
Review of the National Registration and Accreditation
Scheme for Health Professions

Avant submission

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About Avant

Avant Mutual Group Limited (“Avant”) is Australia’s largest medical defence organisation, and offers a range of insurance products and expert legal advice and assistance to over 60,000 medical and allied health practitioners and students in Australia. Our insurance products include medical indemnity insurance for individuals and practices, as well as private health insurance, which is offered through our subsidiary The Doctors’ Health Fund Pty Limited.

Our members have access to medico-legal assistance via our Medico Legal Advisory Service. We have offices throughout Australia, and provide extensive risk advisory and education services to our members with the aim of reducing medico-legal risk.

A. Executive Summary

Avant supports the National Scheme. Uniting 14 professions and passing legislation in 8 jurisdictions is an important achievement in health regulation which has been recognised internationally.

The work undertaken to establish the National Scheme should not be underestimated, however there are still significant improvements that must be made, particularly to the functioning of the complaints and notifications processes.

Both consumers and practitioners have said that the National Scheme suffers from a lack of transparency and that achieving outcomes take too long. Additionally, consumers are often confused by the process and need to be provided with more information and education about how the National Scheme works.

Equally, it is important that the voice of the practitioner is not lost. Health regulation has succeeded in Australia when practitioners have confidence in the regulator, their concerns have been listened to and they have been offered due process and natural justice.

The experience and expertise of health practitioners should be utilised to help improve the National Scheme.

On key issues raised in the Consultation Paper, Avant's position is:

The handling of notifications in the National Scheme should be improved not discarded

We do not support further jurisdictions adopting a co-regulatory model for handling notifications and believe that improvements can be made to the National Scheme to address the issues raised.

These include: one point of entry for consumers, an early triage system to provide quicker resolution for the majority of notifications and disclosure of all relevant documents, e.g. medical records, expert opinion and relevant background material, to the practitioner to ensure that they can respond to the notification and that the process is fair.

More support for the health and wellbeing of the practitioner

As the largest Australian MDO, Avant sees the impact on the health and wellbeing of practitioners who are subject to a notification. We urge regulators to formally recognise and to consider the impact of a prolonged investigation on the practitioner and to ensure that practitioners can access appropriate support at what is often a very stressful time. The adverse impact on public safety from unnecessarily stressed practitioners should not be underestimated.

National standards needed for timeliness in handling notifications

Avant proposes a mixture of legislated milestones and KPIs on the timeframes for handling notifications and supports the publication of the regulators' performance against these measures on a monthly basis.

Procedural fairness requires sufficient time for practitioners to respond

We also propose parity in timeframes so that practitioners are able to have sufficient and equivalent time to respond to regulators' requests. Safeguards need to be in place to ensure that timelines are met but not at the expense of giving practitioners insufficient time to respond.

Support for the WA exemption on mandatory reporting

Avant supports revising mandatory notification provisions to reflect the exemptions included in the Western Australia legislation covering health practitioners under treatment. The provision in Queensland is not the same and should not be adopted.

The merit-based appointment as Chair should be from the profession

Avant supports a merit-based appointment to the position of Chairperson of a National Board – it is important that the Chair has the appropriate knowledge, skills and is the best person for the job - but a part of a merit-based appointment, Avant believes that knowledge of the profession as a member of the profession is fundamental and therefore the Chair should be a registered practitioner of the profession that the National Board regulates.

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B. Introduction and General Comments

Avant supports the National Scheme and does not support further fragmentation by the adoption of co-regulatory models in those states that are in the National Scheme.

Uniting 14 professions from 8 jurisdictions under the umbrella of one national body, with common registration standards, represents an important achievement in health profession regulation. Australia is recognised internationally as a leader in this regard. National, rather than state-based, registration facilitates workforce mobility and flexibility which are key benefits of the National Scheme.

Overcoming the fragmented approach to managing practitioners who put or potentially put patients at risk is another key benefit of the National Scheme. A national scheme (rather than separate state-based schemes) provides better support and consistency of approach for all practitioners. More than 70% of doctors surveyed by Avant in April 2014 preferred a standard national complaints-handling system to state-based systems.

As a medical indemnity organisation that assists practitioners to respond to notifications and complaints, Avant's primary focus in these submissions is on notifications and complaints-handling processes.

As the National Scheme is only 4 years old, it is too early to properly assess its effectiveness. We are aware that the University of Sydney and Queensland University of Technology in collaboration with AHPRA, the NSW Health Care Complaints Commission and the NSW Health Professionals Councils Authority are undertaking research into complaints handling systems and models of professional regulation in Australia¹. As the results of this research are not yet known, it is premature to consider any significant changes to the National Scheme with regard to complaints and notifications handling. The Consultation Paper reveals that at the heart of many of the concerns about the operation of the National Scheme (particularly with regard to complaints and notifications handling) is confusion and uncertainty among consumers about the respective roles and functions of the regulatory authorities and complaints entities.

However, with changing expectations and the increasing recognition of the important interests of the consumer in the regulatory process, there is a risk of the practitioner's voice being lost. It is important to make sure that those being regulated are not forgotten in the process of ensuring patient and

¹ An overview of the research and preliminary findings were presented at the 2014 IAMRA conference 9-12 September 2014 in presentations by Professor Marilyn Walton "Overview of Research Methods for Evidence-Based Regulation" and Professor Belinda Bennett "Evolving Models of Professional Regulation: Insights from Health Practitioner Regulation in Australia".

consumer expectations are met. For a regulatory system to be effective it must have the confidence of the profession being regulated. If the profession does not have confidence in the regulator, it will struggle to accept the consequences of regulation. This will encourage a continued adversarial approach to regulation, leading to increased costs and reduced regulatory efficiency.

In a survey undertaken by Avant in April 2014, nearly one third of doctors surveyed (including GPs, surgeons and physicians from around Australia) did not believe that current complaints-handling processes are fair, transparent and efficient.

Avant acknowledges the efforts that AHPRA and the National Boards have made to date in an attempt to improve notification processes. Although in our experience the majority of matters are handled well, we believe that more improvements can be made at an operational level.

It is also of vital importance to consider the impact of the complaints notifications process on practitioners. We believe that there is currently insufficient regard given to this aspect, yet in our experience even minor matters can have a devastating impact on the professional and personal lives of practitioners. This impact may occur regardless of the outcome of a complaint, and can be compounded by delays and inefficiencies in the complaint-handling process. This has a flow-on effect on the communities the doctors serve and ultimately on patient safety. Health practitioners risk becoming the “second victim” in the regulatory process.

AHPRA and the National Boards should be cognisant of the potential impact of the complaints-handling process on respondents. As there is accountability to the consumer for following the process, so too there should be accountability to the practitioners, recognising the significant impact the regulatory process can have on the practitioner. Research has shown that many doctors describe having a medico-legal complaint as the most traumatic experience in their lives, even when the matter is resolved in their favour.²

Avant submits that recognition of the impact of the complaints process on practitioners should be incorporated into AHPRA’s regulatory principles.

Avant remains committed to working collaboratively with AHPRA and the National Boards and State and Territory Committees to ensure that the practitioner’s voice is heard and that the practitioner’s rights are respected during the process. This will be better for all involved in the National Scheme – AHPRA and the National Boards, practitioners and consumers, and most importantly it will lead to greater public confidence in our health regulatory system.

² Nash L et al The psychological impact of complaints and negligence suits on doctors. *Australian Psychiatry* 2004; 12(3): 278-281.

C. Submissions on Consultation Questions

We provide answers to and commentary on consultation questions 1, 2, 9-16, 19, 24 and 25 and 28, under the following headings:

1. Reporting and accountability (questions 1 and 2)
2. Complaints and notifications (questions 9, 12-15)
3. Regulatory model (questions 10 and 11)
4. Advertising (question 16)
5. Mandatory reporting (question 19)
6. Other issues (questions 24, 25 and 28)

1. Reporting and accountability

Q1. Should the Australian Health Workforce Advisory Council be reconstituted to provide independent reporting on the operation of the National Scheme?

Avant agrees that the National Scheme should be accountable on a national level and also to individual State and Territory Health Ministers, and that the Scheme will be improved if the accountability mechanisms are strengthened.

Avant supports an annual assessment of all regulators by jurisdiction and based on established performance measures (as well as monthly reporting on timeliness measures; see further below in answer to question 12).

Avant is of the view that the lack of independent reporting on the operation of the National Scheme is a significant issue because it is an impediment to transparency and improved performance. The current lack of accountability and transparency has been an element in the frustration experienced by many stakeholders including State and Territory Health Ministers, practitioners and consumers. AHPRA's annual report only reports on how it has dealt with matters within the financial year. Consequently it is not possible to determine how AHPRA is performing in managing matters over the life of a notification (which may take more than a year to resolve).

Timely, reliable and easily available data makes it much easier to assess the performance of the National Scheme and the entities which are responsible for its different elements. We therefore support increased accountability and greater transparency.

Avant agrees that Health Ministers and their parliaments should be provided with jurisdiction-specific information regarding the performance of the regulators and the overall performance of practitioners in their particular state, but makes no comment on the appropriate entity to do this. Whichever entity (or authority) does this, its operations should not be funded by practitioners (many practitioners' registration fees increased with the introduction of the National Scheme and a further increase to fund the Australian Health Workforce Advisory Council would not be acceptable to practitioners, and would in any event be passed on to patients through increased health care costs).

Q2. Should the Australian Health Workforce Advisory Council be the vehicle through which any unresolved cross-professional issues are addressed?

Avant agrees that there should be a mechanism for resolving cross-professional issues but makes no comment on the appropriate authority to do this.

Avant submits that in resolving cross-professional issues key guiding principles should be that:

- patient safety is paramount
- health practitioners should be qualified, trained and supervised (as necessary) to ensure an appropriate standard of care is maintained;
- the Australian public expects a consistent quality of care to be provided irrespective of the category of practitioner providing that care
- there needs to be a mechanism to ensure that consultation takes place between the National Boards and the respective professions on cross-professional issues.

2. Complaints and Notifications

Q9. What changes are required to improve the existing complaints and notifications system under the National Scheme?

The existing complaints and notifications system under the National Scheme can be improved. Improvements are outlined in the body of these submissions but key points are:

- there should be better triaging of complaints especially those that are minor or vexatious
- performance indicators and legislative requirements relating to timeliness should be implemented and publicly reported on a monthly basis (see further below in answer to question 12)
- there needs to be parity in timeframes so that practitioners are able to have sufficient and equivalent time to respond to regulators' requests

- all relevant information should be provided and an early stage as well as throughout the life of a notification, to allow the practitioner to respond.

Avant believes that there should be a nationally consistent approach to complaints and notifications handling, not only in terms of process but also in terms of outcomes.

Avant agrees with the concerns expressed on page 12 of the Consultation Paper about the existing complaints and notification system under the National Scheme, and agrees that improvements can be made. Avant acknowledges the efforts that AHPRA and the National Boards have made to date in an attempt to improve notifications processes.

We provide our comments by reference to the following aspects of dealing with a notification under the National Scheme (see also our answer to Q12 relation to timeliness in respect of some of these stages):

- a) Assessment
- b) Investigation
- c) Use of the immediate action power
- d) Health assessments
- e) Performance assessments
- f) Action after the completion of assessments, investigations, health or performance assessments
- g) Transparency and disclosure of information.

a) Assessment

The acceptance and assessment of notifications is generally working well in our experience, with some notable exceptions.

Although few in number Avant has had to help practitioners respond to complaints that are clearly frivolous, vexatious trivial, misconceived or lacking in substance (as per section 151 of the National Law) Requiring a practitioner's input in cases of this nature is in our submission a poor use of AHPRA resources; these types of matters should in our submission be dealt with quickly and without the need for a response from the practitioner (although notice of the complaint should in all cases be provided to the practitioner).

Case examples: vexatious complaints

A patient complained that a neurologist took away their healthy heartbeat and replaced it with a bad heartbeat.

A patient complained that a doctor did not provide any treatment and said she could not help the patient until the patient stopped smoking but at the same time the patient acknowledged the doctor provided a script for the patient.

AHPRA should exercise caution in accepting anonymous notifications. Anonymous notifications can often contain allegations that are so general e.g. “the doctor is prescribing too many narcotics” that it is impossible for a doctor to respond in other than the most general terms to such a notification such as by denying generally he prescribes too many narcotics.

We believe that the assessment process can be further streamlined, as follows:

- There should be an early triage process whereby notifications are considered by senior, experienced staff and categorised by reference to the possible outcomes:
 - very serious (potentially requiring immediate action to be taken; and/or likely suspension or deregistration if proven);
 - complex (probably requiring investigation including clinical input) or serious (possibility of suspension or deregistration; pattern of low-level complaints), and
 - low-level complaints (no further action; possible caution; able to be dealt with via a fast-track resolution process; single errors; this would include frivolous, vexatious trivial, misconceived or lacking in substance complaints).
- There should be a fast-tracked process for low-level complaints, which could include options such as a quick turnaround time for responses (if required and subject to all relevant information being provided), a face-to-face discussion between the complaints handling body (whether AHPRA, the Board or Health Complaints Entity (“HCE”) and the practitioner, a simple mediation or conciliation between the notifier and practitioner, and/or a decision on the papers.
- To avoid duplication, and to aid in transparency, it should be made clear to the notifier and practitioner which agency will deal with the matter (AHPRA or the HCE), and the basis upon which one agency will deal with a matter rather than another.

- There should be a statutory requirement that all relevant information be provided to practitioners. Provision of all relevant information at an early stage to practitioners will greatly assist in speeding up the resolution of matters and avoid AHPRA and practitioners entering into protracted and often adversarial debates about procedural fairness, as well as ensuring that patient safety is promptly protected.
- There should be a publically available guide outlining the system, administrative steps, timeframes and the approach taken by AHPRA in triaging notifications, and in complaints and notifications handling generally. The practitioner should be informed of the progress of the matter at regular intervals. This would aid in transparency and increase the public's confidence in AHPRA's notifications process.
- AHPRA staff nationally should be adequately trained on how to assess and investigate notifications to ensure that they are handled fairly, objectively and in an efficient manner. Appropriate clinical input should be obtained in relevant matters. In our experience, there is a risk of staff having pre-existing, pre-conceived views of practitioners' conduct before all the relevant information is available.

South Australian Pilot Study

Avant is aware that a triage system incorporating some of these features has been piloted with success in South Australia. Under this system, the notifications are triaged into one of three groups:

- 1. no further action*
- 2. for investigation or*
- 3. practitioner's response required before assessing and making a decision (no further action or investigation).*

The aim is to reduce the number of assessment reports that the AHPRA assessment officers need to write, saving on workload and allowing them to focus time and resources to work on more serious matters.

Avant understands that this pilot program confirmed that many notifications can be dealt with no input from the respondent. We understand that system is to be rolled out nationally. Avant supports a system of this nature that seeks to deal with minor matters expeditiously and efficiently, and allows AHPRA's valuable resources to be concentrated where there is the most risk to the public. This is consistent with the risk-based, responsive regulatory approach that AHPRA seeks to follow, and that Avant supports.

b) Investigation

Many investigations are completed in a reasonable time frame and allowing the practitioner a fair opportunity to present the practitioner's perspective. However many are not, and in Avant's submission significant improvements could be made for the benefit of patients as well as practitioners, in the following facets of investigations:

- timeliness remains an issue (we deal with this in answer to question 12 below);
- provision of information such as medical records or expert reports. Although this has improved there are still cases where Avant's members have to make Freedom of Information applications to AHPRA to obtain documents. In our submission this is a wasteful use of resources, when under the principles of procedural fairness the practitioner is entitled to and should be provided with relevant medical records and expert reports;
- criticising medical records as a "fall-back" position. In almost all States and Territories investigators seem to frequently fall back on criticising a practitioner's records when the evidence, including expert reports, refutes the substantial part of the complaint or notification. Although we acknowledge the importance of good record keeping, using criticism of medical records solely as the basis for disciplinary action when no other issues remain is not appropriate in our view. It is not an effective way of protecting the public to search for ways to take some action against a doctor whose practice is otherwise satisfactory, nor is it in line with the risk-based regulatory approach that AHPRA and the National Boards have adopted. Not only will this lead to defensive medicine, but also it breaks down the relationship between the public and practitioners and between AHPRA and practitioners which could adversely impact on patient safety. It would be better to adopt a remedial and educative approach and recommend to the practitioner to improve their record keeping.

c) Immediate action power

AHPRA has the responsibility of identifying matters where the evidence supports the use of the immediate action power. In some States and Territories the basis for using the power, seems to be very low and in some instances is used inappropriately.

In Avant's submission the immediate action power should only be used when there is a serious risk to the public as required by section 156 of the National Law. Any orders sought to restrict the practitioner's practice should be proportionate with the risk to be averted (in accordance with AHPRA's regulatory principles). The least intrusive action to protect the public should be taken.

Avant considers that AHPRA staff should be trained on this issue to ensure that the immediate action power is exercised only in appropriate cases, where there is a serious risk of harm to the public.

There should be a provision in Division 7 of Part 8 of the National Law giving a right of review from an immediate action decision without the need to lodge an appeal in the tribunal.

d) Health assessments

When issues are raised about a practitioner's health it is appropriate for AHPRA/the National Boards to seek further information and in appropriate cases to arrange an independent medical examination of the practitioner in question. Generally, Avant finds the health and monitoring team in most States and Territories good to deal with and more cognisant of the negative impact of the regulatory process upon a practitioner.

Avant makes the following suggestions for improvement:

- to be cautious of the one size fits all approach – for example in our experience in some States and Territories the monitoring officer will almost always ask our member to cease practice until an independent assessment is carried out. There are many situations where the practitioner has acted responsibly in seeking medical help and often in self-notifying their health condition to AHPRA. It is counterproductive in such circumstances to take an action which penalises the practitioner financially unless there is strong evidence that the public is at risk and that stopping practice is necessary. This further adds to the distress suffered by the practitioner. The role of AHPRA and the National Boards should be remedial and educative rather than punitive. If the practitioner has acted responsibly, is following treatment recommendations and the treating doctor is satisfied the practitioner is safe to continue to practise, then the practitioner should be permitted to do so, pending the outcome of an independent assessment.
- to assist practitioners having undertakings or conditions reviewed, in Avant's submission a letter should automatically sent to the practitioner inviting an application for a review.
- To provide monitoring officers with significant delegated authority to negotiate and finalise matters where an undertaking is given to not return to work. Currently where a supervision requirement is part of the undertaking, practitioners are required to obtain the National Board's approval of the supervisor. The current process of obtaining approval results in practitioners waiting weeks and months to return to work when this is not necessary and can adversely affect patients waiting to see them. Monitoring officers should be given the authority to approve supervisors where appropriate.

Case example: A Practitioner's perspective of two different health programs

Sadly I can only say that being on the Qld health program was frustrating. It seemed to me that the decisions were predetermined, any response I could provide was disregarded, and I was powerless within the process. After the initial decision there was an extensive and unexplained delay during which there was no progress in my case. In Qld they were unable to tell me when they would review their decision and my case was handed from one case officer to another with no explanation of the process. I felt my voice was unheard, the bureaucratic process was opaque and the delays unexplained. Ultimately it seemed to me that there was little interest in my wellbeing. In contrast the NSW health program has been markedly different to my experience from Qld. The approach has been practical and non-judgmental. They listen to me, answer my questions, and have explained the process going forward. There are regular scheduled reviews and I am no longer stuck in limbo. The atmosphere is collegial and I believe that they are genuine in their aim to support my safe and effective return to the workforce. That does not mean that there aren't great challenges to overcome, but for now I have a path going forward. Most important for me is that I have a voice in this process and I am granted the courtesy, consideration, and respect during the process.

Medical Practitioner, October 2014 NSW/QLD

e) Performance assessments

The only State with significant experience in performance assessments is New South Wales where the system works well and provides a sophisticated, flexible, non-punitive and remedial/educative pathway to improve performance. Performance assessments have not been widely used in the other States and Territories, and where they are used there is inconsistency in the way in which they are conducted.

Case example: performance assessment process

Queensland has refused a support person to accompany a practitioner to a performance assessment in contrast to states such as South Australia and NSW. A Performance Assessment report may adversely affect the practitioner's right to practise and in the other states where a support person is allowed the regulatory authorities actively encourage it.

Avant suggests AHPRA adopt the New South Wales approach, practices and legislation in relation to performance assessments. This should include the right of the practitioner under review to have a

support person present. In New South Wales, the regulatory authority welcomes the attendance of a support person at performance assessments.

f) Action after completion of assessments, investigations etc.

It is important to ensure that any action decided upon is necessary and proportionate to the risk sought to be averted, and is the least intrusive action required to protect the public. There should be consistency of outcomes for similar matters throughout Australia, wherever they originate. Action is not about punishment, as noted by a judge in a Queensland case:

“In determining sanction in a disciplinary proceeding, the focus must rest on those features of the conduct that might undermine public confidence in the profession or present a risk to the public, not whether the sentence imposed by the criminal court is lenient or harsh.”³

If there is a single error, there needs to be a proper examination of the risk to the public and a proper consideration of whether action is truly required to protect the public. In our experience, AHPRA and the National Boards have on occasion responded to a single error in a manner that is disproportionate to the potential risk to the public.

Nothing can be absolutely risk-free, and a certain level of risk in healthcare must be accepted by the public otherwise our health system would grind to a halt. As noted in a Victorian case, reasonable people do accept occasional lapses:

“In my opinion, neither the public nor the peers of a medical practitioner expect perfection at all times. Human frailty visits every person, including those who are medical practitioners. Reasonable members of the public, and the reasonable peers of medical practitioners, understand this. Reasonable people are tolerant of occasional lapses, particularly if these lapses do not form a consistent course of conduct or, if taken separately, are insufficiently serious to warrant intervention by those charged with acting on behalf of the State.”⁴

g) Transparency and disclosure of information

AHPRA's *Service Charter* states AHPRA will apply principles of procedural fairness in dealing with notifications. A fundamental rule of procedural fairness and natural justice requires the disclosure of information to a party the subject of an investigation so that they can properly prepare their response, obtain their own evidence as required and rebut or comment on any material that is potentially

³ *Pharmacy Board of Australia v Thomas* [2001] QCAT 637

⁴ *Vissenga v Medical Board of Victoria* [2004] VCAT 1044

adverse to their case.

In the **assessment** phase, although in most cases practitioners are given a copy of the notification there are exceptions. In these exceptional cases, practitioners may be given the assessment officer's version of the notification, or a redacted version.

Case example: inappropriate redaction

Avant has had the experience where a notification was so heavily redacted that only about 10 % is legible. While it may be reasonable to redact a notifier's address or contact details little else should be redacted. The more that parts of a notification are obscured the less likely it is that the process will be fair. It would be inappropriate use of resources to follow the AHPRA processes only to have the outcome set aside by a Tribunal or court as a result of a failure to follow due process.

In our submission the practitioner should be provided with the full complaint. This will allow the practitioner to respond to all of the issues raised by the notifier. Notifiers will be better served by a considered response dealing with all the issues raised.

In the **investigation** phase we have encountered situations where AHPRA has served expert reports on practitioners as part of the investigation but refused to provide briefing material upon which the reports are based.

Case example: failure to disclose relevant information

During an investigation an expert report was provided criticising the practitioner on an additional issue that had been identified during the investigation. We requested that AHPRA provide the briefing material that formed the factual basis for the expert's opinion – this allows an assessment of the value of the expert's opinion, a determination of whether the expert has taken irrelevant facts into consideration or has omitted to consider relevant ones, and permits the practitioner to properly answer the complaint. Following our request for this material we were told 'the expert report... is sufficient information to enable [your client] to provide a response to the additional issue'. This is an unnecessarily prosecutorial and adversarial approach to take.

Without having all the information which was available to the expert, the practitioner was unable to provide an informed response to the additional issue.

To enhance transparency and fairness, practitioners the subject of investigation should be given an opportunity to consider all material viewed by experts appointed by the National Boards. They should

be provided with regular progress updates (as required under the National Law) that are informative. Practitioners should also be provided with meaningful information about the progress of their matter. The following example does not give the practitioner sufficient information.

Case example: lack of information about progress

“The investigation conducted on behalf of the Medical Board of Australia (‘the Board’) has focussed on the material obtained, including clinical records and responses provided by you. The investigation is now at a stage where the matter is expected to be presented to the Board in the near future. You will be informed of any proposed decision by the Board.”

Medical practitioner, May 2014 (ACT)

It is not only practitioners who are sometimes denied access to relevant information. The Boards make decisions about matters based on briefing materials provided by AHPRA investigators. It has been Avant’s experience that formal written statements or submissions lodged with AHPRA have on occasion been paraphrased or had some sections, but not others, ‘cut and pasted’ into briefing documents.

While Avant appreciates the need for investigatory discretion and expediency in the briefing process, this should not come at the expense of procedural fairness. If statements or submissions have been provided to AHPRA, particularly at AHPRA’s request, then this material should be looked at in full by the members of Board determining the matter.

Further, practitioners are often not aware of what material has or has not been provided to the National Board when deciding to take disciplinary action against them. To ensure transparency, practitioners being investigated should be given notice of the materials on which a Board intends to rely in making a decision which might adversely affect that practitioner. If decision-makers are not provided with all relevant materials on which to base their decision, then the quality of the ultimate decision may rightly be called into question.

Finally, we continue to notice concerning administrative errors which tend to undermine the profession’s (and the public’s) confidence in AHPRA’s operational processes (despite recent improvements).

Case examples: breaches of confidentiality through administrative errors

Case 1

AHPRA sent letters to two different health practitioners to one health practitioner in error.

Medical practitioner, May 2014 (South Australia)

Case 2

Avant Claims Manager (medical practitioner) wrote to AHPRA advising that he was assisting a member and requested that all correspondence be directed to him. Avant contact details appeared at the end of the letter. AHPRA sent correspondence to the Claims Manager's private address which was on the Register of Practitioners. Advised AHPRA of the privacy breach, however, received two further letters to his private address. AHPRA then proceeded to solve the problem by amending the Claims Manager's details on the AHPRA Register to reflect the Avant address without reference to the Claims Manager.

Medical practitioner, 2012 (Victoria)

Medical practitioner, 2014 (similar facts – Victoria)

Q12. Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?

Yes. Avant agrees with the Consultation Paper's acknowledgment of the importance of timeliness in response to notifications. Avant agrees that performance measures and prescribed timeframes for dealing with complaints and notifications should be adopted nationally, accompanied by regular, monthly public reporting on compliance. This would evidence a commitment to transparency and enhance the public's confidence in the regulator.

Avant considers that a proper investigation ought to be completed in the shortest time frame possible to ensure that evidence is obtained while it is still reasonably fresh, consumers are not left in limbo, and health practitioners do not have the stress of trying to work for extended periods (or being suspended and unable to work) pending the results of an investigation and the possibility of adverse action hanging over their head. We have assisted many practitioners who have been subject to lengthy delays. These have been documented elsewhere⁵.

In our experience, delays not only cause significant stress and disruption to the health practitioner concerned, but also to consumers of health services: a practitioner who is stressed is at risk of providing substandard care to patients. Delays also reduce public confidence in the complaints handling system. Conversely improved timeliness may lessen the adverse impact of the process on the practitioner involved, and would increase public confidence in the regulator.

⁵ See Avant's submissions to the Legal and Social Issues Committee Inquiry into the Performance of AHPRA and Avant's submissions to the Minister for Health with respect to the review into the performance of QBMA, MBA and AHPRA: both available at www.avant.org.au/Resources/Public/20130628-Avant-submissions

Improving timeliness is not as simple as imposing shorter deadlines. It is important that the main focus be on good quality decision-making and fair regulatory outcomes. Timeliness should not come at the expenses of quality in outcomes. Rather, any improvements to timeliness should take into account the complexity of matters, and importantly, ensure that there is more parity in the time for each party to respond.

Case examples: timeliness

Case 1

Complaint received May 2014 yet practitioner was only notified 11 July 2014. The practitioner did not receive the notification as they were overseas until 29 July 2014. Complex matter and practitioner was only given a 3 day opportunity to respond.

Medical practitioner, July 2014 (South Australia)

Case 2

7 months investigation following practitioner’s response to the notification and statutory requirement to respond in 14 cases within 28 days

Medical practitioner, October 2013 (NSW)

Equal time should be given to regulators and respondents to investigate complaints and provide responses. Timeframes against which AHPRA is measured should be set as KPIs and/or in legislation with flexibility for complex matters to have longer timeframes where there is agreement between the investigator and the practitioner.

Key concerns and proposed solutions

| Issue | Comment | Proposed solution |
|---|---|---|
| Lack of timely notice to practitioner of notification | It is not uncommon for a practitioner to be advised of a notification and invited to provide a response a number of weeks after the notification was first received by AHPRA. | Notice of the complaint and a copy of the notification should be provided to the practitioner within 14 days of receipt by AHPRA. |

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| <p>Lack of parity in timeframes</p> | <p>We have been involved in cases where AHPRA has had months to obtain expert opinion and undertake their investigation but the practitioner is only given 30 days to respond.</p> | <p>AHPRA and the practitioner should be given equal time to prepare their material – if AHPRA has 30 days, the practitioner should have 30 days. This should be included within the timeliness KPIs.</p> |
| <p>Delays in completing investigations</p> | <p>In states such as Queensland a significant proportion of investigations are still taking an inordinate period of time to be completed. The worst period of time was 12 years from receipt of the notification to closure of the file. That case was exceptional. Nevertheless it is not uncommon to have 2 to 3 years or more from the start to the end of a matter.</p> <p>Current financial year reporting in AHPRA's annual report means that it is difficult to assess the performance of AHPRA over the life of a notification.</p> <p>Avant agrees with AHPRA's KPI that 80% of investigations be completed within 6 months. (See further question 1 above)</p> | <p>The majority of investigations should be completed within 6 months, and more complex matters within 12 months, there may be some exceptional cases where further time is required.</p> <p>There should be a legislative requirement for investigations to be completed within 12 months with the possibility of an extension for 3 months by consent and a further 3 months with approval of the tribunal.</p> <p>There should be an accompanying KPI that 80% of investigations be completed within 6 months.</p> <p>Avant agrees that AHPRA and the National Boards should be required to regularly report on compliance with KPIs and statutory timeframes. We recommend monthly reporting.</p> |
| <p>Failure to provide progress updates as required by the</p> | <p>The statutory requirement to provide progress updates is</p> | <p>Notices should provide more substantive information about</p> |

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| <p>National Law, including timely notice to respondents of decisions that have been made</p> | <p>routinely not adhered to. On occasions where notice is given it is given by AHPRA in the form of short correspondence which typically says:</p> <p>'The investigation is continuing. The investigation will continue to be conducted in a timely way, guided by the nature and complexity of the issues being investigated'.</p> | <p>the progress of an investigation and should be provided at regular intervals.</p> <p>Notice of decisions made by the National Board and/or AHPRA (whether assessment, investigation, health assessment or performance assessment etc) should be provided within 7 days of the decision being made.</p> |
| <p>No provision in the National Law for the practitioner to have a right of review (as opposed to a right of appeal) once a National Board has made a decision following receipt of an investigation report</p> | <p>There have been cases where new evidence or information has arisen that is relevant to a National Board's decision, especially a decision to prosecute in a tribunal or to proceed to a panel hearing. There is currently no statutory right of review so a National Board has no power to reconsider its decision in light of new material. Permitting a right of review has the potential to save the costs of proceeding to a tribunal or panel.</p> | <p>Practitioners should have a right to review a National Board's decision, to be exercised within 14 days of receipt of the National Board's decision.</p> <p>The National Board should then have 30 days to consider and make a further decision on the respondent's request for review.</p> <p>The National Board should notify the respondent of the outcome of the review within 7 days of its decision.</p> |
| <p>Delay between time a National Board decides to prosecute a matter in the tribunal and lodging the application</p> | <p>In one instance the gap was 3 days short of 12 months. In another matter the delay was just under 15 months.</p> | <p>The period between a decision to prosecute and papers being filed in the tribunal should be no more than 30 days.</p> |
| <p>Delays in tribunal/panel process</p> | <p>Avant agrees with AHPRA's KPIs regarding panel hearings and tribunal hearings (100% completed within 6 and 12 months respectively)</p> | <p>In addition to these KPIs, Avant recommends a KPI requiring 80% of matters compliance with a tribunal's directions. The National Board should formally</p> |

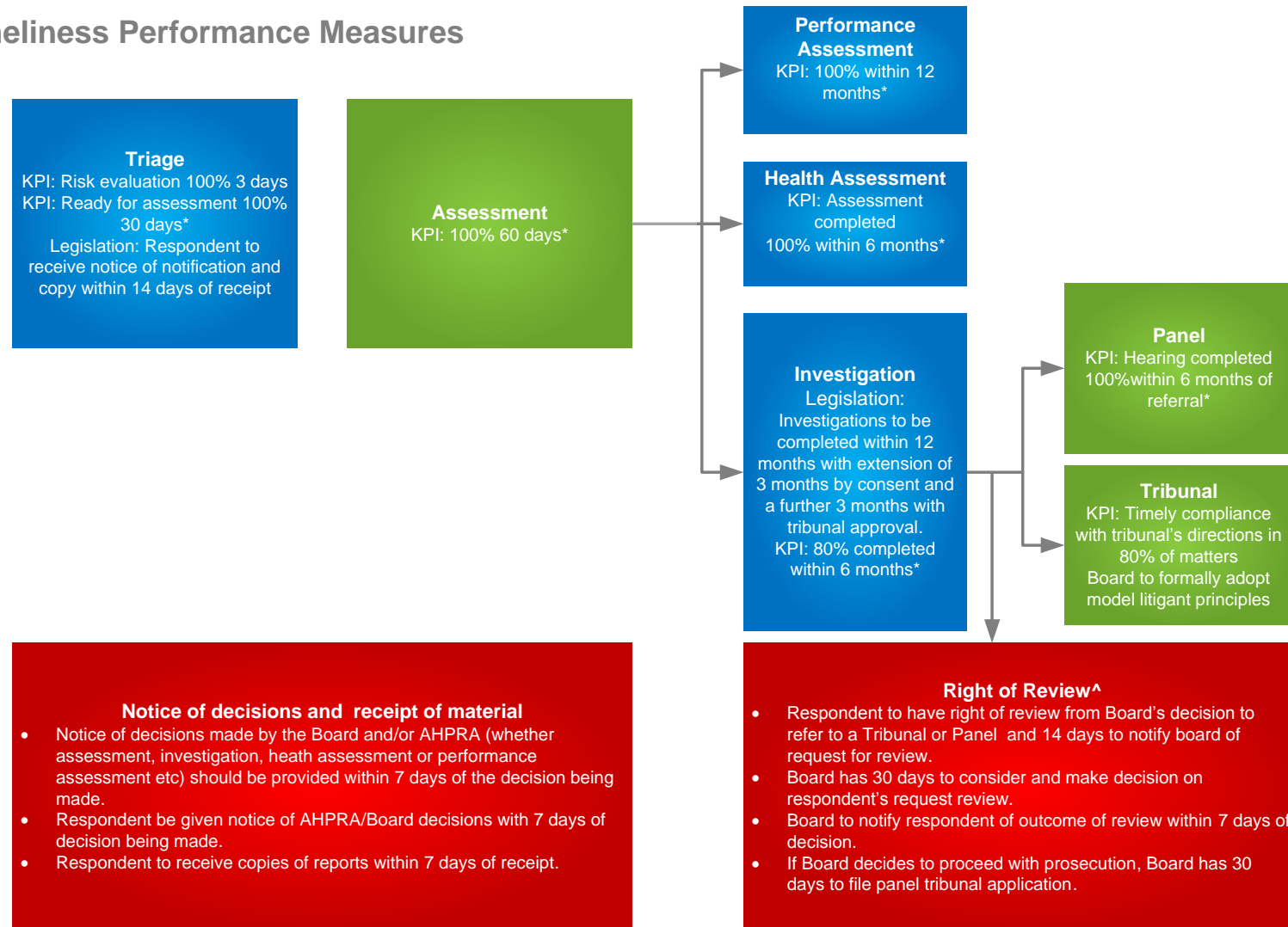
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| | | adopt model litigant principles when litigating disciplinary matters. |
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We note AHPRA's KPI's outlined in the consultation paper. Avant supports performance measures to improve timeliness.

However, we note with concern the findings from the first 12 months of data that indicate that the current KPIs outlined in the Consultation Paper are not being met and the anecdotal feedback the Review has been receiving about the relative poor performance in this area. Similarly, we understand from informal inquiries of Canadian colleagues that although in Ontario there is a timeframe of 150 days from the date of receipt of a complaint to finalise a matter, the Ontario regulatory authority has difficulty complying with this requirement.

Avant proposes a mixture of legislated milestones and KPI's on timeframes for handling notifications, as outlined in the table below and in Figure 1.

Figure 1
Timeliness Performance Measures



* adopting current AHPRA KPIs

[^]Right of review should also apply to immediate action decisions

Q13. Is there sufficient transparency for the public and for notifiers about the process and outcomes of disciplinary processes? If not, how can this be improved?

Avant appreciates the concerns of notifiers about the lack of information about the outcome of the complaints, especially where no further action is taken. Public confidence in the system would be improved by greater transparency.

Section 151 of the National Law requires the Board to give notice to the notifier of a decision to take no further action and the reason for this decision. Avant believes that AHPRA and the National Boards have sufficient power under this section to provide information to notifiers about outcomes of the process. Avant submits that AHPRA and the National Boards have taken an unduly restrictive view of the information they can provide to notifiers. New South Wales has a similar provision (section 28 of the *Health Care Complaints Act 1993 (NSW)*) and the Health Care Complaints Commission has a practice of providing detailed reasons for a decision to take no further action. A good example of this is below.

Case example: clear and appropriate communication by the regulator to the notifier

“With regard to your concern that Dr C was not the only doctor on duty, the Commission contacted the practice manager and found that, whilst another doctor was on duty for some of the time during Dr C’s shift, he was the only doctor on duty for a significant portion of his shift on the date in question and there was a particularly high number of patients at the time; the Commission therefore is not critical of him with regard to his statements about this matter.

I appreciate your concern that patients could suffer serious adverse consequences if their symptoms and circumstances are not adequately discussed and assessed. It is also important for doctors to clearly communicate their assessments, diagnoses and treatment options to patients. The Commission acknowledges that, with regard to your consultation on 17 July 2014, Dr C’s communication with you appears to have been less than optimal.”

Medical practitioner, 8 September 2014 (NSW)

Having said that, Avant strongly believes that information about a practitioner’s health status and other personal or sensitive information should remain private and not be provided to the notifier/complainant (see further below discussion about health conditions in answer to question 19 regarding mandatory notification).

Q14. Should there be more flexible powers for National Boards to adopt alternative dispute resolution, for instance to settle matters by consent between the Board, the practitioner and the notifier?

Yes. Avant supports any process that is constructive and that provides an avenue for issues between patients and practitioners to be resolved in a way which strengthens the trust and engagement between health practitioners and the public.

Alternative Dispute Resolution (ADR) can be a useful mechanism to resolve some matters. In our experience using a process of mediation or conciliation where the practitioner and patient agree on the outcome has a far more positive impact for both parties than taking an adversarial and punitive approach, as well as saving costs.

Case example: complaint re liposuction procedure

The former HQCC had powers to resolve matters using alternative dispute resolution. A patient made a complaint to the then HQCC about a liposuction procedure performed by a cosmetic practitioner. The patient had an area of unevenness in her thigh which she felt was due to the procedure being performed badly. The practitioner stated that he had asked the patient to wait 6 months as often improvement occurred in that period. He indicated that he was intending at the end of the 6 month period to refer the patient to a plastic surgeon for a second opinion and he was happy to pay for any remedial treatment required. The HQCC facilitated a referral to a plastic surgeon who recommended a second procedure. The cosmetic doctor paid for the second procedure and the patient was satisfied.

The Consultation Paper notes that Health Complaints Entities currently have the ability to resolve matters by conciliation and that there is nothing in the National Law that prevents the Boards or AHPRA from referring a matter back to an HCE to be managed as a complaint. Avant does not have any objection to, and would in fact support complaints being dealt with by an HCE through an ADR process concurrently with a notification process through AHPRA.

The Consultation Paper notes that HCEs currently have the ability to resolve matters by conciliation and that there is nothing in the National Law that prevents the National Boards or AHPRA from referring a matter back to an HCE to be managed as a complaint.

Avant supports complaints being dealt with by an HCE through an ADR process concurrently with a notification process through AHPRA.

Avant also supports the National Boards having more flexible powers to be able to use ADR, as long as any process involving ADR (such as conciliation or mediation) is confidential and any information exchanged during the ADR process cannot be used in later proceedings. This is consistent with ADR processes used in other jurisdictions.

Q15. At what point should an adverse finding and the associated intervention recorded against a practitioner be removed?

As noted in the Consultation Paper there is a need to balance the competing rights of the practitioner with the public interest in disclosure to enable informed decisions and public protection.

Avant accepts that it is appropriate to publish information relating to practitioners' registration restrictions on the National Register.

Avant accepts that it is appropriate to publish information in relation to disciplinary proceedings in a manner that is publicly accessible.

Avant does not accept that adverse findings or the results of those findings should remain on the National Board website or the National Register indefinitely.

Once the need for protection is no longer demonstrable, the effect on the practitioner becomes purely punitive.

Avant submits that AHPRA should adopt an approach analogous to the spent convictions legislation that applies to criminal matters. Under this legislation convictions are expunged from a person's criminal record after a period of 10 years (assuming there have been no other offences during that time). The aim of spent convictions legislation is to prevent discrimination, by limiting the use and disclosure of older, less serious convictions and findings of guilt.

Avant submits that a provision similar to the Ontario regulations⁶ for example, be adopted whereby information may be withheld from the public register after 5 years.

Avant submits that there should be a mechanism of reviewing the National Register to identify stale matters, and restrictions that have been in place for a period time without application for review.

⁶ Ontario Regulation 59/94 : Regulated Health Professions Act, 1991 (Loi de 1991 sur les professions de la santé réglementées) available at <http://www.canlii.org/en/on/laws/stat/so-1991-c-18/latest/so-1991-c-18.html>

The National Boards' practice not to include health information about on the National Register should be maintained to ensure that the practitioner's privacy is protected.

3. Regulatory model

Q10. Should the co-regulatory approach in Queensland, where complaints are managed by an independent commissioner, be adopted across all States and Territories? and

Q11. Should there be a single entry point for complaints and notifications in each State and Territory?

The National Scheme is complex and many consumers find it difficult to navigate. We noticed during our attendance at the Review stakeholder forums, that there is some confusion among stakeholders about the use of the term “co-regulatory” in the context of the National Law.⁷ Under the National Law, a “co-regulatory jurisdiction” is one that has opted out of part 8 of the National Law so that complaints and notifications handling is not carried out by AHPRA and the National Boards, but by a separate state entity.

To avoid further confusion, we suggest that if the term “co-regulatory” is used in the final report of the Review that it be consistent with the definition in the National Law.

Avant supports introducing a single point of entry for consumers in each State and Territory but we believe that a single point of entry can be achieved under the National Scheme without the requirement to become a co-regulatory jurisdiction and without adopting the Queensland model. Avant does not support adoption of the Queensland regulatory model across all States and Territories.

Avant expressed concern about several aspects of the Health Ombudsman legislation before it was passed.⁸ Particular concerns relevant to the current Review (about which we remain concerned) are:

- under the legislation, the Health Ombudsman can take immediate action without reference of a complaint to a suitably qualified and experienced practitioner. Fair decisions in relation to potentially serious misconduct by practitioners can only be made if the relevant decision

⁷ In regulatory theory, “co-regulation” is used to describe a regulatory approach that involves a combination of legislation and professional standards or codes of practice – where an industry develops its own regulatory arrangement and government provides the underpinning legislation. Australian Government *The Australian Government Guide to Regulation* (Commonwealth of Australia, 2014) www.cuttingredtape.gov.au at page 28

⁸ See Avant Submissions to the Health and Community Services Committee with respect to the Health Ombudsman Bill 2013 available at www.avant.org.au/Resources/Public/20130628-Avant-submissions.

making power rests with their true peers, who can judge clinical decisions and professional conduct in context

- the legislation allows the Health Ombudsman to take immediate action without giving a practitioner the right to make a submission (before the action is taken and based on all the available evidence) whether the proposed action should be taken, or whether some other action can be taken which provides an appropriate level of protection for the public (see also above section 2(c) Immediate action power)
- the legislation contains extremely short timeframes (7 days) for the Ombudsman to decide how to proceed with complaints. Timeframes should be workable: timeframes that are too short may create a perverse incentive for the regulator to meet the timeframe rather than reach a good outcome.

Avant supports a regulatory model that has the following as its key features (whether in the National Scheme or in a co-regulatory jurisdiction):

- a single point of entry for complaints and notifications;
- the ability to refer notifications/complaints to another body (e.g. a HCE);
- A requirement to consult between the HCE and Board about the matter;
- a requirement to notify the complainant/notifier of the outcome and the reasons for it;
- the ability to refer the matter for ADR where appropriate;
- prescribed performance measures especially on timeframes and public reporting on compliance; and
- separation of powers and functions between investigatory and prosecutorial functions.

We are aware that the University of Sydney and Queensland University of Technology in collaboration with AHPRA, the NSW Health Care Complaints Commission and the NSW Health Professionals Councils Authority are undertaking research into complaints handling systems in Australia⁹. As the results of this research are not yet known, it is premature to consider any significant changes to the National Scheme with regard to complaints and notifications handling. We have outlined our suggestions for operational improvements in section 2 “Complaints and Notifications”.

With regard to the options canvassed on pages 12-13 of the Consultation Paper, Avant submits that improvements can be achieved via a range of administrative and legislative changes and therefore is of the view that Option 1 be adopted. Avant does not support Options 2 or 3.

⁹ An overview of the research and preliminary findings were presented at the 2014 IAMRA conference in presentations by Professor Merrillyn Walton “Overview of Research Methods for Evidence-Based Regulation” and Professor Belinda Bennett “Evolving Models of Professional Regulation: Insights from Health Practitioner Regulation in Australia”.

4. Advertising

Q16. Are the legislative provisions on advertising working effectively or do they require change?

Avant agrees that advertising of a health service should only be done in a manner that engenders confidence in the position of trust the profession occupies in our society, whilst maintaining the ability of the public to make informed choices. However, this view needs to be balanced against the ever-changing appetite of the public for the use of technology to communicate and disseminate information. Practitioners need to keep pace with that drive for information from consumers.

The advertising requirements under the National Law are stricter than the requirements under the Australian Consumer Law. As a consequence registered health practitioners and those operating health services are subject to more onerous requirements than other organisations and individuals.

The ban on testimonials has been surrounded by controversy. The National Law prohibits the use of “testimonials” but does not define the word. AHPRA and the Medical Board of Australia have interpreted “testimonials” to include positive statements about clinical aspects of a regulated health service.

In our experience this has caused confusion among practitioners about what they are permitted to put onto their websites, and leads to the odd situation where a practitioner can include a positive comment about non-clinical matters such as waiting times, the demeanour and manner of staff, but not about the clinical care they provide. It has also lead to the situation where practitioners are unable to counter negative comment by patients on third party sites by including positive comment on their own website.

AHPRA has produced *Guidelines for Advertising Regulated Health Services* (“the Guidelines”) that helpfully clarify the advertising requirements under the National Law but they were not without controversy. Of particular concern was the previously held expectation of the National Boards that health professionals are responsible for monitoring and removing unsolicited testimonials.

Demonstrating the benefits of guidelines versus legislation, AHPRA and the National Boards were able to clarify the situation in frequently asked questions and information sheets.

Thus, for the following reasons, Avant’s view is that Option 1 of the Review be adopted, that is, maintain the status quo:

- anything which encourages the indiscriminate and unnecessary use of health care is clearly not in the public interest, either at a health-economic level, or at an ethical level
- the ban on testimonials helps maintain the health professions' standing and public confidence in health practitioners, and mitigates against the risk of misleading the public
- the current Guidelines are clear and unambiguous, and adequately clarify AHPRA's position.
- the world of advertising, media, and social media rapidly changes. In contrast, legislation is unlikely to keep up with this pace of change. Therefore developing and updating guidelines (after adequate professional and public consultation) is the most effective and cost-effective manner to deal with issues that may arise.

5. Mandatory reporting

Q19. Should the mandatory notification provisions be revised to reflect the exemptions included in the Western Australian and Queensland legislation covering health practitioners under active treatment?

Adoption of Western Australian exemption

Avant submits that mandatory notification provisions should be amended to reflect the exemptions included in the Western Australia legislation covering health practitioners under treatment. The provision in Queensland should not be adopted.

As noted in the Consultation Paper, the intent of the Western Australian exemption ("WA exemption") is that a treating practitioner is exempt from making a notification where the practitioner was undergoing active treatment and did not impose a risk to the public. We agree with this intention and this principle.

The reasons for supporting the WA exemption are outlined in detail in an article recently published in the Journal of Law and Medicine "Mandatory reporting of health professionals: The case for a Western Australian style exemption for all Australian health practitioners"¹⁰ (a copy is provided with this submission), but in summary:

- national adoption of the WA exemption will lead to a nationally consistent approach to health practitioners under treatment which will be fairer to practitioners around Australia as they will be subject to the same laws. Differences in approach cause confusion and uncertainty and result in different outcomes

¹⁰ "Mandatory reporting of health professionals: The case for a Western Australian style exemption for all Australian health practitioners" (2014) 22 JLM 209

- it will reduce real and perceived barriers to treatment. The beyondblue report on its National Mental Health Survey of 12,252 doctors¹¹ found that doctors seeking treatment for mental health conditions faced many barriers including:
 - lack of confidentiality or privacy (reported by 52.5%);
 - embarrassment (37.4%);
 - impact on registration and right to practise (34.3%);
 - preference to rely on self or not seek help (30.5%);
 - lack of time (28.5%); and
 - concerns about career development or progress (27.5%).

- the Consultation Paper notes that the variation in Western Australian law does not appear to have made a material difference to the rate of mandatory notifications. This is supported by the recently published article in the Medical Journal of Australia¹² and the AHPRA data in its 2012/2013 Annual Report

- treating practitioners have an ethical obligation (which manifests in the voluntary notification provisions in the National Law¹³) so are able to report if they feel their practitioner/patient is a risk to the public.

There is a groundswell of support for the WA exemption. As noted in the Consultation Paper it has been recommended by the Victorian Legislative Council inquiry final report, and the 2011 Senate Inquiry into the administration of health practitioner registration by AHPRA. There was strong support at the Review's Western Australian stakeholder forum for adoption of the WA exemption nationally.

This exemption will enable practitioners to obtain the treatment they need without fear of being reported. In a survey of doctors carried out by Avant in April 2014, what concerned 40% of general practitioners and surgeons and 33% of physicians surveyed most was that mandatory reporting discourages doctors from seeking treatment for fear of being reported.

Practitioners who are unwell are at greater risk of practising in a manner that could harm patients. Of Avant members who completed our 2014 member survey, 90% agreed that by doing more to improve their own health, practitioners will practise better medicine. Conversely if practitioners fail to seek help, this will have a detrimental impact on the practitioner and on patient safety. By enhancing

¹¹ Beyond Blue, *National Mental Health Survey of Doctors and Medical Students* (October 2013), http://www.beyondblue.org.au/docs/default-source/default-document-library/bl1132-report---nmhdmss-full-report_web

¹² Bismark et al "Mandatory reports of concerns about the health, performance and conduct of health practitioners" MJA 201(7) 6 October 2014

¹³ Section 144 of the National Law

practitioners' health access, the exemption will enhance public protection and consumer confidence rather than inhibit it.

Recent suggested changes to New South Wales legislation to the effect that practitioners with health conditions should have this information publicly available on the register (following the case of Suresh Nair) will act as a further barrier and disincentive to practitioners seeking help via the National Boards' health programs. Placing the existence and details of health conditions on the publicly-available register is also likely to have an adverse effect on the mental health of practitioners who may already be vulnerable. The National Board should only intervene where the public is truly at risk of harm and where the practitioner needs the oversight of the regulator to ensure compliance with treatment. There is no need for National Board oversight where a practitioner is under active treatment and is compliant in their treating practitioner's recommendations.

Avant submits that the wording of the mandatory reporting provision (section 140 of the National Law) should also be changed. While the Consultation Paper notes the definition of "notifiable conduct" on page 29 in the present tense, the provision is in fact worded in the past tense:

the practitioner has —

- a) practised the practitioner's profession while intoxicated by alcohol or drugs; or*
- b) engaged in sexual misconduct in connection with the practice of the practitioner's profession; or*
- c) placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or*
- d) placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.*

This suggests an obligation to report past rather than current impairment, and an obligation to report even if the practitioner is under active and successful treatment for their impairment.

The wording of the New South Wales legislation introduced in 2008¹⁴ and of the Queensland legislation¹⁵ that preceded the National Law used the present and future tense rather than the past tense.

Avant recommends that the National Law be amended so that the definition of "notifiable conduct" is in the present tense.

¹⁴ *Medical Practice Act 1992* (NSW), s 71A (1).

¹⁵ *Health and Other Legislation Amendment Act 2009* (Qld).

Avant submits that the Queensland legislation does not provide sufficient protection for health practitioners. On close examination, the wording of Queensland's provision merely restates the test already in s.140(c). It does not provide an exemption to treating practitioners from the mandatory obligation to report notifiable conduct, and will not in our view remove concerns raised about the impact of mandatory reporting on practitioners' health access.

Other comments on mandatory reporting provisions

In a survey of doctors carried out by Avant in April 2014, 30% of surgeons and 20% of physicians surveyed were concerned that mandatory reporting may be used for improper purposes such as being misused by competitors for anti-competitive reasons.

In Avant's experience, the professional standards ground of notifiable conduct is the provision most likely to be used for improper purposes. Under this provision a health practitioner has a mandatory obligation to report another health practitioner to AHPRA where the first practitioner has a reasonable belief that the second practitioner has engaged in conduct that (relevantly) has:

Placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.

We have represented medical practitioners in over 20 matters resulting from mandatory reports (not only relating to professional standards, but also including other forms of notifiable conduct) where there is a genuine and reasonable perception by the practitioner under investigation that the report was made vexatiously or may have been motivated by reasons other than protection of the public. Although the threshold for mandatory reporting is stated in the Medical Board of Australia's Guidelines on Mandatory Reporting to be "high", in our experience there is misunderstanding among practitioners about when a mandatory reporting obligation exists.

AHPRA's 2012/2013 annual report reveals that:

- mandatory reports in 2012/13 accounted for just under 12% of all notifications, and 30% of mandatory notifications related to medical practitioners;
- 65% of mandatory notifications against medical practitioners in 2012/2013 related to professional standards;
- immediate action was taken in only 14% of mandatory notifications involving medical practitioners;
- of the mandatory notification matters against medical practitioners closed by AHPRA in 2012/2013 (excluding NSW; and not only professional standards matters), just over 70% were

closed with no further action. In 11% of matters conditions were imposed and in only 1 matter (out of a total of 130) was the practitioner suspended.

Most mandatory notification matters involving medical practitioners are made on the professional standards ground. To reach the required threshold the departure from professional standards must be such that it places the public at risk of harm. Yet immediate action is taken in only a very small proportion of these matters, and most matters are closed with no further action. It is widely believed that mandatory reporting laws would not in any event necessarily have identified a number of high-profile “bad doctors”.

Avant submits that the National Law be amended to incorporate the high threshold that must be reached for mandatory reporting especially under the professional standards ground.

6. Other issues

Q24. How effective are the current processes with respect to assessment and supervision of overseas trained practitioners?

Avant believes that current processes should be improved.

An International Medical Graduate working in Australia may face many challenges, including:

- new language and cultural differences;
- working in isolated communities;
- commencing work in very busy practices; and
- lack of access to adequate supervision, teaching and feedback resulting in poor supervision.

Avant acknowledges the work done by entities including AHPRA, the Medical Board of Australia, the Australian Medical Council (AMC) and specialist Colleges in progressing towards a uniform system across Australia for the registration of International Medical Graduates. It is also encouraging that the Overseas Trained Doctor National Education and Training program is being established.

We believe that Fellowship of the specialist Colleges, or equivalents as deemed by the Colleges, should remain the gold standard for determining if medical graduates (Australian or International) are suitable to work as unsupervised specialists in Australia. Previous departures from this, often under the guise of workforce shortage, have been shown to have detrimental effects on patient safety.¹⁶

¹⁶ *Medical Board action against Dr Jayant Patel*, Media Statement, Medical Board of Australia/AHPRA, 21 November 2013.

International Medical Graduates currently working in Australia who have not yet achieved specialist Fellowship should be provided with opportunities similar to those that may be accessed by Australian graduates, including:

- appropriate supervision and accurate assessment by supervisors. Supervision is not simply achieved by an employer ticking boxes on forms every few months. Some supervision by medical practitioners who are not employers is appropriate; and
- adequate education time and access to teaching. For example, GP Registrars receive compulsory quarantined training time when they do not see patients. This allows them to undergo intensive education activities both within, and external to, their practices. It is also compulsory for their practice supervisors to provide them with teaching.

The Pre-Employment Structured Clinical Interview (PESCI) may not be appropriate for medical practitioners who are applying for a subsequent area of need position/limited registration. By definition, as they have already been employed, a “Pre Employment” interview is not appropriate. Furthermore, if an International Medical Graduate has passed some components of the Royal Australian College of General Practitioners or Australian College of Rural and Remote Medicine exam, they have shown definitive progress towards achieving specialist registration, and Avant members have previously had success in demonstrating this to the Queensland Civil and Administrative Tribunal.¹⁷

Q25. Should the appointment of Chairperson of a National Board be on the basis of merit?

Yes, but a merit-based assessment should include that the Chairperson be from the same profession as the profession being regulated.

Avant supports a merit based appointment of a Chairperson of a National Board – it is important that the Chair has the appropriate knowledge, skills and is the best person for the job - but we believe that the Chair should be a registered practitioner of the profession that the National Board regulates.

It is important that the public has confidence that the National Boards are fulfilling their role and it is appropriate to appoint community members to National Boards. However, it is also critical that the profession has confidence in the decisions of the National Board.

¹⁷ *Medical Board of Australia v Moodley* [2010] QCAT 457 (16 September 2010); *Saini v Medical Board of Australia* [2010] QCAT 514 (14 October 2010); *Saini v Medical Board of Australia* [2012] QCAT 343 (25 July 2012).

The National Board makes decisions about registration of members of the profession, the accreditation of courses to enter the profession and those involved with speciality training. Decisions regarding performance and conduct issues of members of the profession and complaints are based on a peer test. Intimate knowledge of that profession is required to direct decisions in these areas and to ensure that professional standards are maintained.

Having the Chair selected from the relevant profession may increase the efficiency of the working of the National Board. Intimate knowledge of the profession will assist the Chair with leading the National Board through the tasks it is charged with in an efficient and effective manner.

Q28. The Review seeks comment on the proposed amendments to the National Law.

Statutory protection for reporting serious offences

Avant supports a decision to amend the National Law and Western Australian Law to include a statutory protection for health practitioners reporting 'serious offences' (subject to advice being received from Parliamentary Counsel as to the best way to define this in the legislation) to members of the police force.

Comments on the amendments endorsed by the Ministerial Council and amendments proposed by AHPRA and the National Boards are included in the following tables.

Amendments endorsed by the Ministerial Council

| Provision | Legislative amendment proposed | Avant's View |
|--------------|---|--|
| s.149(1)(c) | Amend to clarify that a National Board must in all instances decide whether or not a notification received by a board could be made to a complaints entity and to stipulate what the action the Board must take, including referral to another entity | Avant agrees with the proposed amendment |
| s.151 | Amend to clarify that the section only applies to decisions relating to preliminary assessment and that the Board may decide to take no further action in certain additional circumstances | Avant agrees with the proposed amendment |
| s.167, s.177 | Amend to require the Board to give written notice of its decision and reasons for the decision to the notifier; and written notice of the decision to the practitioner or student | <p>Avant agrees with the proposed amendment, subject to the following comments.</p> <p>The reasons for the decision should also be provided to the practitioner or student concerned. With regard to reasons relating to a health assessment, this should be subject to the proviso that the practitioner or student's privacy must be respected. The Board should retain discretion to withhold sensitive information about the practitioner to protect their privacy.</p> <p>The section should also be amended to include a</p> |

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| | | timeframe (30 days) for the Board to make a decision after receiving the investigator's report. |
| s.180 | Amend to clarify that notice of all decisions under Division 10 is to be given to the practitioner, student and notifier (where applicable) | Avant agrees with the proposed amendment. Notice should be provided within 7 days of the decision. |

Amendments proposed by AHPRA and the National Boards

| Issue | Legislative amendment proposal | Avant's View |
|------------------------------|---|--|
| Commencement of registration | At this time, registration commences on the date of the decision by the Board or the delegate (e.g. s 56(2) (a) however, the point is relevant for all registration types). There are a number of instances when it would be of value for the Board to commence registration on a date to be determined. Such an amendment would be of particular value in the event that further professions were registrable under the National Law. | Avant agrees with the proposed amendment. We have had instances of doctors being adversely affected because the Board has no power to backdate a registration. This amendment would allow the Board the discretion to do this which would be fairer on the practitioner and avoid the unintended adverse consequences that the current provision has. |
| Multiple registration sub- | At this stage, it is not possible to obtain limited registration in a different sub-type | Avant makes no comment on this |

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| types including limited registration | within the same profession (s. 65 (1). This has a negative effect on individuals who are registered, for example, as a dental hygienist but whom then want to undertake limited registration, for example, for the purpose of undertaking examinations to progress to become eligible for registration as a dentist. | proposed amendment. |
| Contravention of undertakings | s.112 (2) (b) makes the failure to comply with conditions on registration a basis on which the Board may refuse to renew an applicant’s registration. We consider that undertakings should have similar weight and suggest Section 112(2)(b) – and ‘or undertaking’ to ... ‘any condition or undertaking to which ... | Avant agrees with the proposed amendment. |
| Actions following suspension | <p>There is no avenue for ending a suspension imposed under section 156 (immediate action). This is problematic as a National Board may want to end a suspension or revoke an undertaking not to practise; and impose conditions.</p> <p>In addition, if a health panel suspends a practitioner under section 191(3) (b), there is no requirement under the National Law for the panel to set a review period. We think that this would be of benefit.</p> <p>When a renewal date arrives during a period of suspension of the practitioner, the National Law does not currently import a clear process for management of practitioner’s registration and the subsequent application for registration/ reinstatement after the conclusion of a period of suspension.</p> <p>Under the National Law practitioners who are suspended over a renewal period are not eligible for renewal – section 207 provides that during a period of suspension a</p> | <p>Avant agrees with the proposed amendments.</p> <p>We submit that the avenue for ending a suspension imposed under s156 should be similar to the avenues available under s125 and s126 to change or remove conditions or undertakings imposed on or given by a practitioner or student. A practitioner should not lose registration due to suspension where there has been no final determination of the merits of the notification or the action required in response.</p> |

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| | <p>practitioner is taken not to be registered and section 107 provides that renewal is only available to registered practitioners. As a consequence, the practitioner will cease to appear on the register and needs to make a new application for registration.</p> | |
| <p>Information on the Register</p> | <p>Section 226 of the National Law sets out when the National Board may decide to exclude certain information from publication on the National Register. The section contemplates that conditions or undertakings entered into by impaired practitioners may be excluded for privacy reasons (s226 (1)). The section also contemplates practitioners requesting information not be published where the inclusion of the information in the register would present a serious risk to the practitioner’s health or safety s226 (2)).The section does not provide for the National Board to consider the exclusion of information where a third party may be adversely affected nor does it allow for the National Board to consider such applications other than on the application of the practitioner.</p> <p>This concern could be addressed by the inclusion of ‘or any other affected person’ after ‘the practitioner’ in both s226 (2) (a) and (b).</p> | <p>Avant agrees with the proposed amendment.</p> |
| <p>Conditions on registration</p> | <p>Under Part 7 of the National Law, the Board is able to impose conditions when registration is first granted, when someone is reapplying for registration and when it is renewed.</p> <p>Consideration could be given to giving a Board the power to accept an undertaking from a registrant to achieve the same purpose, rather than achieving this only by imposing conditions. This would align with the provisions of Part 8 that provide for</p> | <p>Avant agrees with the proposed amendment to allow a Board power to accept an undertaking from a registrant in this context.</p> <p>Avant agrees with an amendment to allow for review periods being set in</p> |

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| | <p>either conditions or undertakings on registration.</p> <p>Where conditions are amended under sections 125 and 126, there is no requirement for a review period to be set and we think that this would be of benefit to practitioners.</p> <p>Co-regulatory issues – under sections 125(2)(b), 126(3)(b) and 127(3)(b), there is no equivalent section in the National Law (NSW) to allow a co-regulatory jurisdiction to change a condition imposed by an adjudication body in a National Board jurisdiction (Part 8) if the adjudication body decided, when imposing the condition, that the subdivision applied. An equivalent section be added to the legislation in all co-regulatory jurisdictions (including NSW and QLD)</p> | <p>respect to amended conditions under section 125 and 126. We submit that any applicable review period should not prevent a registrant making an application if they reasonably believe there has been a material change in circumstances.</p> <p>Avant agrees with the proposed amendments regarding NSW and Queensland.</p> |
| <p>Abrogation of right against self-incrimination</p> | <p>The Health Practitioner Regulation National Law (ACT) has a variant to Clause 2 of Schedule 5 that abrogates the right against self-incrimination. It provides that any information, answer or document required to be given, answered or provided is not admissible in evidence against the individual in a criminal proceeding. The same provision applies in NSW under section ...[sic]</p> <p>The Medical Defence Organisations have advised that they consider such an approach as desirable, as their members wish to cooperate with the Boards without fear that any information provided could be used against them in criminal proceedings.</p> <p>From a practical perspective, an amendment with application across the scheme would [sic] notifications timeframes where there are extant criminal processes.</p> | <p>Avant agrees with the proposed amendment that gives protection to a practitioner so that information provided to the Board cannot be used in criminal proceedings. The ACT variant should be adopted nationally.</p> |

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| | Further, it may enable practitioners to better defend immediate action proposals as they will be able to freely give their version of events. | |
| Notice requirement at section 180 | <p>Section 179 of the National law sets out the requirements for a show cause process to be applied, if a Board proposes to rely on its powers to caution, accept an undertaking or impose conditions under section 178 of the National Law. Section 179(3) provides that a show cause process is not required when a Board has investigated the practitioner under Division 8 of Part 8, or conducted a health or performance assessment under Division 9 of Part 8.</p> <p>Section 180(1) provides that a National Board must give written notice of a decision made under section 179(2). If the Board is not required, because of section 179(3), to use a show cause process, then the effect of section 180(1) is that a notice of the decision to take action is not required.</p> <p>Section 180(1) could be amended to read, 'As soon as practicable after making a decision under this Division, the National Board must give written notice of the decision to ...'</p> <p>It should be noted that an equivalent provision to section 180.</p> | Avant agrees with the proposed amendment. |
| Appealable decisions | Division 13 of Part 8 of the National Law (sections 199 to 203) sets out provisions dealing with appeals against certain decisions made under the National Law. Appeals made under the National Law are made to the responsible tribunal in each of the participating jurisdictions. | <p>Avant agrees with the proposed amendment.</p> <p>Avant also recommends that s.199 be amended to allow a person to appeal a</p> |

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| | <p>There are no consistent provisions about the length of time that a person affected by a Board decision has to make an appeal to each responsible Tribunal. While some jurisdictions have time limits in place because of their respective tribunal legislation, it is submitted that single, nationally consistent time limit ought to be included in the legislation.</p> <p>A new subsection (3) could to be inserted at section 199, so that an appeal made under this section is to be made within 28 days from the date that the person making the appeal receives notice of the reasons for the Board's or Panel's decision, unless the appropriate responsible tribunal otherwise orders.</p> | <p>decision by a panel or Board to caution a practitioner.</p> |
| <p>Obtaining information from other government agencies</p> | <p>Consideration should be given to the addition of a section in Part 8 that mirror Part 4 section 27, to remove any doubt about the ability of investigators to obtain information from other government agencies.</p> | <p>While Avant agrees with the proposed amendment; we submit any amendment should also provide for registrants to be given notice (including copies of any relevant documents) as soon as practicable of information obtained by investigators from other government agencies. In our submission this will ensure transparency to registrants.</p> |
| <p>Notice of a decision to</p> | <p>S.206 requires that notice of a decision to take action against a registered health</p> | <p>Avant submits such a requirement is</p> |

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| <p>take action</p> | <p>practitioner is communicated to the practitioner's employer. This definition might be expanded to require notice to all places of practice – making it clear that s.206 applies equally to contractual arrangements.</p> | <p>overly burdensome on registrants who practice at multiple places.</p> <p>Avant accepts that notice of a decision to take action should be communicated to a registrant's employer. However we do not agree that this should necessarily be expanded in the way envisaged, especially when the action taken may involve a caution only. Other forms of action are, in any event, published on the National Register.</p> |
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