspondence from a board to practitioners may ensue as a result of such resolution.
- Use of board staff, members and outside investigators or combinations thereof in the investigation process. Some even delegate the making of a decision to have a formal investigation.
- Different approaches to avoiding perceptions of bias in those on a hearing panel, through use of Complaints Committees, provision of information in a summary form, exclusion of those likely to be on a panel from relevant board considerations and division of board members into different groups.
- The use of pre-trial hearings or similar meetings between a board or hearing panel or delegate and the practitioner after a formal hearing has been requisitioned. These meetings are usually mainly for the purpose of clarifying issues for the later formal hearings but may also provide a forum for some discussion about the substance which may have the effect of shortening or even completely

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resolving a matter (subject always to the concurrence of the hearing panel).

- The application of therapeutic jurisprudence principles, to maximise the quality of the outcomes as far as future practice by the practitioner is concerned.
- Significant differences in the length of time between complaint and final determination (if proceeding to formal hearing), from a period measured in weeks to over a year.
- Differences in Boards' approaches to contact with complainants at various stages, and the extent of information provided to the complainants in each stage, for instance information about the complaints procedures, what can and can not be achieved by the process, the response from the practitioner to the complaint, information given after a decision to have, or not to have a formal investigation, a decision to have, or not to have an informal or a formal hearing, and outcome of a hearing.
- Differences due to the nature of the professions. Pharmacy and optometry deal with complaints in a retail environment, especially regarding allegations about rudeness which are hard to prove because of the "he says she says" syndrome. They have quick hearings, large numbers of members, and cheap fees. The Dental board deals with many complaints about over servicing. The Psychologists Board – complaints to it often deal with unregistered, deregistered practitioners, many complaints about sexual misconduct, many consumers blaming psychologists for decisions of courts before which the psychologist gave evidence, etc. Large board, high fees. The Nurses Board – largest board, cheapest fees, complaints often from employers, fastest hearings. Medical Board – large board, with several innovations. The podiatrists, physiotherapists and osteopaths are small professions with fewer complaints, hardly any formal hearings a year. Complaints about rudeness are hard to prove because of the "he says she says" syndrome.
- Some boards allowed use of techniques such as notices to admit and plea-bargaining to make the formal process shorter, and less complex.

Further explanation of differences between board approaches to hearings and the use of ADR are presented in the next section.

6.2 ADR use in existing practice

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The determination of whether a board has or has not used ADR depends on the survey participants' perceived definition of ADR. Definitions of ADR used in the project were provided to all participants prior to the interview appointment, or with the questionnaire.

Participants from several boards stated their boards had been utilising methods not provided for in the relevant legislation, but which according to this project's definition, could be classified as ADR. Other participants did not think that such practices were necessarily ADR, but were "just good management". Nevertheless, such techniques help these Boards reach resolution of a complaint at an early stage, and either avoid or simplify a hearing process.

6.2.1 Victorian boards

The following are examples of alternative techniques practised by some Boards that may be considered as ADR.

Chiropractors Registration Board

This Board attempts to resolve less serious matters at an early stage through techniques not provided in their Act. The Board has used communication via telephone calls, in writing or face-to-face meetings, as a method to resolve disputes such as those involving small amounts of money or minor misconduct. The use of this communication applies to disputes between a chiropractor and a health service consumer as well as between a chiropractor and the Board. For example, a meeting was held between the Board's subcommittee and a chiropractor considered to have breached advertising provisions in his newsletters. The meeting resulted in a situation satisfactory to the Board in which the chiropractor could still produce the newsletter and not breach the Act.

Chinese Medicine Registration Board

The Board uses a technique in the investigation stage, which can be considered to have ADR effects. In the course of a preliminary investigation into a complaint, an undertaking or a commitment from the practitioner against whom the complaint is made, might be obtained. In the undertaking, the practitioner might agree to identified deficiencies and be seen to have made changes or be willing to make changes to improve his or her conduct. As a result, the report might recommend no further action and if the report were accepted by the board there would be no need to have an informal hearing.

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Medical Practitioners Board

There have been occasions when the Board utilises some techniques akin to ADR. In a broad sense, they may be classified as ADR. The Board has utilised a vetting process, already formalised in the Act, to assist with the proper administration of complaint handling. Vetting processes enable the level of necessary resources for the management of the complaint to be identified. Complaints have been dealt with more effectively and timely, and hearings have become more efficient.

The vetting process includes interviews with the practitioner against whom the complaint is made, and other people such as expert specialists. In most cases the complainant is interviewed. Complaints in writing are evaluated. For each complaint, a supporting Board member, an investigating officer and a case manager will be specifically nominated. An investigation takes place quickly to clarify issues. The practitioner's comment is sought. His or her response is sent to the complainant for comment. The complaints committee considers the correspondence and makes a recommendation to the Board. Even when the complainant is satisfied with an apology, the Board still looks more broadly into the issue, in order to determine whether to proceed further in terms of professional conduct issues.

The legal member of the Board did not regard the above procedure as a form of ADR, but as being good management of investigative and decision-making processes.

Also, a resolution process of a mediated kind took place in one of the Board's formal hearings. The hearing was resolved through the hearing panel accepting the mediated outcome. The process was not clearly ADR and it was not clear whether the complainant was consulted. It was rather like a form of plea bargaining.

Podiatrists Registration Board

In the President's opinion, informal, alternative mechanisms for resolution have been used in the conduct of informal hearings. The practitioners involved in the complaints have been counselled in the course of the hearings. In such counselling the podiatrist would be advised to improve his or her specific areas of practice, asked to acknowledge the complainant's issues and to offer an apology. The podiatrist would be reassured that there was no permanent damage done to his or her career. In most cases the podiatrists were satisfied with the outcome.

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There was no ADR used during the preliminary investigative stage. Rather, the investigator used interpersonal skills to solicit information from all parties, which might or might not have satisfied the complainant. Resolution did not occur until the preliminary investigation report was presented to the Board with recommendations for decision.

Pharmacy Board

The Board has applied a practice not prescribed in its legislation that may be considered as ADR. It deals with minor complaints about unprofessional conduct such as those not involving patient harm nor public safety. An Inspectoral Committee is established to handle matters that other Boards would deal with in informal hearings, since the Pharmacy Board doesn't have an informal hearings process.

The Inspectoral Committee does not liaise or mediate but obtains information from both the pharmacist and the complainant. It inspects the pharmacy, meets with the pharmacist, and invites the pharmacist to attend a meeting to provide information about the complaint. Both before and after a consumer lodges a complaint, the Board's Registrar, who is also on the Committee, informs them of their options and possible processes. Often the issue is sorted out when the consumer complainant meets with the owner of the pharmacy, as suggested. The Inspectoral Committee reports its findings and recommendations to the Board. Most complaints are resolved because the consumer is happy and the pharmacist has made undertakings not to repeat the mistake. The Board then issues a warning letter to caution the pharmacist and decides that there will be no further action. The Inspectorial Committee does not have the power to impose any penalty. Its role is to help achieve a consensual outcome, if possible, without the need for the Board to refer the matter to a formal hearing.

During the formal hearing, the Pharmacy Board, through the counsel, forms an agreement about facts with the practitioner as well as submission on penalty. This practice helps speed up the formal hearing process.

Psychologists Registration Board

While it is not legally valid for the Board to act beyond its legislated authority, the Board has adopted a strategy of incorporating therapeutic jurisprudence in its interactions with parties involved in complaints, especially the psychologists. Consistent with the therapeutic jurisprudence principle, the Board counsels and educates the psychologists so that the issue of professional misconduct is acknowledged and the psychologists are assisted in improving their practice.

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When a psychologist is notified and asked to respond to a complaint, the Board attempts to enhance communication. During the preliminary investigation, the complainant and the psychologist may be interviewed. Information exchange takes place and the psychologist may review his/her own actions and become aware of inappropriate conduct. The psychologist may respond directly to the complainant. Some conclusion may be reached.

At the end of a preliminary investigation, if the Board decides that no further actions will be taken, the Board may write a letter to the practitioner to caution him or her of the unprofessional issues raised in the complaint. The Board may suggest that the psychologist make an apology to the complainant. If they decide to hold an informal or a formal hearing, the psychologist often responds to the hearing panel in a co-operative way, as a result of the enhanced communication and the Board's support. The manner in which the Board communicates and provides support to parties involved in a complaint is considered as incorporating an ADR process.

In dealing with consumer complainants, ADR, in the forms of mediation and conciliation, may not be appropriate, due to the nature of complaints the Board has received. Each year about half the complaints are made by consumers who sought psychological help because they had been frustrated by other courses of action, for example, a decision of the Family Court. Because the frustration has a negative impact on their consultation with the psychologists, these consumers may hesitate to have a face-to-face meeting with them.

Veterinary Practitioners Registration Board

Prior to 1997 when the new Act became effective, the Board used an informal interview process to deal with complaints at a low level of seriousness. This was a voluntary process and the Board reassured the veterinarian of their confidentiality, and that any information they gave would not be held against them in any formal hearing. This informal process was successful in resolving complaints of a low level of seriousness. In the process, the veterinarian was supported by the Board so that they were aware the problem and were able to fix it. The interview panel was comprised of two or three Board members. Sometimes undertakings were given that improvements to practice would be made. The complainant was not interviewed, but was fully informed of the process and outcome of the interview.

After informal hearings were introduced in the new Act, the Board has had more interactions with the complainant in the process. Complainants would be asked of their expectation from lodging a complaint. Before a decision is made about how to manage a complaint, the veterinarian is asked to respond

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to the complaint. The complainant is then invited to comment on the response, in order to clarify information. There is further communication with both parties if necessary.

The Office of the Health Services Commissioner

All health practitioner registration bodies in Victoria are required to refer all complaints to the OHSC. The OHSC then refers complaints about professional conduct back to the relevant Board. The OHSC deals with any remaining complaints. Approximately two-thirds of complaints are resolved after the complainants comment on the health practitioner's response to the complaints. The remainder of the complaints are dealt with through mediation or conciliation processes.

In mediation, the complainant is assisted by the OHSC to identify issues that remain unsolved, tender evidence required for resolving the issue, voice the expected outcome, or suggest possible ways of resolving the issue. A meeting with the practitioner may be suggested. The practitioner is also supported by the OHSC when addressing the concerns of the complainant. He or she is reassured that the information provided will not be used against them in any other legal process. Most complaints are resolved through such information exchange.

Only about 15% of all complaints proceed to formal conciliation. A conciliator is empowered to take whatever steps may be required to obtain additional evidence for both parties to consider. The two parties may have a series of meetings facilitated by the conciliator. This may include, if necessary, private conversations with each party. Usually lawyers are not involved in this process.

Confidentiality is maintained in both mediation and conciliation processes, that is, what is presented cannot be used later in a court setting.

Other Boards in Victoria

Not all Boards in Victoria apply ADR in dealing with complaints. However, some participants from Boards with a small number of hearings, such as the Optometrists Registration Board, felt that there was a degree of mediation in the investigative stage between the complaints committee and the practitioner. A legal member of two Boards accepted there were cases where ADR might have been appropriately utilised. Most Boards would welcome ADR use, whether or not it is mandatory.

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The Chinese Medicine Registration Board has articulated their commitment to early resolution of complaints. The Registrar is permitted to explore and use different venues to resolve some matters early in the process of clarifying with the complainant and the practitioner what the issues really are, prior to a complaint being first referred to the Board.

6.2.2 Other Australian (non-Victorian) and New Zealand Boards/Councils

The survey found that other Australian (non-Victorian) Boards have applied ADR methods in their complaint management processes. Most of these Boards/Councils do not have reference to ADR in their current legislation. By and large, ADR has been used in resolving matters between a Board and a practitioner rather than between a practitioner and a health service consumer.

New South Wales

The New South Wales Medical Board tries to use ADR in dealing with complaints of a relatively minor nature. This applies to disputes between the Board and a practitioner. Their Medical Practice Act provides for dealing with professional performance and impairment in non-disciplinary structures. Through its Impairment and Performance Assessment Procedures, the Board deals with less serious complaints by seeking the respondent doctor's comments, assessing these against the original complaint and finalising the matter based on this material.

The decision to use ADR methods is generally taken at the initial assessment point. Once a pathway has been embarked upon, a further decision has to be made by the Board if a different approach is to be adopted.

Australian Capital Territory

One ACT respondent, the Pharmacy Board, reported that ADR is not relevant to the Board's process after receipt of a complaint, and there is no ADR use by the Board.

Queensland

According to the respondents, there has been no ADR use by Queensland Medical Board and Pharmacists Boards.

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The Queensland Nursing Council has implemented ADR techniques since May 2000, in the forms of “without prejudice” meetings and submissions. This has been made possible through its revised Professional Standard Policy. The “without prejudice meeting” was introduced in the Policy to strengthen the non-adversarial approach to handling concerns about competence and professional misconduct. Evaluation of the “without prejudice meeting”, made two years after, revealed satisfactory results in that it:

- Avoids an adversarial approach which can be unpleasant for all parties involved;
- Improves efficiency which reflects favourably on Council, the nursing profession and public confidence;
- Provides Council with significant savings; and
- Facilitates the nurse’s early return to the workforce.

Northern Territory

The Medical Board and other health practitioner registration boards in the Northern Territory are currently in the process of adopting legislation to formalise the use of ADR. The new legislation allows the Boards to:

- Dismiss complaints that are frivolous, vexatious or without substance;
- Conduct a preliminary investigation into a complaint;
- Allow less serious complaints to be dealt with at Board level, with the outcomes being ; to caution or reprimand the practitioner; accept an undertaking; impose conditions on registration; or impose a fine; and
- Refer complaints to the Tribunal, the commissioner for Health and Community Services, or any other relevant body

More serious complaints are to be dealt with by the Tribunal.

The new legislation will allow the Board to deal with Impaired Practitioners in a supportive environment, as opposed to applying disciplinary measures, and also to conduct professional performance assessments of practitioners suspected of unsatisfactory professional performance.

A mechanism currently employed by the Boards is the use of voluntary undertakings, whereby the Board enters into an agreement for the practitioner to do a certain thing or abstain from doing a certain thing. This mechanism is entirely voluntary as the Board has no statutory power to compel the practitioner to enter into such an agreement. As long as the public is protected, it is a very successful mechanism for resolving a complaint.

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Western Australia

All Western Australia Boards participated in the survey, namely, Western Australia Pharmaceutical Council, Chiropractors, Psychologists and Nurses Boards, do not use ADR techniques in dealing with complaints. There are no other alternative mechanisms to deal with complaints within the Act.

South Australia

A respondent who serviced three bodies in South Australia - Chiropractors, Psychologists, and Occupational Therapists Boards, reported no ADR use. The Nurses Board of South Australia, however, is about to undertake a project to investigate mediation and conciliation as an alternative to disciplinary proceedings for competence issues relating to new nurse graduates.

Tasmania

A respondent from Tasmania, who is responsible for Chiropractors and Osteopaths, Pharmacy and Optometrists Boards, reported that these Boards do not practise ADR techniques, and that ADR is not necessary. The Boards do not deal with matters unless there is a professional conduct issue whereby judgement by peers is required.

The Nursing Board of Tasmania does not formally utilise ADR because there is no mechanism under the current Act to enable the Board to so proceed. The Board defers to the Tasmania's Office of the Health Complaints Commissioner when a matter arises where it is possible to utilise mediation or conciliation as part of the processes. The majority of complaints received and dealt with by the Board come from either an employer or a colleague rather than a patient.

The Nursing Board of Tasmania attempts to use a "without prejudice or by consent" approach to certain complaints received. ADR applies when a matter is referred to the Professional Review Tribunal, if it has been proved in another jurisdiction, for example, the court, that unprofessional conduct has taken place. The Professional Review Tribunal is independent of the Board. ADR would also be applied in the matter of an incapacitated nurse who may consent to voluntarily accepting restrictions on practice and / or engage in a rehabilitation process. After the formal process proceeds, the Board may still attempt to negotiate with the nurse and their representative to agree by consent to certain restrictions on practice, or for the nurse to comply with orders relating to further education, or mental / physical assessment, for example.

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New Zealand

There is no provision under the current Acts governing health registering bodies for ADR to be incorporated into the complaints and disciplinary process. However, the Health Practitioners Competence Assurance (HPCA) Act 2003 has been introduced and will be effective in September 2004. The HPCA 2003 does provide for settlement of complaints by conciliation. It applies to 20 registered health professions including medicine, nursing and physiotherapy.

Under the HPCA 2003, upon receiving a complaint, authorities must promptly forward the complaint to the Health and Disability Commissioner (HDC). The HDC may refer the complaint to the relevant authority if it appears that the competence of a health practitioner or appropriateness of his or her conduct may be in doubt.

When the HDC refers a complaint to the authority, the authority must promptly assess the complaint and consider the action that it should take to respond to the complaint. It may decide to refer the complaint to a Professional Conduct Committee (PCC) consisting of two health practitioners registered with the authority and one layperson.

Section 80 of the HPCA provides that conciliation may be one of the three determinations that a PCC may make upon a completion of its investigation.

These three determinations are:

- That no further steps be taken;
- That a charge be brought against the health practitioner before the Health Practitioners Disciplinary Tribunal
- In the case of a complaint, that the complaint be submitted to conciliation

If a PCC decides to submit a complaint to conciliation, it must appoint an independent conciliator to assist the health practitioner and complainant concerned to resolve the complaint by agreement. The conciliator must, within a reasonable period of time, provide the PCC and the responsible authority with a written report as to whether or not the complaint has been successfully resolved by agreement.

6.3 Views of registering bodies and health complaints bodies on ADR

Definitions of ADR were provided to all participants in the project information available prior to the interview appointment, or with the questionnaire.

ADR can have different meanings for different authorities and people. Complaints or disputes can be between a practitioner and a health service consumer or a complainant; or between a Board and a practitioner. Most participants seemed more familiar with ADR use in the former than the latter. The purpose of the question is to explore whether some of the processes that the Board may not view as ADR, but can be classified as ADR, have existed in the practices of the Board. The following perspectives are derived from the study carried out.

6.3.1 Victorian Boards

ADR is useful for Boards

The participants have various perspectives about ADR. The view held by most participants is that ADR is a good alternative to the current complaints management procedure. The current procedure, especially when the formal, disciplinary process begins, is seen by many as complex, expensive and intimidating to both the complainant and the practitioner against whom the complaint is made. ADR is also described as flexible. It is particularly useful for disputes over money. It is an intermediate step in the complaint process against a health practitioner where the complainant can be satisfied by a means other than simply instituting disciplinary proceedings. Some of these participants stated that ADR ensures a Board's complaints handling processes go faster**.** It would also remove the requirements for the Board to have so many formal, and perhaps informal, hearings.

A number of Boards reported that the majority of complaints they received were about minor matters that were clearly not professional misconduct, and that the complainant would only want the practitioner to admit his/her mistake and apologise. They thought that these matters could be resolved during the investigation procedure by using ADR, for example, and having all parties involved in a meeting with a mediator.

A Board's President stated that ADR is simply necessary because:

> *People are different and support different ideas. Most problems are people problems, so in order to tackle different kinds of people problems,*

it is good to have a range of different tools, provided that those tools are understood and can be applied consistently and fairly and transparently.

ADR is therefore desirable and Boards should be able to utilise it in their handling of complaints. With ADR as an option for choice from a bigger menu, Boards can make better choices and get things resolved more effectively and quicker.

ADR as an opportunity for complainants

ADR is also described as an opportunity for complainants to express themselves effectively. A Board's legal member said that complainants often did not understand the formal process, the evidence they gave in the hearings was not always believed, and they have not had any opportunity to really express what they wanted to say.

This aspect of ADR is a support mechanism for complainants. Complainants should be offered choices such as: going through a Board's disciplinary processes; having mediation; or joining conciliation meetings. The President of a Board which has been using ADR said:

Any human being who comes to a Board with a set of concerns does so because they are upset, and it's not a good thing if they end up feeling worse at the end of the process. We like to use all sorts of things to try to help the complainant feel satisfied with the process, have their concerns addressed, feel that there is some constructive outcome from making a complaint, perhaps receiving an apology. All these things may come under definitions of ADR.

ADR as common sense

A few participants perceived ADR as employing techniques that have already been used in some Boards. ADR is common sense used by a Board's personnel in communicating with all parties. Based on this view, it is not necessary to mandate ADR as a mechanism because it can be applied naturally within the existing regulation. One participant said:

It's about common sense. It's about a Board's communication with complainants and with practitioners. It's about good communication skills and handling things well.… Boards can do it if they want to.

Participants who held the perspective that ADR is about communication skills, and the Boards that have already used ADR successfully, supported the current system of complaints handling. In this system, which is working well, complaints suitable for mediation and conciliation are referred to the health

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complaints body, and complaints about professional conduct are dealt with by the registration bodies. To introduce ADR in the Boards' processes would duplicate the procedures of the health complaint body.

ADR is beyond Boards' role

A small number of Boards reported that, although they are aware of ADR's effectiveness, they were prevented from utilising ADR. The current legislation, which governs all health practitioner registration boards in Victoria, makes no reference to ADR. These Boards felt that their role was to protect the public through the prescriptive power of the legislation and did not want to act beyond it.

One participant explained that a Board's role is to investigate professional conduct and to determine whether there is evidence of unprofessional conduct. If the latter has occurred then it must be dealt with. This procedure does not involve any sense of a dispute. And whether the complainant is satisfied with the process or not, is not the key issue. The key issue is whether the practitioner has engaged in unprofessional conduct, and whether there is a risk to public.

A Board's legal member said that the Board's role would be fundamentally misconceived if ADR principles were imported into the Board's processes for complaints handling. The Boards are constituted as inquisitorial bodies operating for the public interest. If there is unprofessional conduct, it is the statutory obligation of the Board to proceed through the formal processes to reach a finding, whether the complainant and the practitioner are satisfied or not. ADR is not relevant for a Board that receives a large number of complaints, many of which would be about minor matters. In principle, it is not the Boards' role to do ADR. Nevertheless, ADR is applicable to minor matters, where the practitioner shows sufficient remorse which indicates it unlikely that he/she will repeat the mistake, and that the complainant is happy with receiving an apology.

6.3.2 Other Australian (non-Victorian) and New Zealand Boards/Councils

The Boards and Councils which expressed their views on ADR had a similar opinion to that of Victorian participants. They stated that ADR is a useful alternative, having enough flexibility to resolve disputes in other ways outside of complex, expensive and intimidating legal processes. A Western Australian participant responded:

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There should be an intermediate step in a complaints process whereby the complainant can be satisfied by a means other than simply instituting disciplinary proceedings against the health practitioner.

6.4 Types of complaints suitable and unsuitable for ADR

Respondents from Victorian as well as non-Victorian Australian and New Zealand Boards and Councils, shared common views about the types of complaints suitable or unsuitable for ADR. This study was interested in complaints, whether or not involving professional standards, that should not be handled by the health complaints bodies, and which would be appropriate for ADR use. Characterisation and examples of complaints provided by the participants referred to matters between a complainant and a practitioner as well as between a Board and a practitioner.

6.4.1 Complaints suitable for ADR

Participants considered that an ADR approach would be useful for dealing with complaints that:

- Involve breakdown in communication, rudeness, or a clash of personality between a client or a patient and a practitioner, or where there are different perceptions of information. These cases constitute the vast majority of complaints received by many Boards, and according to most participants, are best resolved through ADR techniques.
- Involve minor unprofessional conduct but do not warrant an inquiry, disciplinary actions or formal investigation. A Queensland Council which has been using ADR referred to matters about the practitioner's competence, minor conduct and some health issues as appropriate for ADR techniques.
- The prescribed outcome that the Board is seeking is rehabilitation, professional development, education, support and supervision in the workplace, and that the practitioner agrees to the outcome.
- Could be resolved with an apology, even if the complaint appears to have sexual connotation to it. An example includes a complaint where a patient was told to undress in front of a practitioner and he or she was not given a gown to wear. The investigation found that the practitioner was not aware of the embarrassment he caused the patient. Such a complaint does not need to be dealt with in a hearing.
- The complainant feels aggrieved because their story is not heard, or where there is a need to bring all parties together to benefit from mediation. A Victorian Board's legal member cited an example whereby a consumer, relative or the patient made a complaint, and there was a

feeling that some resolution or a sounding board was needed to enable them to tell their stories.

- Concern inappropriate working environment, for example, a patient lodged a written complaint that the state of the room at the practitioner's surgery was not clean.
- Involve minor confidential matters, for example, disclosure of patient's record.
- Are about overcharging or over servicing and are not involving Medicare.
- Are about management issues such as poor record keeping, and contractual arrangements between practitioners.

6.4.2 Complaints unsuitable for ADR

Survey participants were of the view that ADR should not be applied to complaints:

- Involving gross professional misconduct.
- The outcome of which may be expected to result in the de-registration of the practitioner.
- About sexual misconduct, boundary violation, predatory behaviours and when there is power manipulation for sexual gratification.
- About clinical incompetence or potential clinical incompetence.
- Concerning the health of the professionals.
- Involving public safety, even though the consumer is satisfied with the practice and does not want to notify the board or proceed further with a complaint.
- About breach of legislation, potentially illegal conduct or fraud.
- Where the complainant does not want to face the practitioner again and wants him or her to be dealt with by the board.
- Where conciliation is impossible because the practitioner is recalcitrant, or the complainant is not satisfied unless the complaint is dealt with legally by the Board.
- Where the practitioner is a frequent offender, or has frequently been the subject of complaints.

6.4.3 Difficult matters

A few participants pointed to complaints about which it would be difficult to decide whether to use ADR techniques or to conduct a formal investigation. These complaints would normally go through the formal processes, however

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an ADR approach would benefit everybody involved. These complaints might be:

- Complaints that have gone through the board's formal processes and the complainant is not satisfied with the outcome, eg, complaints about work and fees. In a hearing the practitioner has been found guilty of poor professional standard and punished, but the complainant who has paid a lot of money for the poor work is not recompensed, and is left unsatisfied.
- Complaints about serious professional misconduct, such as those involving death, or where relatives of the patient are suffering and the practitioner is clearly remorseful and going to concede. Such complaints could be dealt with expediently or more informally through an ADR approach.

Some members of Victorian health registering authorities said that categorising the complaints does not make it easy for an early decision to be made by Boards about the use of ADR in any particular case, and a rigid division between complaints to be or not to be dealt with using ADR principles should not be formalised in legislation. A complaint about a minor offence might have serious implications for community safety, whereas a complaint involving allegations of sexual transgression might result from a lack of communication rather than of professional misconduct. Each board should therefore be enabled to gather an appropriate amount of information about an individual complaint before deciding whether it is appropriate to use ADR.

In the practice of the Office of Health Service Commissioner, a complainant is asked about what they want to achieve by lodging a complaint, and to justify how and by whom the complaint should be adjudicated. The ADR approach is most effective when complainants are genuinely aggrieved and they want to know what went wrong. They would be satisfied when a service provider explained, apologised and put a strategy in place to protect other patients from the same problem.

6.5 Outcome of ADR techniques

All participants thought that there are both benefits and risks for Boards utilising ADR, whether or not they have already done so in their organisation. It should be noted that those who have used ADR usually referred to it in the context of a dispute between a complainant and registered practitioner, rather than between a Board and a practitioner. In general, they felt that ADR is an approach that can benefit the complainants as well as the practitioners.

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6.5.1 Benefits

The Victorian respondents provided the following views on the specific benefits of ADR techniques for Boards, practitioners and complainants. Many of these views are shared by Non-Victorian Australian and New Zealand Boards/Councils.

Improves efficiency

The strongest impression about ADR beneficial outcome is that it is a time and cost effective method. All participants felt that the formal procedure of complaints resolution, especially the formal hearings, is expensive and time-consuming for the Board as well as the practitioner involved. At present, Board's expenses in hearings are met by Boards through registration fees contributed by registered practitioners. Members of some Victoria Boards have already expressed a view that the funding of hearings in this way is unfair to registrants who conduct their profession in the correct manner. ADR can resolve a complaint at an early stage. It saves time and money for Boards through fewer matters being recommended for hearings. The practitioner against whom the complaint is made can save expenses on legal arrangements and, where appropriate, can return to the workforce earlier. The improved efficiency which results is favourable to Boards, the registered professionals and public confidence. A participant from the Northern Territory commented:

> *The use of ADR is vital if complaints are to be managed effectively and in a timely manner, and to ensure the appropriate amount of resources are allocated to each complaint.*

Enhances communication

ADR techniques, such as mediation and conciliation, provide good outcome for communication among all parties involved, because people are brought closer to each other than they are in formal processes. ADR environment is more closed, controlled and made for open dialogue, while a formal or informal hearing is legalistic, and the exchange of information is limited to strict question and answer, and cross examination.

Some participants believed that good communication achieved through mediation would be a good learning experience which could only enhance a practitioner's communication skills. One registrar said:

> *A practitioner could say, I'm sorry for doing this, in a way that he wasn't going to get a legal suit against him and I think the complainant would be quite happy…. I'm sorry I didn't sit down and explain every thing to you and I'm sorry that you've gone through all this stress. They go off feeling*

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they have got closure and it would probably be a very good lesson for the practitioner.

One Registrar of a Victorian Board held the interesting view that Boards protect the public more effectively in an ADR environment. The legislation states clearly that a Board's role is not to punish the practitioner, but to protect the public. A penalty imposed as a result of the formal process does not guarantee that the practitioner will not be involved in another form of professional misconduct, whereas in mediation, through effective communication, the practitioner clearly gets the message and is not likely to commit unprofessional conduct again.

However, a few participants held the opposite view, stating that a hearing is still the best way for Boards to protect the public. Recommendations from a hearing, such as the practitioner undertaking educational or counselling programs, provide more reassurance that the person will not re-commit the offence.

Empowering and satisfying consumers

The involvement of consumers is limited in Boards' complaints management process. In the normal practice among Victorian Boards, complainants are given information after a decision is made for a formal investigation, or not to have a formal investigation, or when a decision is made to have an informal or a formal hearing, or not to have an informal and informal hearing, and the Board's findings from a hearing. There have been a view that some complainants are unhappy with their limited status as witnesses in complaints proceedings which are regarded by boards as being "between" Boards and practitioners. Consumer complainants cannot appeal if they are not happy with a Board's decision. Some participants said that complainants are in a powerless situation because they are not legally represented and not involved in the process. Rather, they become witnesses, providing evidence to the hearing panel. In ADR processes, complainants are listened to and their concerns properly addressed.

A New Zealand Council also reported that under their current legislation, complainants are often left unsatisfied. This is because a complaint may result in the matter not being investigated, the practitioner being found not guilty, or if there is a hearing, the Council's decision is not perceived as being sufficient. Use of ADR may bring closure to the matter, better satisfying health service consumers.

A better method of addressing competence issues

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Some of the non-Victorian Boards in Australia which have been applying ADR techniques in disputes between the Board and a practitioner found that ADR is a better method of addressing competence issues as it is less punitive. ADR offers expediency and confidentiality.

Avoiding trauma in the formal procedures

Applying ADR techniques helps Boards to avoid the adversarial approach in the existing system. Participants in Victoria and other states shared the common view on the experience of hearings, whether formal or informal, that it is an unpleasant experience that can be traumatic for both practitioners and complainants. It can also be a frustrating process for Boards, because it is believed that a small proportion of lawyers may abuse the process and prolong formal hearings through either incompetence or in pursuit of their own pecuniary interest.

Two members of a Victorian Board empathised with complainants who had experienced a formal hearing:

> *People who make a complaint particularly about a serious issue and follow it through to the end of the processes are worthy of admiration, … and worthy of public respect because only by their being prepared to follow the processes through to the end does the public benefit from the system.*
>
> *Very, very nasty experience – about details often of your private and personal life.*
>
> *Or in a technical treatment details of a matter that may have happened two or three years ago.*

6.5.2 Risks

According to the Victorian, non-Victorian and New Zealand participants, the following are perceived risks associated with the use of ADR by health practitioner registering authorities.

Professional standard issues

A Queensland Board has made an evaluation of their utilising 'without prejudice meetings', regarded as an ADR technique, to deal with matters between the Board and the practitioner. It was found that using the 'without prejudice meeting' could increase the risk of the practitioner not gaining insight into, or overcoming the professional standard problem of, the complaint being made. Further, the practitioner may or may not comply with recommendations resulting from the ADR meeting.

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Decreases public confidence in Boards

If a Board deals with a complainant and a health practitioner using an ADR technique, it could risk losing the public's trust and confidence. Boards are self-regulated and dominated by the professional groups and most of the Boards' Presidents are professionals. Every Board is funded through registration fees. There is the possibility of a Board of being biased and taking sides when mediating a case between a practitioner and a consumer, or the public could perceive the Board as protecting the interests of its registrants. Consumers can thereby lose trust and confidence in the Board. They may not perceive any penalty imposed on the practitioner as sufficient. Seen in reverse the Board may take a consumer's side, so the practitioners can lose trust and confidence in the Board.

Further, as a Victorian Board's President puts it, there is a potential risk of corruption in the use of ADR. A Board may try to reach an agreement by suggesting some financial compensation which could be seen as an attempt to buy off the complainant.

Dissatisfied complainants

ADR techniques may not provide satisfactory results to a small number of complainants who would rather have the practitioner punished by the system than an apology. A number of participants in Victoria and other states shared this view. A New South Wales Board stated that, on applying ADR techniques, complainants may not accept that their complaint does not reach the threshold of seriousness that requires a formal investigation. This could possibly lead to ongoing consumer dissatisfaction.

Confrontational nature

Although mediation and conciliation involves two-way communication between the complainant and the practitioner, one Registrar felt that the situation may be confrontational, especially for the complainant. Many patients are unassertive, and once they had managed to lodge a complaint, they did not want to face the practitioner they had complained about any more. ADR processes may not be useful in these cases.

What if ADR techniques are not successful

Some participants in Victoria were concerned about the consequences of unsuccessful ADR use in some complaints. One was concerned that,

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because Boards' members are not equipped with counselling skills, they may not be able to handle mediation or conciliation properly. As a result, it would be more time-consuming and more costly to use ADR than to deal with a complaint in the accepted manner.

A New South Wales Board commented that if ADR processes do not reach a satisfactory conclusion, then there may be allegations of conflict if the matter has to proceed to an inquiry, equivalent to a hearing in Victoria. Further, there is a risk of the evidence already presented in an ADR meeting being used later against the registered practitioner.

6.5.3 Concerns about ADR use

Along with benefits and risks involved in using ADR techniques, Victorian, non-Victorian and New Zealand authorities have some concerns if they had legitimate power to use ADR.

Mechanical side of ADR

Many participants raised concerns about mandatory use of ADR. Survey participants suggested that if legislation gives an authority discretion in this regard, it is important that:

- The process is fair and transparent;
- The ADR options can be applied consistently;
- ADR occurs as soon as possible after the event that has led to a complaint being made;
- Confidentiality during the mediation processes be maintained;
- There is a mechanism for reporting back to the Board after ADR;
- There is sophisticated criteria for justifying when to use ADR and so prevent its overuse;
- When the result of ADR techniques is unsatisfactory, a pathway to the future should be provided, and
- It should be reviewed on a regular basis.

Informing all parties

Members of several Boards agreed that if ADR is to be introduced to Boards' complaint handling processes, all parties involved should be well informed of the ADR process and expected outcome. These include Boards' legal and non-legal members, practitioners and members of the public. Some participants were particularly concerned about practitioners' knowledge and

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feelings about ADR. Some education programs for practitioners about ADR would inform the practitioners and make them feel comfortable with it.

ADR for dissatisfied complainants

Where a matter had been resolved, but the complainant is clearly dissatisfied and has gone to anybody they can think of for help, it could be worth having a mediator involved in a final discussion between the complainant, the Board and the practitioner. Office of the Health Service Commissioner's staff recommended that if the person is still dissatisfied with the outcome, perhaps within their own setting, a meeting should be set up in order to resolve any outstanding issue.

Who performs ADR for Boards?

A difficulty for some Boards in using ADR concerns the person who will potentially be responsible for ADR at Board level. For example, in the Medical Board of Victoria, the person who communicates with the complainant and the practitioner for the purpose of achieving an early resolution, is a person who is not a Board member. Although the Board will make the final decision, there is a concern about how appropriate it is for preliminary decisions to be made by such a person before presentation to the Board.

Conflict of interest

There is a conflict of interest between an ADR approach and the board's investigation of conduct. Boards, whether holding a conciliatory position or not, should not compromise their obligation to investigate under the Act. For instance, there are cases in which ADR may be used to resolve a conflict between a consumer and a practitioner with the consumer complainant being satisfied and not wanting to take the matter further. However, if the matter involves professional standards, Boards must still interfere, taking the matter through the formal process.

If this is the case, the practitioner might not be aware that Boards still have to deal with the matter after ADR. Another concern was that the complainant might not want to come to the hearing and give evidence because they have been satisfied with the result of their complaint.

6.6 Health Registration Bodies using ADR and issues with the health complaints body

Survey participants were asked whether the working relationship between the Board and the OHSC, or equivalent, would be affected if health practitioner regulating bodies were given power to utilise ADR. A related question for survey participants was who should be responsible for ADR if the scope of ADR was expanded.

6.6.1 Victorian Participants

In Victoria, the Office of Health Service Commissioner, as an independent body, has been taking care of health complaints using major ADR techniques: mediation and conciliation. When a complaint is received, either by a board or the Office, registrars of both organizations will inform each other of the complaint and decide who should be dealing with such a complaint.

Issues with the health complaints body: Views from Boards

All participants reported that their working relationship with staff members of the HSC has been good. Some believed that the relationship between HSC and Boards would be affected if ADR is to be operated Boards as well as by HSC. Some were concerned that the HSC might see Boards using ADR as an intrusion into their area of expertise. Some thought that the HSC might not support Boards using ADR because it could confuse Board and HSC roles. Others said that the HSC is the most effective body for dealing with health complaints using ADR, because it is independent and it has the legitimate power to use it. The President of a small board said:

> *If you start to do that (introduce ADR use to boards) you then have to give boards greater power. For instance the Health Service Commissioner has significant power in terms of ordering clinicians or defendants to restitute money. … I know that they have more power than the boards do. So that's one of the reasons we use them.*

Some participants did not think that the relationship between Boards and HSC would be affected by Boards having power to apply ADR techniques. There is the possibility of both bodies working together effectively. A legal member of a large Board said:

> *If there is not a defined breakdown about what her role is and what our role is, and the Act says, well in certain circumstances the two offices should implement or can implement if they want to. Make it discretionary then it leaves us the ability to talk to her office and say, what about in this situation? You have got a complaint, you have sent it to us, it is clearly a*

cross over. How about we try and mediate, get the parties to work together on this one?

A member of one Board said that the current system is quite effective in terms of working with the Health Service Commissioner. The nature of complaints received by the Board requires HSC involvement more than those received by other Boards.

We have often written back to the Health Service Commissioner saying we can't resolve this problem, if you want it there it is. … It's so different that you never work out who is right who is wrong, especially in an open retail area where people are yelling at one another. It's very different in a private consulting situation, but where you've got customers in open areas and he says, she says, it could be anything.

Issues with the health complaint body: Views from the Office of Health Service Commissioner

The Health Service Commissioner felt that it was important that Boards have some power of mediation as ADR is a good process. Her concern was that the Boards' roles in doing ADR might duplicate those of her Office. Victoria has already had a good model, good legislation with good co-operation among health registering bodies and health complaints bodies. An advantage in having the OHSC perform mediation is that the public perceives it is an independent body. The Health Service Commissioner felt that the current system works well and she was concerned that if a Board was to formally apply ADR such a perception would be undermined.

… I'm absolutely all for ADR, but whether it is appropriate at the Board. … The Board is co-regulation at the moment. It's still quite a large degree of self regulation because they tend to be dominated by the professional groups and the presidents are a professional…..

First of all registered practitioners have the privilege of doing things that other people don't …. With that privilege comes a whole bunch of responsibilities which is that you have to put the public interest above the interest of any individual practitioner. The perception that the Board is unbiased and doing that work is really important.

In the Commissioner's view, the focus of improvement should be on the system rather than on ADR alone. The Commissioner was concerned that if ADR was formalised as a part of a Board's function it would become too technical and legalistic. The Commissioner viewed ADR as a distinct and separate process to that undertaken by the Boards.

If changes were made, who would perform ADR? - Boards' views

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If ADR is to be introduced to Victoria health registering authorities, there are two possibilities of how the change can be made: either Boards increase their capacity to operate ADR internally or a wider range of complaints are made capable of referral to the OHSC or another independent body.

Referrals to the OHSC

Most participants, including those from large Boards, said that if they had the power they would refer more matters to the OHSC, for the following reasons:

- The OHSC have already has ADR expertise while Boards would have to develop it.
- The OHSC has government funding support, whereas Boards will have to use their registration fee-income to fund ADR facilities.
- The OHSC has settled staff members who are ADR professionals, while Boards frequently recruit new members who are not likely to have mediation skills, from the health professions.

One participant suggested that perhaps Boards could apply ADR if their structure is changed. For example, if on the Board there are consumers, lawyers and a chosen person with mediation skills, an ADR panel might be formed. However, the OHSC has been and will still be the best authority for doing ADR.

> *As the Board is currently structured, definitely not, I don't believe that a complainant would see any fairness or equity in facing a panel of (health professionals) to complain.*

Teamwork approach

Two participants suggested that Boards and the OHSC work in combination to resolve matters at an early stage, because many matters are capable of being dealt with by both bodies. The president of a Board thought that to refer matters back and forth between the organizations could require lengthy administrative procedure and be affected by differences in management. A teamwork approach would be desirable as it has greater continuity than the two bodies working in isolation.

Bring OHSC facilities to Boards

A participant said that if complaints get referred from one jurisdiction to another, complainants might be unhappy with this process. One suggestion is that boards may call in a trained conciliator from HSC to run the process of

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conciliation within the board. This could be a service that HSC provides through government's funding.

Some participants were more concerned about the range of complaints capable of referral for ADR rather than the issue of which organisation should handle ADR. Some matters of unprofessional conduct, although at a low level of culpability, may have serious implications on the public. These complaints might be considered suitable for conciliation but may require disciplinary sanction, and therefore should be dealt with by a Board's formal procedures.

If changes were made, who would perform ADR? - The Office of Health Service Commissioner's views

If Boards have power to refer more complaints to the HSC for mediation, and if the Boards would like to do so, HSC staff members said that their office would have the facility and be ready to cope with the task. Under the existing system, Boards could refer a complaint to HSC at any stage of the procedures, even after a hearing. However, it will be more helpful if Boards communicated more information about the complaint with the Office, especially when referring a matter some time after the complaint was first received.

The OHSC personnel felt that it would be useful if Boards have their own ADR processes to deal with some complaints about which Boards are unsure as to whether there had been unprofessional conduct. This could be done now without a referral, thus avoiding duplication with OHSC's tasks.

> *They haven't got a finding of unprofessional conduct but they do have some concerns and they would like to bring the parties together just to talk through those (issues), that would be great. If they want to send it to us we need to know, but that's time consuming and it's another bureaucratic process.*

6.6.2 Other Australian (non-Victorian) and New Zealand Boards and Councils

Other states in Australia, except South Australia, have similar bodies liaising with health practitioner regulating authorities and manage a range of complaints. They include the Health Complaints Commissioner in ACT, the Health Care Complaints Commission in New South Wales, the Health Rights Commissioner in Queensland, the Office of Health Review in Western Australia, the Health Complaints Commissioner in Tasmania and the Health and Community Services Complaints Commission in the Northern Territory.

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In New Zealand, health practitioner regulating authorities refer all complaints to the Health and Disability Commissioner for investigation.

Ten participants provided brief comments on their existing relationship with the health complaints bodies, but did not described how the relationship would be effected by the Board/Council's use of ADR. In general, they reported to have had a good working relationship with the respective health complaints authority, and that the authority has provided good service to the Board. Nevertheless, some respondents pointed out to existing and potential problems in the relationship. A member of a large Australian Board stated the relationship was complex and always subject to tension. Another Australian Board member said that time delay could result when the two parties *are* working together. A New Zealand participant was concerned about the low level of resources provided to the health complaint body:

> *Unless the HDC is adequately resourced, the potential exists in the face of mounting number of complaints for his office to refer increasing number of complaints to registration authorities.*

Preparation for change has already taken place in Tasmania to adopt a teamwork approach. The survey participant said:

> *In the most recent review of the Act, the recommendation has been made for the two bodies to be able to formally enter into joint investigations and handling of the matters.*

6.7 Health Registration Bodies using ADR, and issues with the relevant professional organizations

There is a clear distinction between the roles of a professional association and a health registering body. A professional association usually exists for the benefit of its members and the profession. A health registering body exists for the benefit of the public through registering and de-registering health professionals and in performing other regulatory functions. Members of a professional association may feel under scrutiny by a board, so there could be a conflict of interest between the two bodies. Despite that, all the participants interviewed stated that their Boards have had good working relationship with the relevant professional associations.

6.7.1 Victorian participants

A number of health professional associations in Victoria receive complaints from the public and have complaints resolution mechanisms, for example, a peer review committee. Some investigated complaints as required by their

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codes of ethics. Some used ADR techniques such as mediation and conciliation to bring about resolution to a complaint. The associations could refer complaints to the Board, or the Office of Health Service Commissioner if they wished. Most participants believed that the associations always referred complaints about professional standards to the Boards, and that this was an appropriate practice.

One participant from a small Board was concerned that the relevant professional association might receive a larger number of complaints than the Board, because the association appears to be more open and accessible to the public than the Board. Complaints that deserved disciplinary sanction would be resolved by the associations instead of being dealt with by the Board, as they should be. Another participant was concerned that, because some professional associations are closely linked to professional indemnity insurers, the resolution of some complaints might have been through an offering of financial compensation to the complainant to withdraw the complaint.

While most health registering authorities accepted ADR being conducted by the professional associations, the Health Service Commissioner did not support the practice and would rather have complaints capable of ADR referred to the Office. Potential problems are that the associations do not have statutory power to resolve complaints through ADR and they could be subject to litigation and could be sued.

All the participants, including members of the OHSC, believed that if health registering authorities are to have power to apply ADR through their legislation, there would not be any effect on their relationship with the professional associations, and that the professional associations would support the change. Members of various Boards held a view in common that ADR would be to the advantage of the professional associations. They said:

> *If they are looking after their members' interest, if they can diffuse a circumstance so it doesn't go as a formal complaint to the Board, then they can feel they are doing the right thing.*
>
> *They would also welcome it if they actually think there is something that can take hard things off of their own books. … For the association, people have professional relationships, people have friendships, count on each other's votes when they have the AGM. … So it's actually very difficult for them to police each other. … If Boards take on more and more of the professional ethic side of things, that could potentially be helpful.*

6.7.2 Other Australian (non-Victorian) and New Zealand participants

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Only six participants responded to the question about the relationship with the health professional associations, if the health practitioner registering authority is going to engage in ADR. All stated that there would be no effect on the relationship. A Queensland Council said that the professional association, in this case a union, has represented the practitioners against whom a complaint has been made. Having used some ADR techniques, the Council reported that their link with the union remained good.

As in Victoria, some professional associations in other states and in New Zealand have their complaints handling mechanism. A New South Wales Board commented that the professional association's complaints management tended to focus on their members and might tend to be unreasonably supportive to their members. A New Zealand Council shared a concern with some Victorian respondents that some complaints ought to be dealt with by the Council in stead of the professional association.

> *This (the Association's complaints management) is ADR rather than disciplinary system. However the Council does have some concerns about instances where serious issues of public safety have arisen and would like the Association to refer such cases towards the Council.*

6.8 Views on legislative change for the adoption of ADR

Victorian participants expressed mixed views on the need for legislative change to formalise ADR use in resolving complaints about professional misconduct. Participants from smaller Boards, or Boards which have not practised many ADR techniques, are more likely to support the legislative change than those from larger Boards, or from Boards which have used ADR techniques frequently. Presidents and Registrars of some Boards held a neutral view and expressed some concerns if there was legislative change.

Thirteen participants from other states and territory and in New Zealand commented on this issue. Almost all supported that there should be an ADR approach provided by the legislation to the resolution of complaints about professional conduct. Their views are incorporated below.

6.8.1 Reasons for supporting legislative change

The participants who thought that change should be made to current legislation to allow Boards to utilise ADR based their views on the following reasons:

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Providing appropriate mechanism and guidelines to Board's practice

If Boards are going to use ADR techniques, there needs to be an appropriate mechanism provided in the legislation. So Boards can determine what ADR is, and how it will be conducted. A legal member of one Victoria Board's view is that without clear guidelines, Boards may operate ADR differently; this could be dangerous.

Current ADR capacities should be better recognised

Although some Boards exercise discretion and use ADR techniques in resolving complaints, some participants felt that this capacity to use ADR should be better recognised, so that people are compelled to adopt it. The Board's legal position will be clear and parties involved in a complaint will comply with the process. To make the most effective use of ADR, one participant suggested that it should be formalised in their individual health registration Act.

> *Just to formalise our ADR process a little bit more, that would be best done legislatively.*

A participant responsible for all the Northern Territory Boards, which are about to adopt ADR techniques, stated that the legislative change will assist the Board to deal with complaints more effectively.

Justification to educate health professions on the public

As ADR techniques become widely used by health registering authorities, the health professionals will need to have sound knowledge of the techniques and their impact on the public. An additional benefit of legislative amendment to adopt ADR is that it will make more certain an ADR education campaign. Legislative change not only produces rules of behaviours but also sets community standards.

6.8.2 Reasons for not supporting legislative change

A number of participants preferred that the legislation not be changed. The reasons they provided were:

It's not necessary, Boards can perform ADR in the present system

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Several participants said legislative change was not necessary, because the present system allows enough flexibility for Boards to manage complaints effectively. Two members of a large Board said:

> *We have not given it ADR connotation, but we have seen ways of doing investigations that are more expeditious and are more effective, that are certainly less resource intensive and I think get a better result for both the notifier and the practitioner. … What we are trying to do is to make sure that the resources of the Board are focused on the practitioners who are potentially unsafe to the public.*

A Board's legal member described how a Board might use its discretion within the Act to help every body. In dealing with a complaint, a Board can:

- try to smooth the way as much as possible for complainants;
- offer practitioners the support they may well need;
- enhance the quality of information from investigations;
- try to make hearings as non-intimidatory as possible, and
- provide additional support to both parties after the hearing finishes.

It's not necessary, the Boards' role is to protect the public, not to perform ADR

Several participants said that the fundamental role of Boards is to safeguard the public by maintaining professional standards, not to provide mediation and conciliation services. Boards have to make the correct decision on how to deal with a complaint even if that decision is unsatisfactory to the complainant and the practitioner. Some expressed concern that if Boards concentrate on ADR, public safety could be compromised.

A number of Victorian participants agreed that it is not the Board's role to facilitate ADR officially. The OHSC was established to deal with complaints not related to professional conduct, using ADR. They have done so effectively, helping parties involved in a complaint to arrive at satisfactory conclusions. Therefore it is not necessary to formalise ADR in Boards' legislation.

> *It comes down to what you are trying to accomplish. … If what you are trying to do is set standards, give guidance and make decisions whether people have done other than they should, then actually I don't see a lot of room for ADR.*

If mandated, it is too rigid, difficult to change and might be used inappropriately

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If Boards want to utilise ADR, they should do so voluntarily, based on the flexibility in the existing system. Some participants cautioned that if ADR was formalised in the law, it would have disadvantages. A Queensland participant pointed out that it could be difficult to draft a meaningful legislation with ADR approach. Other participants said that legislative change might dictate the Board's processes and remove flexibility. Concern was expressed that the legislation might be used inappropriately, might be overused, or might become another layer of bureaucratic process. If mandatory, and part of, rather than an alternative to the formal system, concern was expressed that ADR legislation might not be used as effectively as it is now.

One participant with a legal background stated that the use of ADR could be encouraged by Boards being made more aware of their options, which could become standard practice for all Boards before a matter goes to hearing. Legislative change is not only unnecessary, but also difficult to alter later on.

6.9 Views on law recognition about specific issues

The survey explored with participants a number of possibilities of how legislation could be changed to allow more flexibility in Boards' practice. It included asking the participants from health registering authorities whether there would be advantage if the law were altered so that Boards could be given certain powers including:

- The power to recover legal or other costs from a practitioner;
- The power to award legal or other costs in favour of a practitioner;
- The right, after investigation, to resolve a complaint through the use of warning letters or undertakings;
- The right to use the "notice to admit" procedure, after a decision to go to hearing has been made;
- The right of a hearing panel to take a "guilty plea" into account in the consideration of penalty;
- The right, after investigation and in an appropriate case, to refer a matter to a settlement conference for conciliation between the practitioner and the complainant; and
- Suggestions on legislative change to enable "little formality and technicality" in the conduct of hearings.

The findings in this topic concentrate on participants perspectives as to why an authority should or should not have the powers described above. Perspectives of other Australian and New Zealand participants are presented here with the views of Victorian participants.

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6.9.1 The power to recover legal or other costs from a practitioner

Participants from health registering authorities were asked if it would be an advantage if their boards had the power to recover legal or other costs from a practitioner, and what effect this power would have on the number and resolution of complaints. While most interview participants provided extensive responses to the question, questionnaire respondents only discussed whether they had the power and commented on the effect of the power on complaints management.

In Victoria, only the Pharmacy Board has legitimate power to recover costs from a practitioner. In New South Wales, a Medical Tribunal or Court may award costs against a practitioner. The Pharmacists Board of Queensland can recover such costs by order of the Health Practitioner Tribunal. Registered nurses in Queensland, South Australia and Tasmania have to pay for costs through the order of the Nursing Tribunal, if the charge~~d~~ has been proven. In New Zealand, the Nursing Council may order cost recovery from the defendant, whereas the Medical and the Dental Councils can recover costs through the order of the Medical Practitioners Disciplinary Tribunal and the Dentists Disciplinary Tribunal respectively.

Why Boards should have this power

Participants gave mixed responses to the issue. Some were in favour of Boards having the right, and the Board that already has this power wanted to maintain it. The strongest argument supporting this view was that the current situation was unfair to the majority of complying practitioners who pay registration fees, as Boards have to use fee income to fund hearings about the practitioners who are involved in unprofessional conduct. Some Boards have had to increase their registration fees to stabilise their finances after expenses of hearings. At least one participant admitted that financial constraint was one of the reasons why the Board was not able to schedule as many formal hearings as it should have in a financial year. Others said that their Boards endeavoured to function in the interest of the public and did not consider the cost of running hearings.

A positive effect of this right on complaint management is that hearings would be faster. Boards will be able to afford to fund all hearings they need to have, and work better for protection of the public. Members of Victorian and non-Victorian Boards who have had the power to recover legal costs said that the system works well. They did not think this power had any negative effect on the number and resolution of complaints. A South Australian respondent commented that the practitioners may be more willing to enter into ADR programmes to avoid costs. Others said the practitioners would be more inclined to be honest, or to get into plea bargaining quickly for the reasons about costs.

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Why Boards should not have this power

Some participants were not in favour of Boards having the right to recover costs from practitioners. A Western Australia Board stated having no power to recover costs has little or no effect to the number of complaints or complaints resolution. The Board has a duty to protect the public and in so doing is required by law to investigate matters.

A legal member and a President of Victorian Boards thought that this power would be highly problematic to the integrity of the system. The costs recovered could even be greater than any fine imposed as a result of a hearing. Litigation about costs could be more expensive and time consuming than litigation involved in an actual hearing. This would be counter-productive and discourage practitioners from thoroughly contesting allegations against them. A Queensland Council which has had a mechanism to recover legal costs shared this view:

> *Council has been concerned that practitioners may feel that they must plead guilty to charges that they would otherwise defend, in order to reduce their risk of being liable for costs that would cause excessive hardship.*

Unsure and cautious of consequences

The majority of participants were unsure whether this right would benefit Boards. One said that the right should be there as a general rule but there should be a presumption against overusing it. Most agreed that the right was good in principle, but were cautious of its adverse effects on the profession and the Boards. A few interviewees said that making the practitioners pay for legal costs would not do justice. Going through the trauma of a hearing as well as having a disciplinary sanction imposed upon them, is great enough a penalty for any practitioner. A Victorian Board's registrar said:

> *You are suspending a person from practice for say three years and you then want to impose a $ 50,000 fine on them as well to recover costs. Is that really the fair thing to do? The Board is thinking on those in terms of what is morally right as opposed to legally.*

In the circumstance where a complaint involved professional indemnity insurance, the insurer would be responsible for the practitioner's legal expenses of a hearing. Introducing a Board's right to recover costs from a practitioner could add more pressure on professional indemnity insurance in the market. If, which is however believed unlikely, it became the norm to insure against a potential liability to pay one's registration Board's costs, premium rise would be a consequence. One said:

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> *Members of the profession rightly resent paying twice for the cost of disciplining their members, because they pay once through their registration fees for our side of it, and then they pay through their insurance for the defence as well.*

A Victorian Board's president was concerned that if a Board does not make good judgements on cost recovery, it will risk losing trust and confidence, especially from practitioners who expect the Board to look after them. Another Victorian participant felt that it is an independent tribunal such as courts, rather than Boards, who should deal with issues about legal costs because Boards do not have the necessary skill.

Ideas and concerns about cost recovery

A number of Victorian participants stated that as the health registering authorities perform functions in the public's interest, they should receive funding support from the government. Without this subsidy, Boards will have to seek to recover costs of hearing from the practitioners.

A Board that has to deal with many complaints involving unregistered as well as deregistered practitioners would like to increase the amount of fines the Board can impose on a practitioner rather than having the power to recover costs. The Board can use the right to impose fines effectively whereas the right to recover costs is likely to be counter-productive and not useful.

In New Zealand, a Council member reported that the cost recovery ordered against the practitioner was limited to around 20% - 50% of the actual amount. A Queensland Council has adopted the capping of cost recovery to a minimum of $ 10,000 through their recent amendments of the Act. The capping of cost orders permits reasonable cost recovery while avoiding the situation of practitioners feeling reluctant to defend a case.

6.9.2 The power to award legal or other costs in favour of a practitioner

Participants were asked, if in a hearing it was found that the practitioner is not guilty, whether their Board or a hearing panel should have the power to award legal or other costs in favour of a practitioner; and what effect this power has on the resolution of complaints. Victorian Boards do not have this power at present and a small number of Victorian participants supported the idea of Boards' having this power. All, except for one, non-Victorian and New Zealand respondents stated that their Boards/Councils did not have the power, and did not indicate if they wanted to have the power legitimately.

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Why Boards should have the power

Some Victorian participants said if Boards have the power to recover costs from a practitioner they should also have the power to award costs in favour of them. Others felt that it seems fair to have the power. An aggrieved practitioner should get financial compensation from Boards.

If the power is given to Boards, the participants felt that the effect on complaints resolution would depend on how a Board uses the power. If the Board overuses the power, or never uses it, there would be an effect on the complaints.

Why Boards should not have the power

The majority of Victorian participants disagreed that Boards should have the power to award costs in favour of a practitioner. One said it is not necessary because the Board, of which she is a member, runs formal hearings in a cost effective manner. Others felt that it would be an unusual practice for Boards. A Board would choose not to have a hearing if there was not an absolutely watertight case. Even if a practitioner is not sanctioned, the hearing process in itself may often be worth having.

A few Victorian participants said that the power to award costs is too problematic. When a Board cannot reach a finding following a complaint's hearing because the evidence is not strong enough, it does not mean that the practitioner is not guilty or that the Board has lost. The Registrar of a small Board said:

> *The process of hearing is worth going through regardless of the outcome. And if it is only the outcome which determines the awarding of costs, I think you could find yourself in deep water.*

A legal member of a Victorian Board said this power was a misconceived notion and could put Boards in a negative position. If a Board were facing a large potential payout to a practitioner for costs, there could be temptation in the Board to make poor decisions. Using this power would also be difficult for Boards:

> *The principles for the exercise of discretionary award of costs would be very difficult because sometimes you would not want to award full costs. You would have to articulate the basis upon which you were making that decision. …*

Other participants were concerned about the circumstance when a practitioner did not pay for costs in a hearing but had insurance arrangements

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in place to cover those costs. Arguments about costs would become more complex and time consuming than those about professional standards.

A member of two large Boards in Victoria pointed out that to introduce the power to award costs against, or in favour of, a practitioner, would not solve the current problem about the financial situation of many Boards. He said:

> *It is a terrible thing for a Board to go broke because the department does not help you. You are out there on your own and subject to tremendous castigation from the profession, and there is only one way to fix it and that is by significantly increasing fees. And the professions are up in arms about their increase understandably. So it is a sensitive issue and I think importing those sorts of pressures is not going to help a whole lot.*

6.9.3 The right, after investigation, to resolve a complaint through the use of warning letters or undertakings

After investigation and prior to a decision to go to a hearing being made, it may be advantageous if a Board has the right to resolve a complaint through the use of warning letters or to insist on undertakings being given by a practitioner. It might be that the practitioner, if aggrieved by such an approach, would have the right to insist on a formal or open hearing. Participants were asked if a Board should have this power as an option instead of the two existing choices of going to a hearing or having no further action.

As well as other Australian and New Zealand Boards/Councils, some Victorian Boards are already using warning letters, or an equivalent thereto, in resolving complaints. Many use this procedure without prescription in their Acts.

Why Boards should have the right to use warning letters

A number of participants said Victorian Boards can utilise warning letters in the current system, and many of them have done so. There are circumstances that warning letters can be used effectively without having to form a hearing panel. An ACT Board commented that this process resolved minor matters that did not justify formal inquiry, a process that is slow and expensive. However, members of one Victorian Board, that used this process in dealing with some complaints, said that the Board had no legal power to enforce the compliance sought by the warning letter. Therefore, some of Victorian and other Australian participants thought it would be an advantage for Boards to have this right provided for in the Act or a regulation.

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One Victorian participant said that it would be good to formalise the right to use warning letters, whether to be used by the Board or the Office of Health Service Commissioner.

Boards should be cautious about the right to use warning letters

Some Victorian participants were concerned about outcomes of making legislative change to recognise this right. They would rather not formalise the power because Boards can use this power already. To formalise it is to put another step in the process which puts more pressure back on Boards. Either the Board or its registrar has to make a decision to use warning letters and the registrar might not be capable of doing so if he or she is not a member of the profession. A Tasmanian Board member, although supporting specifying the use of warning letters in legislation, was cautious that the Board could be restricted by having a too prescriptive Act.

Views on undertakings

Undertakings have been used by a small number Boards in Victoria and interstate without reference in their Acts. Two respondents from other Australian Boards said they did not support, nor require the power to use, undertakings as they had little legal effect. One said that to insist on undertakings being given by a practitioner could result in an increase in appeals. The management of the practitioner defaulting on undertakings that were insisted on, instead of agreed to, could be very time consuming and difficult. Consequently the matter could go before the Board again formally at a later date.

A Victorian participant with a legal background was unsure whether to recognise this power in a regulation, because undertakings given by a practitioner cannot easily be enforced. Boards cannot be certain about compliance. Accordingly a hearing would usually be more appropriate than accepting an undertaking unless:

> *It was put in the Act that or in a regulation that where a written undertaking has been given by a health professional that undertaking must be honoured. If it is not, then that amounts to a breach of professional conduct.*

6.9.4 The right to use a "notice to admit" procedure, after a decision to go to hearing has been made

Using a "notice to admit" procedure after investigation and a decision to go to a hearing has been made involves forwarding a notice to the practitioner seeking formal admission of certain facts. If no admission was forthcoming

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and the hearing panel at hearing found the facts involved proven, the panel would have the discretion to impose either cost penalties or some other sanction additional to any other penalty imposed. It is one way that in which a procedure could be introduced to encourage shorter hearings.

At least one Victorian Board has used this procedure without provision in their legislation. Others may have used it in different forms. Respondents from two Boards, in Western Australia and Queensland, reported they have used the "notice to admit" procedure. One did so through their "without prejudice" meetings.

Useful to have this right

Most participants said that the use of a 'notice to admit' is helpful. The Victorian Board that has used the procedure voluntarily found it very effective. It simplifies the process and lessens sitting time, for example, instead of the Board calling a witness from overseas to give simple evidence of which the practitioner should admit, the Board would send the notice to the practitioner inviting him or her to admit certain facts. If the practitioner admits them, they will go into evidence and the board will not have to bring the witness from another country. If not, it is going to cost the board such an amount to bring in the witness, and the practitioner will bear the cost if there is a finding of unprofessional conduct.

Many participants said that under the current legislation, Victorian Boards are not constrained from using the "notice to admit" procedure. Solicitors assisting those involved in a complaint have discussions where they have reduced the issues before a hearing commences. Nevertheless, several participants, from Victorian and other Australian Boards, thought that recognition in law of this right would be helpful. Some said it would help Boards to deal with a situation when people decline to co-operate with boards, or deliberately obstruct them. For instance, it might prevent some (wealthy) practitioners from trying to prolong hearings in order to force a board to its knees financially.

Unsure about this right

Many participants were unsure about how possible it was for legislative change, and what effect it would have on complaint resolution. It is a difficult issue and needs further consideration. One Victorian respondent stated that it would entail *an*other legislative change, giving Boards power to award costs.

Small Boards in Victoria did not find the use of 'notice to admit' relevant to their operation, such as the Physiotherapy, Podiatrists or Osteopaths Boards

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because the majority of their complaints are about rudeness and issues of a similar nature and these issues are not amenable to the suggested procedure. A large South Australian Board respondent stated that this power would not be necessary as the Board has a rehabilitative rather than punitive approach.

Members of a large Victorian Board that usually has co-operative practitioners and solicitors did not support legislative change in this respect, feeling that it would complicate matters for their Board.

6.9.5 The right of a hearing panel to take a "guilty plea" into account in the consideration of penalty

Participants were asked whether there should be formal recognition of the right of a hearing panel to take a 'guilty plea' into account in determining the outcome. For instance, at a hearing, a practitioner may admit that he failed to apply professional standards, be remorseful and show he has taken measures to prevent recurrence of the problem, such as having counselling. The panel may consider a lower degree of penalty appropriate. Many boards may apply this approach in practice now, but there may be benefit in a 'guilty plea' being formally recognised.

Should be recognised by law

A few Victorian and other Australian participants thought the law should recognise such a right. A Victorian participant said that this would encourage concessions and admissions to take place more frequently in hearings. It would encourage people to be frank.

A legal member of a large Victorian Board supported formal recognition of such a right, particularly because it would make clear to Board members, especially those with no legal experience or training, that such an approach was possible and desirable. However, it has to be carefully constructed in the law so that it is not overly prescriptive. It should be simple enough to help ensure fairness and provision of natural justice for the individual.

Law recognition is not necessary

Several Victorian participants including two from legal backgrounds felt legislative change is not necessary. There is enough flexibility in the existing system to utilise this power. Some participants, from small as well as large Boards, felt that if there were formal recognition of this right, flexibility in its application would be lost. Another Victorian participant said that to ask one's

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response to the complaint made against him or her is commonsense, and is within boards' power to make such a decision.

> *It does not need to be there because there are cases which effectively say that the purpose of the penalties is not to punish, it is to protect the public. And therefore you would always, if you have got a reasonable panel, … you would always take those matters into account in mitigating the penalty that you would impose.*

A respondent from New South Wales was concerned about the Board's integrity; if it takes a guilty plea into account without having evidence produced, it may prejudice further actions by the Boards. Another participant from Victoria was unsure whether mandating the consideration of remorse for lower penalty would help or benefit, because some people could abuse it. For example:

> *They have admitted every thing but what is their level of understanding of their professional misconduct? So admission (of facts) is one thing, understanding genuine remorse is another. How can you write that into a piece of legislation? … If you are really remorseful the panel will be more lenient of you, so you go there and do a sob story.*

6.9.6 The right, after investigation and in an appropriate case, to refer a matter to a settlement conference for conciliation between the practitioner and the complainant

The question explored was whether Boards would want to have the right to refer complaints, which are normally dealt with by the Board, to the Office of Health Service Commissioner, after it has been investigated or gone through a hearing and there is an issue outstanding.

Most of Victorian interviewees thought it beneficial for Boards to have such a right. Complainants would be happier after mediation, even if they might have been dissatisfied with such a decision as "no further action" by Boards. One participant commented that this power should be treated as an option only and Boards should use it with discretion. Some Victorian Boards believed that they already have the right to do this under their current Act, and to have it formalised would be useful. Most of the Australian and New Zealand respondents supported the right of Boards to use this power, or said that the issue was worth exploring. An ACT respondent said that the Board should still be informed of the matters so that it can identify patterns in its registrants' practice behaviours.

Some Victorian participants felt that to make such change is a difficult process would intrude into the Health Service Commissioner's area of responsibility. The Health Service Commissioner should be fully consulted on the matter. Two out of 11 other Australian and New Zealand Boards/Councils who

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responded to this question did not support such a right by Boards. One said the Board's mandate is to investigate matters on behalf and the public not on behalf of the individual.

6.9.7 Suggestion on legislative change to enable "little formality and technicality" in the conduct of hearing

Most Victorian legislation states, in relation to complaint hearings, that, "the proceedings must be conducted with as little formality and technicality as the requirement of the Act and the proper consideration of the matter permit."

Many Victorian participants who commented on this issue said they had no suggestion for legislative change. They believed that at present things work well under the Act and that rules of natural justice always apply. A Victorian Board's registrar felt that the hearings conducted by his Board are quite formal, and there is no other way to do it under the interpretation of the current Act. Another Board's legal member made a specific comment that the current wording is in fact helpful because people can be inquisitorial when necessary, to shorten some processes. A registrar said:

> *I think you have to have some formality in this to ensure every one gets a fair go, and there are proper rules of evidence for the more serious cases. Because you know someone could lose their registration out of it or the complainant may not be fairly dealt with, I think there has to be some formality. I think the present circumstance is all right.*

A New South Wales participant who made no suggestion commented however that such requirements of the Act may result in varying interpretation, depending on persons involved.

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7 DISCUSSION

This survey set out to explore, among members of the health practitioner registering boards and councils in Australia and New Zealand, the extent of the use of ADR in the complaints handling process including: the nature of the ADR techniques adopted; the stages in the complaints management processes where ADR is used; outcomes of ADR techniques; types of complaints suitable and unsuitable for ADR; and issues about the Board's relationships with other health complaints bodies. The need in Victoria for legislative change to embody ADR in general, and some specific aspects of ADR in particular, was also explored.

7.1 Summary of results

The survey found that most participants viewed ADR techniques as useful, flexible and desirable, as a good alternative to the existing complex, expensive and intimidating system, and as a mechanism beneficial for consumer complainants as well as the involved practitioners. Many perceived ADR as a commonsense part of good management and thus within the role of a Board but not necessarily ADR.

Several bodies in Victoria, other states and New Zealand have applied a number of ADR techniques, mostly without relying on legislative powers. These techniques may or may not be regarded as ADR by a Board, depending on a Board's view about the definition of ADR.

ADR techniques have been used mainly in the initial stage in complaint management prior to Boards dealing with complaints. ADR techniques used include: various forms and levels of contacts with parties involved in a complaint; attention given to complaints before consideration by the board; 'performance pathway' – an alternative to professional conduct or professional health pathways; a vetting process to assess proper management of a complaint and the resources it requires.

At the investigative stage and prior to a Board's decision about a complaint, the following have been used: undertakings, warning letters, and a Board's delegate communicating with the parties involved. After a decision to go to a hearing has been made, pre-trial meetings and some forms of plea-bargaining, submissions, and notices to admit, have been used. Therapeutic jurisprudence principles have been adopted by a Board to maximise the

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quality of the outcomes of complaint handling as far as future practice by the practitioner is concerned.

Among Australian and New Zealand boards, 'without prejudice' meetings, submissions, undertakings, counselling and practitioner support have been applied.

ADR techniques are suitable for: complaints that do not warrant formal investigation or hearings; complaints where removal of the practitioner's registration is not an expected outcome; or where rehabilitation or counselling of the professional is a desired outcome. Examples of these complaints are: communication and manner problems, personality clashes, some health issues and small management matters. Complaints about gross professional misconduct, breaching of legislation, sexual misconduct or manipulation of power for sexual gratification, clinical incompetence or the health concerns of the practitioner are not suitable for ADR. Boards must have sufficient information about a complaint in order to justify the application of ADR.

ADR use has provided, or is perceived to provide, positive outcomes such as improving Board's efficiency, enhancing communication for all parties, empowering consumers, and avoiding trauma in formal procedures. Anticipated risks include those of the public losing confidence in Boards through a view that any failure to proceed to a formal hearing is reflective of a bias in Boards in favour of practitioners, the practitioner not gaining insights for overcoming professional standards problems, ADR's confrontational nature, the possibility of the process being further extended and consumer complainants still being dissatisfied after ADR. Some of these views were a reflection of many literature review findings.

If Boards are to use ADR, the participants suggested that the processes must be fair, transparent, consistent, have a mechanism to prevent overuse, have a pathway after ADR, and have a means for informing all parties. There is a shared concern that, using ADR, Boards must not compromise their obligation under the Act to properly investigate matters.

In terms of issues concerning other health complaints bodies, the participants, particularly from Victoria, reported good working relationships with the OHSC. Both bodies were concerned about duplication of ADR use. Boards would need legislated power to perform ADR. Working together was suggested. Although the OHSC supported ADR practice by Boards, it nevertheless welcomed the extra workload if Boards wanted to refer more complaints to it. OHSC personnel were cautious however believing that the public might perceive Boards as protecting their professionals when doing ADR. Most participants felt that the OHSC had the best expertise to deal with ADR.

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A number of professional associations have complaints management processes. In general, Victorian Boards have a good relationship with the respective associations. The concern about the association protecting their members is mutual. Associations might be dealing with serious matters, having implications for public safety, without Boards' knowledge.

Views on the need for legislative reform to adopt ADR are divided. One side felt that Boards could at present use many ADR techniques at their discretion, and that legislative change is unnecessary because the Boards' essential duty is to protect the public. Thus to formalise ADR would reduce existing flexibility, and lead to inappropriate use. The other side felt that ADR use by Boards should be legislatively recognised so as to give Boards some power regarding compliance, and to provide transparent and consistent guidelines for ADR use by all Boards.

7.2 Emerging themes

Throughout data analysis processes, a number of themes emerged. These themes help to explain the importance of factors surrounding Boards' adoption of ADR use, and provide a foundation for recommendations.

7.2.1 Boards' integrity

In many phases of the survey participants frequently raised their concerns about Board roles, the ultimate duty, as a non-biased body, in watching and maintaining practitioners' standards of practice and applying disciplinary procedures under their Act to deal with registrants whose professional conduct could put public safety at risk. Boards cannot and should not compromise this duty with alternative procedures, even if these might better satisfy complainants or practitioners. The public as well as practitioners must have confidence in a Board's integrity. Boards cannot afford to be seen as leaning towards either side. This is why pursuing the power to perform ADR in Boards is perceived by many to be outside Boards' responsibilities, and why the Office of Health Service Commissioner is seen as the best organisational body for carrying out ADR - they have the expertise and are also independent from health professionals. The debate about whether Boards should adopt ADR centres around their integrity. On one hand, legislative change to embody ADR is not relevant because public safety, not an individual's satisfaction, is their immediate concern. On the other hand, Boards would be less able to function in the public interest without the power to use ADR to help manage complaints in a timely and cost effective manner.

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7.2.2 Consumer's voice

ADR's mediation and conciliation processes ensure consumers' voices are heard, and attention is paid to their stories. Several times during the course of the survey, Board member participants referred to consumers' feelings, that the current complaints management procedures often left them dissatisfied. ADR brings a sense of closure for consumers because it expands the focus of complaint management to include them. Boards' pursuit of power to carry out ADR satisfies these goals of the consumer movement. The functioning of the Office of Health Service Commissioner adds weight to this contention for, being the current repository of the legislated mandate to perform ADR, it is known for bringing satisfaction to consumers involved in complaints handled by them.

7.2.3 Justice for professionals

In discussions of various matters, the health practitioners' welfare was frequently emphasised. The processes of a hearing or facing peer review have been seen as intimidating and traumatic for the practitioner. Disciplinary sanctions imposed by a Board could result in the loss of livelihood or extreme hardship. Recovery of legal costs from a guilty professional could be unfair to the professional, and the order of cost recovery must certainly have a limit. ADR techniques already adopted by some Boards and Councils are about providing emotional and educational support to the practitioner against whom a complaint has been made, to enable return to useful practice. These ADR processes have been adopted in order to bring a rehabilitative rather than punitive approach to disputes between a board and a practitioner in appropriate cases.

7.2.4 Flexibility in the current system

"The current system works well" has been stated many times by several participants. This is a reference to the use by some Boards of techniques not prescribed in legislation in order to manage complaints effectively. Victorian health practitioner registration Boards follow a similar model of legislation. Yet some Boards appear to be more creative, more flexible, adopting more innovative ideas than others. ADR processes are implemented according to an individual Board's perception of a particular complaint, and are therefore more sensitive to the needs of the individuals involved. The ability to be flexible while satisfying legislative requirements is the key to Boards managing complaints more effectively without legislative reform. There are prominent concerns that such flexibility would be lost if ADR is formalised in the Act because legislation could become over prescriptive, standardised and difficult to change.

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7.2.5 Uncertainty of ADR definitions

Arguments over the meaning of ADR occurred long before this survey was undertaken. Even given the ADR definition used in the survey, various members of Boards participating in the interviews and questionnaire interpreted ADR differently. Within one Board, a practice viewed by one member as ADR could be seen by another as good management. Many participants, who reported that their Boards did not use ADR, later described informal techniques viewed by the survey team as ADR. The interpretation of ADR and its impact on complaints resolution seems to be unclear for many people. Participants have already identified the need for In-Service Education for the professionals, the public and Boards on ADR.

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8 RECOMMENDATIONS

As a result of the literature review and survey, the following recommendations are made:

Recommendation 1: The term 'Alternative Dispute Resolution' is not used in relation to additional case management powers for health practitioner registration boards. This is to avoid confusion raised by different meanings of the term in common usage and to avoid confusion about the role of boards and the role of the Health Services Commissioner in this area. The term "case management processes" is preferred.

Recommendation 2: Health practitioner registration acts be amended to include a broader range of case management processes for the use of boards at the conclusion of the preliminary investigation process and for the use of panels during the formal hearing process.

Recommendation 3: The Health Services Commissioner, acting within her powers under the Health *Services (Conciliation and Review) Act* 1987 is acknowledged as the most appropriate person to conduct conciliation and like processes. Boards which consider complaints as suitable for conciliation should refer these cases to the Health Services Commissioner under the existing pathway in the health practitioner registration acts and the *Health Services (Conciliation and Review) Act* 1987.

Recommendation 4: Health practitioner registration acts are amended to make available new case management processes to boards carrying out preliminary investigations and to panels appointed by boards to carry out formal hearings. The new case management processes will be:

At the close of the preliminary investigation, it will be open to the investigator to recommend to the Board, and open to the Board to accept one of the following recommendations:

3. If the Board is satisfied that having had regard to the need to protect the public, and the need for fairness to the complainant and to the registered practitioner, that it is appropriate to issue a warning letter to the registered practitioner in the prescribed form which notes the behaviour complained of and draws the practitioners attention to certain relevant statutory obligations of practitioners under the relevant health practitioner registration act, the Board may determine that such a letter be sent. The prescribed form of the letter will include a statement that this letter does not constitute a finding of unprofessional conduct. A copy of the letter is then placed on the practitioners file. It would be required that a copy of the letter was also sent to the complainant.
4. If the Board is satisfied that having had regard to the need to protect the public, and the need for fairness to the complainant and to the

registered practitioner, that it is appropriate and if the practitioner is prepared to agree, that an undertaking is drawn up in the prescribed form which notes the behaviour complained of and includes an undertaking that the practitioner will not engage in the behaviour complained of. The prescribed form will include the statement that this undertaking is not an admission of unprofessional conduct or a finding of unprofessional conduct. The signed undertaking is then placed on the registered practitioners file and a copy given to the registered practitioner. It would be required that a copy of the undertaking was also sent to the complainant.

When a panel is appointed to conduct a formal hearing into the professional conduct of a registered practitioner, the board will have the following additional power:

3. If the board is satisfied that the case management of the hearing would be assisted by the appointment of a case manager, it would be open to the board to appoint a case manager from the board, other than a board member who is an appointed panel member for that formal hearing or another suitably qualified person. The case manager would be able to conduct pre hearing meetings in which the case managers purpose would be to seek to narrow the matters in dispute. Case management meetings would be conducted on a 'without prejudice' basis. The conduct of the case management meetings would be at the case mangers discretion, but could include the seeking and exchange of witness statements. The case manager could also ask questions of parties and expert witnesses to establish areas of agreement and to narrow issues in dispute.
4. If a panel conducting a formal hearing into the professional conduct of a registered practitioner makes a finding of unprofessional conduct of a serious nature and the case manager considers it may assist the board in making a determination, the case manger may conduct a pre determination meeting to assist the registered practitioner in considering the development of a written or oral submission on any determination the panel may make. It would be the purpose of the case manger to narrow issues in dispute and to encourage the registered practitioner to make a submission which would assist the panel in reaching a determination.

Recommendation 5: After a formal hearing, if a panel makes a finding of unprofessional conduct of a serious nature, panels are empowered to invite the complainant or person or persons affected by the unprofessional conduct to submit an unprofessional conduct impact statement to be considered by the Board in reaching a determination.

Recommendation 6: Once a case manager is appointed, the case manager may not have discussions, written communications, electronic communications or communications of any other kind with any members of the panel appointed to conduct the formal hearing. The case manager would inform him or herself about the progress of a formal hearing by reading the

documents relevant to the case in the possession of the board, attending the formal hearing or reading the transcript of the proceedings. Any order to hold a closed hearing must exempt the case manger.

Recommendation 7: The amending legislation must state that these case management processes are not intended to be exhaustive. The amendments are not intended to alter the existing powers and discretions of boards and panels to institute case management processes.

Recommendation 8: Boards should be educated in the use of a variety of case management processes and better understand the role of the Health Services Commissioner in conducting conciliation. The Department of Human Services may consider making a contribution to a fund to encourage the health practitioner registration boards to join together, using a contribution formula which is based on the number of registrants of each contributing board, to fund a tender to develop case management guidelines for the use of all boards which explore both the use of legislative processes and pathways and other case management processes which are open under the legislation, but not specified in the legislation.

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10 APPENDICES

10.1 Interview Questions/ Questionnaire

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Survey of the use of ADR in Australia and New Zealand by registering bodies and health complaints bodies

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Date:

SECTION A

1. YOUR ORGANISATION

Name of organisation:

Length of time in existence:

Governing legislation:

Which titles and activities are regulated?

Is only the use of titles restricted, or are aspects of practice also restricted?

How is your organisation funded?

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2. YOUR INFORMATION

Position with the organisation:

Time in that position:

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SECTION B: QUESTIONS

1. COMPLAINTS ABOUT THE CONDUCT OF REGISTERED PRACTITIONERS

1.1 What is the formal procedure adopted by your organisation, commencing with receiving a complaint and proceeding through to its final disposal, and identifying the status of the personnel involved?

1.2 What are the arrangements about the costs involved in dealing with complaints?

Are they met exclusively from your organisation's revenue or is there some recourse elsewhere?

2. THE USE OF ADR IN YOUR ORGANISATION

2.1 What are general perceptions of ADR in your organisation?

Please refer to board definitions of ADR n the project information sheet attached.

2.2 Is there any reference to ADR in the legislation governing the complaints process?

2.3 What ADR techniques are in fact applied in the following processes:

Please describe the roles played by the relevant personnel in any such process.

2.3.1 After receipt of the complaint and prior to formal dealing with it? Is ADR issue relevant at this time?

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2.3.2 After the formal process commences?

2.3.3 Alternative mechanisms? Does your organisation have any other ways of applying an ADR approach at this point? If so, how do they usually work in practice?

2.3.4 After the decision to proceed to hearing?

2.3.5 During an informal or closed hearing?

2.3.6 During a formal or open hearing?

2.3.7 Are ADR techniques used at stages other than the above?

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3. YOUR ORGANISATION & ADR

3.1 What types of complaints are found suitable for ADR?

3.2 What types of complaints are found *unsuitable* for ADR?

3.3 What type of ADR techniques are adopted by your organisation?

Are techniques such as video-conferencing or multi-party telephone contact employed and in what circumstances?

3.4 How are the ADR outcomes compared with traditional methods of complaints management?

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3.5 Risks and benefits you see in the use of ADR:

For your organisation?

For the registered practitioners?

For the complainant bodies?

For the complainants (health consumers)?

3.6 Are there any issues about the relationship of registration boards with Health Complaints Commissioners and other complaints bodies?

3.7 Is use of ADR affected by links with professional association complaints handling and disputes resolution arrangements?

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4. OTHER MATTERS ABOUT ADR

4.1 Does your organisation have the power to recover legal or other costs from a practitioner?

If so, in what circumstances?

What effect do you believe this power has on the number and resolution of complaints?

4.2 Does your organisation or a hearing panel have the power to award legal or other costs in favour of a practitioner and in what circumstances?

What effect do you believe this power has on the resolution of complaints?

4.3 Would it be advantageous if the law were altered to give your organisation all or any of the following powers? Please give reasons.

The right, after investigation but prior to a decision to go to hearing being made, **to resolve a complaint through the use of warning letters or to insist on undertakings being given by a practitioner.** It might be that the practitioner, if aggrieved by such an approach, would have the right to insist on a formal or open hearing.

Your response:

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The right, after investigation and in an appropriate case, **to refer a matter to a settlement conference for conciliation between practitioner and complainant.**

Your response:

Black letter **law recognition of the right of a hearing panel to take a "guilty plea" into account in the consideration of penalty**, and in what circumstances.

Your response:

The right of your organisation to use a "Notice to Admit" procedure whereby, after a decision to go to hearing has been made, it would forward a notice to the practitioner seeking formal admission of certain facts. If no admission was forthcoming and the hearing panel at hearing found the facts involved proven, the panel would have a discretion to impose either costs penalties or some other sanction additional to any other penalty imposed.

Your response:

The right of a hearing panel to award costs, on what basis as to amount and in what circumstances.

Your response:

Most Victorian legislation states in relation to complaints hearings that **"the proceedings must be conducted with as little formality and technicality as the requirements of the Act and the proper consideration of the matter permit."** Do you have any other suggestions as to **changes** to the legislation to enable this to occur.

Your response:

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5. YOUR OPINIONS ABOUT ADR

Please advise your further views on the following:

5.1 Do you think there is need for legislative reform to support adoption of ADR techniques?

If so, please describe reasons.

5.2 Should there be an ADR approach provided by legislation to the resolution of complaints about professional conduct?

If so, in what circumstances should it apply?

5.3 Should a wider range of complaints be made capable of referral to other complaints bodies such as the Health Services and the Ombudsman?

If so, please give reasons.

5.4 Any issues in relation to the role of professional association complaints management?

5.5 Would you favour the use of techniques such as video-conferencing or multi-party telephone contact?

In what circumstances would you use it?

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6. FINAL QUESTIONS

Are there additional comments you want to make about ADR?

Your comment about this project and this questionnaire.

We thank you for your co-operation.

Genevieve Howse, David Halstead and Charin Naksook
The Centre for Public Health Law, La Trobe University

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10.2 Letter of Invitation to Participate in the Project

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10.2.1 Letter to President of Victorian Boards

School of Public Health letter head

Centre for Public Health Law

Address

Date

Recipient (President)

Address

Dear ….

Re: Survey of the use of ADR in Australia and New Zealand by registering bodies and health complaints bodies

The Latrobe University of Public Health Law is pleased to assist the Victorian Department of Human Services ("DHS") by providing a service around the issue of Alternative Dispute Resolution ("ADR").

The service includes a critical review of international literature on ADR techniques and regulatory authorities, a survey of the use of ADR in Australia and New Zealand by registering bodies and health complaints bodies, and a consequent report with recommendations on use of ADR techniques by health practitioner registration boards in Victoria.

The DHS requirement with Victorian respondents is for interviews to be conducted. Two people in each of the Victorian health practitioner registration boards will be interviewed individually, including the President or a legal member and the Registrar. I have also sent this letter to the Registrar of your organisation.

This letter is to introduce you to the project and also to introduce you to Charin Naksook and David Halstead, the interviewers. I would be grateful if you would afford them every assistance you are able. If you are not available for an interview, please introduce a legal member of your organisation who will participate in the interview. The ADR issue is one which I believe will become increasingly important in future for registration authorities and this research will be of great value to all persons interested in the health regulation area.

Enclosed is background information of the project.

Charin will be in contact with you soon to answer any questions you may have about the project, and make an arrangement for the interview with you or with the legal personnel you have introduced.

DRAFT

Thank you for your co-operation.

Yours sincerely,

Genevieve Howse
Director (Programs)
Centre for Public Health Law
Contact details ….

DRAFT

10.2.2 Letter to Registrar of Victorian Boards

School of Public Health letter head

Centre for Public Health Law

Address

Date

Recipient (Registrar)

Address

Dear ….

Re: Survey of the use of ADR in Australia and New Zealand by registering bodies and health complaints bodies

The Latrobe University of Public Health Law is pleased to assist the Victorian Department of Human Services ("DHS") by providing a service around the issue of Alternative Dispute Resolution ("ADR").

The service includes a critical review of international literature on ADR techniques and regulatory authorities, a survey of the use of ADR in Australia and New Zealand by registering bodies and health complaints bodies, and a consequent report with recommendations on use of ADR techniques by health practitioner registration boards in Victoria.

The DHS requirement with Victorian respondents is for interviews to be conducted. Two people in each of the Victorian health practitioner registration boards will be interviewed individually, including the President or a legal member and the Registrar. I have also sent this letter to the President of your organisation.

This letter is to introduce you to the project and also to introduce you to Charin Naksook and David Halstead, the interviewers. I would be grateful if you would afford them every assistance you are able. The ADR issue is one which I believe will become increasingly important in future for registration authorities and this research will be of great value to all persons interested in the health regulation area.

Enclosed is background information of the project.

Charin will be in contact with you soon to answer any questions you may have about the project, and make an arrangement for the interview with you.

DRAFT

Thank you for your co-operation.

Yours sincerely,

Genevieve Howse
Director (Programs)
Centre for Public Health Law
Contact details …

DRAFT

10.2.3 Letter to Australian (not Victorian) and New Zealand participants

Centre for Public Health Law's letterhead

Centre for Public Health Law

Address

Date

Recipient

Address

Dear ….

Re: Survey of the use of ADR in Australia and New Zealand by registering bodies and health complaints bodies

The Latrobe University of Public Health Law is pleased to assist the Victorian Department of Human Services ("DHS") by providing a service around the issue of Alternative Dispute Resolution ("ADR").

The service includes a critical review of international literature on ADR techniques and regulatory authorities, a survey of the use of ADR in Australia and New Zealand by registering bodies and health complaints bodies, and a consequent report with recommendations on use of ADR techniques by health practitioner registration boards in Victoria.

This letter is to introduce you to the survey and also to David Halstead and Charin Naksook, who are jointly working on this section of the project. I would be grateful if you would afford them every assistance you are able, if they have occasion to discuss this matter with you. The ADR issue is one which I believe will become increasingly important in future for registration authorities and this research will be of great value to all persons interested in the health regulation area.

Enclosed are background information of the project and the survey questionnaire itself.

I commend the survey to, you and would be grateful if you return the completed survey in two-week time. David or Charin will be in contact with you soon to answer any questions you may have.

Thank you for your co-operation.

DRAFT

Yours sincerely,

Genevieve Howse
Director (Programs)
Centre for Public Health Law

Encl: 1. project information, 2. questionnaire

DRAFT

10.3 Project Information Sheet

10.3.1 Project information for Victorian participants

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Centre for Public Health Law's logo and Department of Human Services' logo

Survey of the use of ADR in Australia and New Zealand by registering bodies and health complaints bodies

Explanation of the Project

The Latrobe University Centre for Public Health Law, on behalf of the Victorian Government's Department of Human Services, is conducting a research project to examine the use of Alternative Dispute Resolution Techniques ("ADR") within regulatory schemes that register health professionals. A literature search is being conducted into the use of ADR in this context internationally, and a survey of Australian and New Zealand registering and health complaints authorities is required. An interview with legal members of health practitioner registration boards and health complaints bodies in Victoria is the means used to conduct this survey.

The Project's objectives

1. To understand how Alternative Dispute Resolution techniques (ADR) are used within regulatory authorities internationally.

2. To identify the extent to which ADR techniques have been adopted by health practitioner regulatory authorities in Australia and New Zealand.

3. To make recommendations concerning the potential for ADR techniques to be incorporated into Victorian health practitioner board complaints and disciplinary processes.

Definitions of "ADR"

ADR means different things in different environments. An alternative way of resolving a dispute. Alternative to the formal, traditional or established way disputes are resolved. Yesterday's ADR may become today's established and main method of dispute resolution and there will then tomorrow be efforts to try new alternatives. ADR is thus an evolving concept. A literature search into the use of ADR by health registration authorities in Australia and overseas reveals a variety of approaches, with mediation and conciliation being the main methods applied.

It is felt that it is vital to clearly differentiate between two separate processes. On the one hand, ADR techniques can be employed towards resolution of a "dispute" between a practitioner and the patient or consumer of the health service. On the other hand ADR techniques can be employed towards resolution, as between a health registration authority and a practitioner, of a complaint made about the conduct of a practitioner and to which a legislatively mandated investigation and hearing or similar procedure applies. This survey focuses on the latter, however we take into account any ADR techniques you may use in the former process.

How you can help

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Participation in the project is voluntary. However, your contribution made by being interviewed is invaluable to the Project and is most appreciated by the Centre for Public Health Law and the Victorian Government's Department of Human Services.

The interview will be about an hour long and will be held at the time and the venue you identify as most convenient. Charin Naksook and David Halstead, the Project Researchers, will conduct the interview. You will be asked to describe the use of ADR in your organisation, types of ADR techniques used in various circumstances and your opinions about ADR.

Only if you permit, the interview will be tape-recorded for the purpose of data analysis.

Privacy

Your name and the information you provide will be treated as highly confidential. If used, the interview tapes will be kept in a locked cabinet at the Latrobe University Centre for Public Health Law and will be destroyed within five years. The information will be used only by the Centre for research purposes and as the basis of a report for and commissioned by the Department of Human Services of the Victorian government.

Project results

Findings of the survey will be reported to the Department of the Human Services of the Victorian Government. An anonymous report on summary of the findings will be posted to all respondents upon completion of the project, around early 2004.

Communication with the Project team

Charin Naksook will contact you by telephone next week to answer any questions you may have about the survey and organise the time and venue for your interview. You can contact Charin any time on (03) 9847 0214 or 0419 391 576.

Alternatively, you can discuss any matters of concern with Genevieve Howse, Director of the La Trobe University Centre for Public Health Law on (03) 9479 5788.

We thank you for your interest in the project and look forward to hearing your comments on ADR.

Genevieve Howse

David Halstead

Charin Naksook

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10.3.2 Project information sheet for non-Victorian and New Zealand participants

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Survey of the use of ADR in Australia and New Zealand by registering bodies and health complaints bodies

Explanation of the Project

The Latrobe University Centre for Public Health Law, on behalf of the Victorian Government's Department of Human Services, is conducting a research project to examine the use of Alternative Dispute Resolution Techniques ("ADR") within regulatory schemes that register health professionals. A literature search is being conducted into the use of ADR in this context internationally, and a survey of Australian and New Zealand registering and health complaints authorities is required. This questionnaire is the means used to conduct this survey, and your co-operation in answering it is very much appreciated.

The Project's objectives

1. To understand how Alternative Dispute Resolution techniques (ADR) are used within regulatory authorities internationally.

2. To identify the extent to which ADR techniques have been adopted by health practitioner regulatory authorities in Australia and New Zealand.

3. To make recommendations concerning the potential for ADR techniques to be incorporated into Victorian health practitioner board complaints and disciplinary processes.

Definitions of "ADR"

ADR means different things in different environments. An alternative way of resolving a dispute. Alternative to the formal, traditional or established way disputes are resolved. Yesterday's ADR may become today's established and main method of dispute resolution and there will then tomorrow be efforts to try new alternatives. ADR is thus an evolving concept. A literature search into the use of ADR by health registration authorities in Australia and overseas reveals a variety of approaches, with mediation and conciliation being the main methods applied.

It is felt that it is vital to clearly differentiate between two separate processes. On the one hand, ADR techniques can be employed towards resolution of a "dispute" between a practitioner and the patient or consumer of the health service. On the other hand ADR

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techniques can be employed towards resolution, as between a health registration authority and a practitioner, of a complaint made about the conduct of a practitioner and to which a legislatively mandated investigation and hearing or similar procedure applies. This survey focuses on the latter, however we take into account any ADR techniques you may use in the former process.

How you can help

Participation in the project is voluntary. However, your contribution to complete the survey is invaluable to the Project and is most appreciated by the Centre for Public Health Law and the Victorian Government's Department of Human Services.

Please take time to complete the questionnaire attached and returned it to the Centre for Public Health Law in the self-addressed envelope provided. We will be grateful if you please return the completed questionnaire within two weeks after you receive it.

Privacy

Your name and the information you provide will be treated as highly confidential. The information will be used only by the Latrobe University Centre for Public Health Law for research purposes and as the basis of a report for and commissioned by the Department of Human Services of the Victorian government.

Project results

Findings of the survey will be reported to the Department of the Human Services of the Victorian Government. An anonymous report on summary of the findings will be posted to all respondents upon completion of the project in early 2004.

Communication with the Project team

The Project Researchers David Halstead or Charin Naksook will contact you by telephone next week to answer any questions you may have about this survey. After we receive your completed questionnaire, David or Charin may call you again to clarify some of your answers that may be significant to the project findings.

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Any other times you can contact them by calling:

David Halstead on (03) 9489 9442 or 0438 599 231 and

Charin Naksook on (03) 9847 0214 or 0419 391 576.

Alternatively, you can discuss any matters of concern with Genevieve Howse, Director (Programs) of the La Trobe University Centre for Public Health Law on (03) 9479 5788.

Thank you for your interest in the project and we look forward to receiving your completed survey.

Genevieve Howse

David Halstead

Charin Naksook

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10.4 List of Victorian Participants

Boards	Participants
1. Chiropractors Registration Board of Victoria	President Ex legal member
2. Chinese Medicine Registration Board of Victoria	President Registrar
3. Dental Practice Board of Victoria	President and Chief Executive Officer
4. Medical Practitioners Board of Victoria	President and Chief Executive Officer Legal member[60]
5. Nurses Board of Victoria	Professional Conduct Manager and Registrar of Registration Legal member
6. Optometrists Registration Board of Victoria	Registrar
7. Osteopaths Registration Board of Victoria	Registrar[61]
8. Physiotherapists Registration Board of Victoria	President (Registrar) Legal member[62]
9. Podiatrists Registration Board of Victoria	President (Registrar) (Legal member)
10. Pharmacy Board of Victoria	President and Registrar Current member and ex President
11. Psychologists Registration Board of Victoria	President Registrar (Legal member)
12. Veterinarians Registration Board of Victoria	President, Registrar and Complaints Officer
13. Office of Health Services Commissioner	Health Service Commissioner Registrar and Manager of Assessment and Investigations

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[60] Also sits on Psychologists Registration Board
[61] Also sits on Physiotherapists Registration Board and Podiatrists Registration Board
[62] Also sits on Podiatrists Registration Board

10.5 List of Australia and New Zealand respondents

Participants	Means of participation	Boards/Councils
1. Complaints Manager	E-mail	All health registration boards in Northern Territory including: Medical Board; Pharmacy Board; and Psychologists Board
2. Chief Executive Officer	Follow-up call	Medical Board of Queensland
3. Executive Officer	Questionnaire	Queensland Nursing Council
4. Pharmacy Co-ordinator	Questionnaire	Pharmacists Registration Board of Queensland
5. Registrar and Chief Executive Officer	Questionnaire	Medical Registration Board of New South Wales
6. Registrar	Questionnaire	Pharmacy Registration Board of Australian Capital Territory
7. Registrar	Letter	Nurses Registration Board of New South Wales
8. Chief Executive Officer	Questionnaire	Nursing Board of Tasmania
9. Registrar	Follow-up call	Chiropractors and Osteopaths Registration Board of Tasmania Pharmacy Registration Board of Tasmania Optometrists Registration Board of Tasmania
10. Chief Executive Officer and Registrar	Questionnaire	Nurses Registration Board of South Australia
11. Registrar	Follow-up call	Chiropractors Registration Board of South Australia Psychologists Registration Board of South Australia Occupational Therapists Registration Board of South Australia
12. Manager of Professional Standards	Questionnaire	Nurses Board of Western Australia
13. Registrar	Letter	Psychologists Board of Western Australia
14. Registrar	Questionnaire	Chiropractors Registration Board of Western Australia
15. Registrar	E-mail	Pharmaceutical Council of Western Australia
16. Chief Executive Officer	Questionnaire	Medical Council of New Zealand

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17. Chief Executive Officer	Questionnaire	Nursing Council of New Zealand
18. Policy Analyst	Questionnaire	Dental Council of New Zealand
19. Registration Board Secretariat	E-mail	Eight New Zealand Boards including: Chiropractic; Dieticians; Medical Laboratory Technologists; Medical Radiation Technologists; Occupational Therapists; Opticians; Podiatrists; and Psychologists

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