AUSTRALIAN MEDICAL ASSOCIATION
(SOUTH AUSTRALIA) INC

21 January 2019

Hon Stephen Wade MLC
Minister for Health and Wellbeing

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Dear Minister

Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) Amendment Act 2017

Thank you for your letter of 9 November about the Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) Amendment Act 2017, and the opportunity to respond to a discussion paper on the drafting of Regulations for the Act.

You may recall the AMA(SA)'s letter to you about the Bill this Act came from (October 2017). Our letter stated the AMA(SA)'s concern in relation to Section 77E(1), which states: *"Subject to this section, a health practitioner to whom this Division applies must not attend a callout to which this division applies unless the health practitioner is accompanied by a second responder."* We note that the wording of the Act in this section remains unchanged from the Bill.

Our letter expressed the AMA(SA)'s concern that such a universal prohibition would present doctors with ethical and legal conflicts. Doctors are concerned that this provision runs counter to their Code of Ethics. As one doctor put it to us, "Just because the medical practitioner wouldn't be legally liable, doesn't mean that it wouldn't pose a significant ethical dilemma for many." We thank you for highlighting the AMA(SA)'s concerns in this area in your response to the Bill in Parliament on 28 November 2018, where you rightly noted the significance of the Regulations in this area and indicated that Parliament would have the opportunity to consider the Regulations and ensure that they do not infringe on ethical and legal duties of health professionals.

The AMA(SA) considers that doctors should be permitted to exercise some independent discretion in determining whether to attend a callout, if a second responder is not available. Naturally, this should include an assessment of any risks, and we do not advocate that doctors should be careless of their own safety.

We note that the Act provides that the above section does not apply "in any other circumstances prescribed by the regulations for the purposes of this subsection" (Section 77E(3)(b)). However, the discussion paper does not reflect any flexibility on this prohibition, and in fact reinforces it.

We urge the department to undertake further consultation with medical practitioners who would be affected by this provision and determine how a degree of discretion can be maintained.

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We are concerned at the statement in the discussion paper that *"to respond without being accompanied by a second responder could result in a notification against the practitioner to a regulatory authority or have an impact on the professional indemnity insurance of the practitioner".* This punitive approach does not reflect the fact that a health practitioner in such a case would be acting from a sense of professional duty and concern. The AMA(SA) holds that if a second responder is not available and a health practitioner attends, it should not put the practitioner's registration at risk, or make them legally liable.

Indigenous health is a galling failure in our health system and society. As one of our members who has worked significantly in rural and remote SA in Indigenous health has raised (see Appendix), to legislate in this manner removes the flexibility required in the unpredictable circumstances of remote Aboriginal communities, creating danger for the patient in need of emergency care, and creating stress or worse for the health professional.

We are concerned that this approach will make it harder to deliver health services in remote Aboriginal communities, resulting in higher mortality, and increasing the likelihood of closure of remote communities, which in turn has adverse health and wellbeing impacts.

We would also note that, if a health practitioner declined to respond to a call out, because no second responder was available, the community's trust in that practitioner could be undermined to the extent that it was no longer possible for them to work effectively in that community. This may apply to Aboriginal communities in particular. For example, a motor vehicle accident, or a suicide attempt. Communities would need to understand very clearly the constraints under which health practitioners are working.

On a legal note, *Lowns v Woods* (1996) AustTortsReps ¶81-376 (Kirby P and Cole JA; Mahoney JA dissenting) provides some precedent in relation to the question of duty of care to attend in an emergency and treat a person, even in the absence of a pre-existing relationship with the injured person. Given this landmark case and the impact upon the tort of negligence, we ask the department to consider and take advice on this legal aspect, if it has not already, and share the resulting information with us.

As mentioned above, we received some very telling and moving feedback from an AMA(SA) member with extensive experience working in rural and remote areas, who also discussed this matter with colleagues. We were so struck by this feedback that I have included it in full as an appendix to this letter. I wish to highlight in particular the following specific questions and issues, and seek responses to them:

- What measures will be put in place to protect those most at risk of violence within remote Aboriginal communities: Aboriginal people themselves?

- What consultation has been, or will be, undertaken with health practitioners working in remote areas, and Aboriginal people living in remote areas, before the Regulations are finalised?

- Does this legislation apply to remote mining camps (where a Registered Nurse may be employed)?

- It seems likely that this legislation will increase the budgetary requirements of remote Aboriginal health services: will the SA Government cover these costs?

We would also add the following further feedback:

- Section 77D: There must be a clear definition of "second responder". In general, a second responder should be a trusted, responsible community member, Aboriginal or otherwise. Proof of this somewhat nonspecific attribute would be required. Perhaps there could be several broad categories – e.g. public servant, professional, Aboriginal

community leader. Essential requirements should include a criminal record check and working with children checks. Preferred requirements may include Basic First Aid Training, a driver's licence etc. They should have knowledge of the area and community, and be competent to provide help and/or call for help. A second responder must adhere to confidentiality requirements.

- There would need to be a database of second responders, easily accessible (ideally on every health practitioner's phone) and it would need to be updated regularly. We would anticipate that contact should preferably be made by calling or texting, rather than emailing (as email may not be checked regularly or readily available at all times). Confirmation of receipt of the call/text, by the second responder, and confirmation of their engagement to respond, would be essential.

- To ensure that second responders can be relied upon to be engaged, a roster could be considered, depending on the prevalence of out of hours/unscheduled call outs.

- There should be remuneration for second responders, for the hours spent actively supporting the health practitioner.

- In terms of liability, we consider that the second responder should be covered until they return home.

Thank you for the opportunity to provide feedback. We respectfully seek a prompt response on the issues we have raised, in particular about the prohibition against a response without a second responder.

Yours sincerely

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LLB(Hons), BSc(Nursing), DipAppSc, GAICD
CHIEF EXECUTIVE

Enc. Appendix

APPENDIX:

Comments on Discussion Paper: Health Practitioner Regulation National Law (SA) (Remote Area Attendance) Amendment Act 2017 - from an AMA(SA) member with extensive experience working in rural and remote areas

Since the earliest days of settler-colonialism in Australia, the frontier has been portrayed by non-Aboriginal Australians as a dangerous place, where non-Aboriginal people are at risk of violence from the "uncivilised natives". However, more Aboriginal people have died on the frontier than non-Aboriginal people. This legislation appears to be based on a continuation of this mindset, with potentially the same consequences.

While violence occurs in many settings within Australia, from the metropolitan areas to the most remote settlements, this legislation specifically targets remote communities (clearly with Aboriginal communities in mind) and does nothing to protect those most at risk of violence within remote Aboriginal communities: Aboriginal people themselves. It only considers the needs of a particular subset within the community, almost all of whom are non-Aboriginal.

Violence against health professionals in remote communities can occur, but it is a rare event. Health professionals working in emergency departments in major hospitals are at much greater risk of violence than health professionals working in remote Aboriginal communities, but there seems to be no need envisaged to develop [new] legislation to protect these health professionals.

It would be more appropriate for the South Australian government to consider what is necessary to improve safety for all people living in remote Aboriginal communities, such as ensuring a police presence in all communities. No other jurisdiction has developed legislation to protect health staff from Aboriginal people in remote communities. In other States and Territories it is deemed sufficient to ensure that appropriate policies, practices and systems (including the use of second responders) are in place to achieve a high degree of occupational health and safety.

The problem with legislation is that it removes the flexibility which is required in the unpredictable circumstances of remote Aboriginal communities. By creating a threat of legal or registration consequences for a health professional who has a duty of care in an emergency situation, but who on that particular occasion may not have easy access to a second responder, the legislation will create a danger for the patient in need of emergency care, and create stress or worse for the health professional.

Health professionals are, by definition, professional people and should be allowed to make appropriate decisions in the context of the particular circumstances (which may include delaying attending to a case until safety is assured). Such decisions may lead to an incident report and follow-up within the organisation employing a health professional but it should not require legislative oversight. Legislation will make things worse.

Aboriginal people living in remote communities have amongst the worst health status of any group within Australia. They also suffer anxiety from repeated political announcements about the non-viability of remote communities and threats of closure. This legislation has the potential to increase mortality in remote Aboriginal communities, by making responses to medical emergencies more difficult/onerous and to increase the likelihood of closure of remote communities (with the concomitant adverse effects on health and well-being) by making the delivery of health services in these communities more complicated.

The Discussion Paper [refers to] extensive consultations with 'stakeholders', but I have discussed it with health colleagues working in remote areas and they have not been given opportunity to comment. I also wonder how much consultation there has been with Aboriginal people living in remote areas. The question as to whether this legislation applies to remote

mining camps (where a nursing sister may be employed), or only to Aboriginal communities, needs to be asked. It also should be pointed out that the legislation is likely to increase the budgetary requirements of remote Aboriginal health services but I have heard no suggestion that the SA government has offered to cover these costs for all remote Aboriginal health services.