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Progressing reforms to the Health Practitioner Regulation National Law - Regulation of Australia's health professions: keeping the National Law up to date and fit for purpose.

AMA submission to the Council of Australian Governments' Health Council

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The AMA welcomes the opportunity to outline our views and concerns regarding potential reforms to the Health Practitioner Regulation National Law (the National Law).

The AMA has consistently advocated, in the previous reviews of the National Registration and Accreditation Scheme (NRAS), for a scheme that supports:

- registration arrangements that enable medical practitioners, who are qualified and safe, to work anywhere in Australia;
- independent accreditation of medical education and training that meets international guidelines;
- medical practice registration standards set by the Medical Board of Australia (the Medical Board), with clear jurisdiction over all health care provided by medical practitioners; and
- a notification process for the Medical Board to receive, consider and determine concerns about the health, performance or conduct of individual medical practitioners where there is a risk of harm to the public, and which is efficient and affords due process to the medical practitioner under review.

The AMA is satisfied that the NRAS has met the expectations of the medical profession in respect these three points. We continue to work collaboratively with the Medical Board and the Australian Health Practitioner Regulation Agency (AHPRA) to improve the notification and compliance functions of the scheme.

Notwithstanding this, there have been recent issues where the AMA has struggled to understand the rationale behind decisions, some of which seem arbitrary and are likely to have a negative impact on the health and wellbeing of medical practitioners. These include:

- *mandatory reporting* – medical practitioners need legislation that does not actively discourage them from seeking medical treatment when they need it. Doctors are patients too. They should have the same rights to access confidential high-quality medical treatment as their own patients and all other Australians do. The AMA has been deeply disappointed that the National Law has not been amended to stop the pain, suffering, and, in some tragic cases, the suicides of our hardworking doctors.
- *links to the register* - the AMA has been very vocal regarding its concern about the potential for medical practitioners to suffer discrimination as a result of being named in a previous tribunal proceeding, particularly where:
 - The issue was relatively minor;
 - The issue occurred some years ago;
 - The medical practitioner or their practice complied with the tribunal's recommendations; and
 - Other safeguards have been introduced to protect patients.

The AMA finds it difficult to comprehend that medical practitioners, who are named in a tribunal procedure, are offered less protection from discrimination than a person who has served a prison term

The AMA understands the need to ensure that all regulatory schemes and legislation should be reviewed and tested regularly, however we are deeply disappointed that the opportunity to really evaluate the effectiveness of the NRAS has been squandered. The consultation document provided has not sought to analyse the effectiveness of the scheme, using the significant wealth of case information that would now be available. To determine whether the scheme is fit for purpose and operating appropriately, it seems only logical that some data on how the scheme is operating compared with the early years would be provided.

In the absence of data or any analysis, what the consultation paper offers is a grab bag of ideas and thoughts accumulated in an undisclosed manner. Information that could be used to support the proposed options is not provided. Such information would have assisted the AMA (and likely other organisations) to objectively critique proposals and options, and to respond to the questions posed in the consultation paper in a considered manner.

Even more disappointing, is that fact that this very lack of analysis and information, was the same criticism the AMA levelled¹ at the consultation paper prepared for the 2014 review of NRAS.

Accordingly, the AMA is not able to categorically respond to each of the questions and options in the consultation paper. The AMA is also concerned that any changes that arise from this process will not be based on appropriate evidence and therefore should not proceed without adequate identification and quantification of any 'problem', and a full analysis of the impact of the proposed 'solution'.

As we have stated previously, when that happens the AMA stands ready to work with the Medical Board and AHPRA to identify where the scheme can be improved, as we have done in the period from the last review.

It is in this context that the AMA provides our best opinion on the questions and proposals raised in this consultation paper. Additionally, in a section after the AMA has addressed the posed questions, the AMA has added a number of issues we believe need to be considered as the NRAS goes forward into the future.

Section 3.1: Objectives and guiding principles – inclusion of reference to cultural safety for Aboriginal and Torres Strait Islander Peoples

- 1. Should the guiding principles of the National Law be amended to require the consideration of cultural safety for Aboriginal and Torres Strait Islander Peoples in the regulatory work of National Boards, AHPRA, Accreditation Authorities and all entities operating under the National Law? What are your reasons?**

The guiding principles of the National Law should include an additional guiding principle for the National Scheme to foster cultural safety for Aboriginal and Torres Strait Islander (A&TSI) peoples.

Indigenous Australians have the right to access health care that is easily accessible, comprehensive and respectful of their culture. Unfortunately, wide disparities remain between the health status of Indigenous and non-Indigenous Australians. Primary reasons for such differences are; inadequate access to primary health care, poor understanding of the holistic needs (body, mind, spirit, land, environment, custom, socioeconomic status, family and community), social determinants including unemployment, poor education, poor living conditions and social exclusion, are major contributors to the health disparities and higher disease burden in the Indigenous population.

¹[AMA submissions to the review of the national registration and accreditation scheme | Australian Medical Association](#)

Reasons:

To overcome the inequality in health care to A&TSI people, embedding of culture safety in Australian main health care standards is necessary. Current quality and health safety standards are inadequate to guarantee culturally safe care for Indigenous patients. It is argued by the Indigenous health care service providers that culturally safe clinical care would improve health outcomes. Data supports this contention, with health outcomes improving without additional expenditure when delivered in a culturally appropriate setting. Cardiovascular disease is the leading cause of death in Indigenous Australians. Cancer is the second biggest killer: the mortality rate for some cancers is three times higher for Indigenous than for non-Indigenous Australians. Clinical leaders in these two disease areas have identified the need for culturally safe health care to improve Indigenous health outcomes.²

Combined with the late Dr Puggy Hunter's statement that *"The body parts approach has been a complete failure in Aboriginal health. There is no use treating the heart or the ears alone, when the whole person is in danger of breaking down"* (July 1999). The AMA advocates for a holistic, culturally appropriate approach to inform all areas of government policy development and supersede the current disease-based and fragmented policy and funding strategies.

The AMA is strongly committed to improving health and life outcomes for A&TSI peoples and is working to shape a health system that is responsive to the unique health and cultural needs of A&TSI patients.

2. Should the objectives of the National Law be amended to require that an objective of the National Scheme is to address health disparities between Indigenous and non-Indigenous Australians? What are your reasons?

The AMA notes the pressing reasons to address health inequalities between Indigenous and non-Indigenous Australians:

- Health disparity ratios show that Indigenous Australians experienced a burden of disease that is 2.3 times higher than of non-Indigenous Australians³, which means Indigenous people are living with poor health conditions.
- The overarching Council of Australian Government Goal is to close the life expectancy gap in a generation.
- A recent Australian Institute of Health and Welfare (AIHW) report shows that the life expectancy gap is not only not closing, but is widening⁴.

² [Laverty et al., 2017. Embedding cultural safety in Australia's main health care standards. The Medical Journal of Australia.](#)

³ [Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011](#)

⁴ [Closing the Gap targets: 2017 analysis of progress and key drivers of change](#)

- Potentially preventable admissions and deaths (PPAs/PPDs) are 3 times higher in A&TSI people and these are the conditions which health services can and should address, but aren't to a level enough to close the life expectancy gap
- A key issue is underspending by the Commonwealth government (approximately 53% of the needs-based requirements). The main Commonwealth schemes are the Medicare Benefits Scheme, where the use by A&TSI people is approximately 50% of the needs-based requirements, and use of the Pharmaceutical Benefits Scheme, which is even lower at approximately 30% of the needs-based requirements.
- Note that underspending by the Commonwealth is the main issue because;
 - i. while the Commonwealth only spends \$1.21 per capita on A&TSI people for every \$1 spent on the rest of the population (approximately 53% of needs-based requirements), the jurisdictions spend \$2 per capita (87% of needs-based requirements); and
 - ii. most preventable admissions and deaths are dealt with by out of hospital services for which the Commonwealth government is largely responsible.
- Almost 80% of A&TSI people do not know that they have high blood pressure, renal disease or diabetes and these conditions are so important in contributing to the undiagnosed and untreated PPA/PPDs, which make such a major contribution to the life expectancy gap.
- It is simply impossible for the life expectancy gap to close so long as preventable admissions and deaths are three times as high in A&TSI people.
- The AIHW has also identified approximately 40 areas where there are no services at all. These are largely small populations in remote areas and would also need to be served by satellite, outreach or permanent Aboriginal Community Controlled Health Services as appropriate.

The AMA cannot however see how the National Law with its role in regulation of accreditation of health practitioners can effectively influence health outcomes for Indigenous Australians beyond the mandation of cultural safety standards without generating conflicts and unnecessary duplication of activities with health service authorities.

3. Do you have other suggestions for how the National Scheme could assist in improving cultural safety and addressing health disparities for Aboriginal and Torres Strait Islander Peoples?

The AMA has no further suggestions.

Section 3.2: Chairing of National Boards

4. **Which would be your preferred option regarding the appointment of chairpersons to National Boards? What are your reasons?**
5. **If your view is that the role of chairperson should be reserved for practitioner members only, then how should circumstances be managed where there is no practitioner member willing or able to carry out the role, or where there is a need to appoint a non-practitioner for the good governance of the board?**
6. **If your view is that the role of chairperson should be open to both community and practitioner members, then how should the need for clinical leadership be managed when a chairperson is required to speak authoritatively on behalf of the National Board?**

In the AMA submission to the implementation project for the NRAS, the AMA first requested that this proposal not proceed. It is frustrating to the AMA that we have been providing the same advice on this issue for over a decade.

The Chair of the Medical Board is a very influential and challenging position which (if the last few years are to go by) will have a substantial work agenda. The Chair of the Medical Board should be in a position to represent professional standards and discuss matters of professional development. The AMA view is that a non-medical Chair is simply not equipped or appropriate with such experience and understanding and therefore credibility becomes an issue.

This was amply demonstrated when the Queensland Government reconstituted the State Medical Board in 2014 and appointed a chair with a background from a different profession. This created consternation and significant loss of confidence in the work of the State Medical Board among Queensland medical practitioners. It should also be noted that the decision was subsequently reversed, so that there is now a capable medical practitioner as the Chair.

It is the Medical Board's responsibility to ensure it is diligent and expert in its entire decision making and it would be highly regrettable to see this same mistake repeated at a national level.

Section 3.3: System linkages

7. **Are the current powers of National Boards and AHPRA to share and receive information with other agencies adequate to protect the public and enable timely action?**

It is concerning to the AMA that the question of system linkages with other laws and agencies, that directly or indirectly influence safety and quality in health care, is being raised nine years after this scheme has been in operation. It is of even more concern that this section of the document does not provide any analysis of how these interactions have been taking place over time and therefore where (or if) there are gaps or issues that have arisen. This section, like many others in this document, does not identify if there is a problem that needs to be considered and the AMA would, in the first instance, argue that there needs to be appropriate evidence and analysis before potential solutions could possibly be considered.

The AMA is aware that according to good practice principles, all regulators should be empowered and required to co-operate with other bodies (non-government and other levels of government) where this will assist in meeting common objectives.

As experts in governance and regulations, the AMA is surprised that this question has not been addressed by the Governments who have established and mandated this scheme. The AMA believes that detailed evidence of any problem needs to be presented to all stakeholders, before further governance arrangements are put in place that could hinder, rather than promote, the efficient achievement of policy objectives and further undermine confidence in the operations of AHPRA and the Medical Board. From the AMA's perspective the regulators under the National Law should not duplicate or place an added burden on practitioners.

Key to a good regulatory scheme is the ability to operate within scope. The AMA is concerned that a number of suggestions in this section appear to propose the extension of the National Law beyond its current scope, for example:

to better equip governments and regulators to address national reform priorities – for example, to reduce family violence, address Aboriginal disadvantage and inequality, or achieve effective quality and safeguarding in disability services.⁵

Such proposals are well outside the scope of a national registration and accreditation scheme. There is no evidence that the current arrangements are not working or that they are not efficient.

The AMA's members do not want to see their registration fees being used to support government policy development and would prefer that AHPRA and the National Boards focus on improving and enhancing their core business only.

8. Are the current linkages between National Boards, AHPRA and other regulators working effectively?

In the absence of any information being provided on how these links are currently operating the AMA is unable to comment. The AMA is aware of the work AHPRA does behind the scenes with Health Ombudsman's in other jurisdictions, but AHPRA is best placed to advise on these linkages.

The AMA does support the work AHPRA does in publishing (in the interests of transparency) instruments for co-ordination between entities, such as memoranda of understanding, formal agreements or contracts. The AMA believes these could be better organised on the website in a common governance area rather than left in publications.

⁵ [Consultation paper: Regulation of Australia's health professions: keeping the National Law up to date and fit for purpose October 2018](#) p21

9. Should there be a statutory basis to support the conduct of joint investigations with other regulators, such as drugs and poisons regulators and public health consumer protection regulators, and if so, what changes would be required to the National Law?

Whilst the consultation document again does not provide evidence to support a change, the AMA does not support this proposal. The area of health practitioner regulation across Australia is complex and different aspects are managed by different entities. The AMA has significant concerns that providing the ability for different regulators/ombudsmen to conduct joint investigations that we would see duplication of effect, an increased burden on practitioners and a reduction in transparency in how to navigate this already complex and unclear system.

Section 3.4: Name of the Agency Management Committee

10. Should AHPRA's Agency Management Committee be renamed as the Australian Health Practitioner Regulation Agency (AHPRA) Board or the AHPRA Management Board? What are your reasons?

The AMA has no comment to make regarding the naming of the Agency Management Committee.

Section 4.1: Registration improperly obtained – falsified or misleading registration documents

11. Should the National Law be amended to enable a National Board to withdraw a practitioner's registration where it has been improperly obtained, without having to commence disciplinary proceedings against them under Part 8?

Misusing any registered title, particularly the title medical practitioner, is unacceptable. The general public, patients and the profession expect that, the registration processes under the NRAS provide protection for the public, by ensuring that only appropriately qualified and registered practitioners practice their profession. Properly registered medical practitioners have the skills and qualifications to provide safe care to the Australian community.

Pretending to be a registered health practitioner ('holding out') is an offence under the National Law, as in force in each state and territory. Individuals holding out to be a practitioner without proper registration or appropriate qualifications, risk bringing the scheme and the profession into disrepute.

The consultation paper notes that AHPRA only has a limited period in which to refuse registration or renewal under Part 7. This means that is often limited to taking action under section 156 (Power to take immediate action) or section 193 (Matters to be referred to responsible tribunal) of Part 8. Given the serious risks that improperly qualified practitioners pose to the health of the community, the AMA supports the proposal to withdraw a practitioner's registration (where it has been established that their application relied on false or misleading documentation) without having to refer the matter to tribunal

However, there should be the option for individuals to require that the matter be referred to a tribunal to allow the person in question to mount a case, where the individual believes this action has been undertaken erroneously. This would provide a balance between streamlining proceedings and ensuring that individuals have some avenue for 'appeal'.

Section 4.2: Endorsement of registration for midwife practitioners

12. Should the provision in the National Law that empowers the Nursing and Midwifery Board to grant an endorsement to a registered midwife to practice as a midwife practitioner be repealed?

The AMA considers the National Law empowering the Nursing and Midwifery Board to grant endorsement to a registered midwife to practice as a midwife practitioner should be repealed. Not to do so is detrimental to patient outcomes.

The AMA values the expertise and contribution of nurses and midwives in providing health care services and caring for patients. The AMA supports models of care which fully utilise nurses' and midwives' training and expertise, within their scopes of practice.

However, midwifery training is narrower in scope and much shorter than obstetrician training. Midwives are trained to deal with normal, low risk births. Despite this, midwives are often in the position of managing a patient's entire pregnancy and labour. This is despite the AIHW 2016 report, on National Core Maternity Indicators stage 3 and 4 results from 2010-13, showing that critical obstetrician assistance is required in almost half of all births amongst mothers from a 'low-risk' group.

An obstetrician has broad medical education in addition to their specialty training spanning 15 years, giving them the clinical and surgical skills to assist mothers and babies in all scenarios. Obstetrician-led maternity services, with midwives working in collaboration, provide the best outcomes for mothers and babies. There is compelling recent Australian evidence that women accessing 'low risk' models of care delivered by midwife teams and birth centres in large public hospital units, have a significantly higher perinatal mortality rate (2.3/1000) when compared to that of women accessing obstetrician-led care (1.2/1000)⁶. The practice of obstetrician-led care ensures risk is managed appropriately and any co-morbidity or extra precautions to improve patient safety are properly considered.

The Commonwealth Government acknowledges the risks of midwives practicing independently, by requiring that midwives must practice in a formal collaborative arrangement with an obstetrician in order for their services and prescriptions to be eligible for MBS or PBS subsidies.

⁶ Permezel & Milne, Pregnancy outcome at term in low risk population: study at a tertiary obstetric hospital, J Obstet Gynaecol, Res. 2015 Aug; 41(8):1171-7

Section 4.3: Undertakings on registration

13. Should ss. 83 and 112 of the National Law be amended to empower a National Board to accept an undertaking from a practitioner at first registration or at renewal of registration?

The AMA fully supports increased flexibility in the application of the National Law in order to reduce the administrative, financial and mental health burden that can be experienced by medical practitioners in their dealings with the Medical Board and AHPRA. Accordingly, the AMA supports the ability of a National Board to accept an undertaking voluntarily proffered by a health practitioner, instead of the more onerous process of applying a condition.

14. Should the National Law be amended to empower a National Board to refuse to renew the registration of a practitioner on the grounds that the practitioner has failed to comply with an undertaking given to the board?

The AMA notes that under section 112(2)(b), failure to comply with conditions on registration is a basis on which a National Board may refuse to renew an applicant's registration.

The AMA accepts that if a medical practitioner enters into a voluntary undertaking in lieu of a mandatory condition, then failure to comply with this undertaking, breaking this arrangement, should be equally able to be considered by a National Board as part of renewing registration. In particular, the National Board should have the power to refuse registration on the basis of failure to comply with an undertaking, as it does in relation to a failure to comply with a condition. The AMA notes "it is anticipated that the National Board would only consider this course of action if it was assessed that the practitioner presents a risk to public health and safety". The AMA is supportive of this approach given that:

- the undertaking was provided voluntarily; and
- practitioners may be reluctant to give undertakings if minor non-compliances result in non-renewals.

The AMA also submits that, given the professional and financial consequences, practitioners should have the ability to appeal a refusal to renew on this basis or, at the very least, the National Board should issue a show cause notice before finalising their decision.

If this proposal is to progress it will need to be done with full consultation with the sector.

Section 4.4: Reporting of professional negligence settlements and judgements

- 15. Should the National Law be amended to require reporting of professional negligence settlements and judgements to the National Boards?**
- 16. What do you see as the advantages and disadvantages of the various options?**
- 17. Which would be your preferred option?**

The AMA believes that the proposed amendments are fraught and have the potential to make significant changes to the medical insurance claims landscape.

Medical indemnity insurance is different to many other types of insurance. Most substantive medical malpractice claims can take several years (potentially more than five years) to settle from occurrence of the injury. Claims involving obstetrics can literally take decades to emerge, let alone be resolved in a short time frame. This means that:

- the report would relate to something that occurred years if not decades earlier; and
- would not be a reliable indicator of current or future risk to patients.

The consultation paper on page 31 acknowledges that:

Although a professional negligence settlement or judgement is not, on its own, an indication that poor practice has occurred, data such as a practitioner's professional negligence record, when used in conjunction with other sources of information, can assist boards to identify patterns of behaviour that may warrant further regulatory scrutiny. There are, however, concerns that such information can be subject to misinterpretation or misuse, and that, depending on the way the obligation is framed, may create a perverse incentive for a practitioner to enter into a confidential settlement where no judgement is reported.

We would agree. Currently there are many times where the decision to settle a claim is taken by the insurer not the practitioner. This decision is not necessarily based on any wrong doing by the medical practitioner, but what is legally and fiscally expedient. Usually these settlements are on the basis that they are confidential and involve no admission of liability. Should the National Law be amended as proposed, medical practitioners will have no choice but to vigorously defend each and every case in court, as any settlement would effectively be seen as an admission of liability.

Reporting of civil claims by insurers to AHPRA will undermine the relationship medical practitioners have with their Medical Defence Organisations (MDOs). MDOs provide the support for their clients when they are facing notifications and investigation by AHPRA and the MBA. Doctors will not be able to trust that their MDO has their interests first and foremost and, as we have seen with mandatory reporting, this will lead to medical practitioners withholding information from their MDO.

It is also the case that there are medical practitioners, who by the very nature of their practice, have a higher level of risk – they undertake higher risk procedures, deal with higher risk clients, work in areas with less support and infrastructure available. All these situations will see these practitioners having potentially higher risk levels than their comparable peers. How would these medical practitioners not be unfairly disadvantaged under the proposed approach.

In August 2017 the Commonwealth Government began a First Principles Review of the Indemnity Insurance Fund and a Thematic Review of Medical Indemnity Legislation⁷. The Department of Health invited comments and perspectives on whether the schemes continue to be fit for purpose, their strengths and weaknesses, and any suggested improvements. This process is still ongoing. It does not make sense to propose further legal changes in an area where legal and administrative changes are still being considered.

The AMA strongly supports the option to retain the status quo.

Section 4.5: Reporting of charges and convictions for scheduled medicines offences

18. Should the National Law be amended to require a practitioner to notify their National Board if they have been charged with or convicted of an offence under drugs and poisons legislation in any jurisdiction?

The AMA is deeply concerned that this proposal will further undermine medical practitioners trust in the NRAS. As the AMA has continually stated, the unintended consequences from the operation of the current National Law are far reaching – this is one such example.

First the AMA is concerned about the lack of analysis and evidence for this proposal. The report upon which this is based was Queensland specific and based on a limited, targeted consultation. That report also talks about allowing police to refer issues under investigation to the National Boards, to ensure the practitioner is appropriately managed. This is substantially lower than the current standard (convicted or charged) and provides none of the protections that apply to those standards. Adopting this proposal would undermine trust and do nothing except strike fear into the hearts of practitioners.

This is compounded by the fact that there is no analysis done, which shows how this proposal would operate nationally. As each jurisdiction maintains a different set of legislation in this area, a medical practitioner could find themselves referred to the police for a minor infraction. As the consultation document itself states:

Such an amendment would require the practitioner to report when they have been charged with or convicted of a relatively minor offence under drugs and poisons law such as selling a controlled drug that is not packed in compliance with the poisons code.

⁷ [Department of Health | Medical Indemnity First Principles Review and Thematic Review](#)

This would be compounded by the fact that a medical practitioner operating across a border or via electronic means, could unintentionally commit a minor infraction against a strict liability offence they did not know existed. Under the Queensland model, when they have come under police scrutiny they could then be directly referred to a National Board – regardless of whether they have charged with or committed any offence.

Finally, it is even more disappointing that there is no analysis of the work currently being done moving towards real-time prescription monitoring, that would provide a much better means of targeting medical practitioners at risk of self-prescribing and therefore likely to be at risk of harming their patients.

Australia's medical practitioners desperately need legislation that does not actively discourage doctors from seeking treatment when they need it. Doctors are already avoiding seeking treatment for their own health concerns, particularly mental health concerns, out of fear of the consequences and they and their families are suffering as a result of the current provisions of the National Law – this proposal as it stands will only exacerbate this position.

As stated previously, the AMA is disappointed with the lack of evidence and analysis in this document (as we were in 2014). If there is a problem with the current system, then the minimum standard would be that the problem was explained and then evidence about the extent of the problem produced, before any proposal could be appropriately considered. That is absolutely the case with this particular proposal.

Section 4.6: Practitioners who practise while their registration has lapsed

- 19. Should the National Law be amended to provide National Boards with the discretion to deal with a practitioner who has inadvertently practised while unregistered for a short period (and in doing so has breached the title protection or practice restriction provisions) by applying the disciplinary powers under Part 8 s. 178 rather than prosecuting the practitioner for an offence under Part 7?**

Whilst the AMA does not support individuals 'holding out' to be a practitioner without proper registration, we do recognise that there are situations in life where a practitioner may end up inadvertently practicing while unregistered for a short period. Accordingly, the AMA supports the proposal to increase the discretion of the National Boards, to use disciplinary powers in this instance rather than prosecuting the practitioner for an offence.

Section 4.7: Power to require a practitioner to renew their registration if their suspension spans a registration renewal date

20. **Should the National Law be amended to require a practitioner whose registration was suspended at one or more registration renewal dates, to apply to renew their registration when returning to practice?**
21. **Noting the current timeframes for registered practitioner's applying to renew their registration (within one month of the registration period ending) and for providing written notice to a National Board of a 'notifiable event' (within seven days), what would be a reasonable timeframe for requiring a practitioner to apply to renew their registration after returning to practice following a suspension?**

The AMA believes that the practitioner should be able to apply to renew their registration after returning following suspension straight away. If the pre-suspension registration period extends to beyond the suspension period, renewal should follow the normal process. However, the AMA believes that providing written notice to a National Board within seven days is unworkable and instead proposes a period of one month.

Section 5.1: Mandatory notifications by employers

22. **Should the National Law be amended to clarify the mandatory reporting obligations of employers to notify AHPRA when a practitioner's right to practise is withdrawn or restricted due to patient safety concerns associated with their conduct, professional performance or health? What are your reasons?**

According to the discussion paper on mandatory reporting issued by the Australian Health Ministers' Advisory Council (AHMAC) in September 2017:

Under the National Law, employers and practitioners are required to notify AHPRA if they reasonably believe a registered health practitioner has behaved in a way that constitutes "notifiable conduct". Notifiable conduct means that 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.⁸*

⁸ Australian Health Ministers' Advisory Council Discussion paper - Mandatory reporting under the Health Practitioner Regulation National Law. 12 September 2017

The AMA is unable to determine how an employer would be able to withdraw or restrict a practitioner's right to practice, due to patient safety concerns associated with their conduct, professional performance or health and NOT have triggered the mandatory reporting requirements of the National Law. The AMA suggests that this is not a problem related to the National Law but is an area that AHPRA and the Boards could target with better communication and education.

The AMA is aware that there may be instances where a practitioner is requested to withdraw from certain procedures, where their complication rates that may exceed accepted averages. This may be mutually agreeable between a practitioner and their department in the interests of patient safety, but this does not constitute a notifiable concern and does not warrant any change in the approach to mandatory notifications.

Section 5.2.1: Access to clinical records during preliminary assessment

23. Should Part 8 Division 5 of the National Law (preliminary assessment) be amended to empower practitioners and employers to provide patient and practitioner records when requested to do so by a National Board?

Management of clinical records is legally and ethically complex. In the Australian Capital Territory, New South Wales and Victoria, specific laws govern the management of medical and other practice records. In other jurisdictions, there are privacy and information management laws of general application, including the federal Australian Privacy Principles (which replaced the former National Privacy Principles on 12 March 2014). These overlapping laws mean that practitioners and employers need to comply with the Australian Privacy Principles, as well as the relevant requirements of state or territory law.

This question conflates two different issues:

- i. Should practitioners be authorised by law to provide patient records in response to a request by the National Board?
- ii. Should practitioners be required by law to provide patient records to the National Board during the preliminary assessment stage?

In both cases, changing the law would allow the National Board to access a patient's record without patient consent. Doctors have a very strong ethical obligation to protect the confidentiality of patient information. While this amendment can make life 'easier' for AHPRA and potentially for the notifier and the practitioner, that may not justify a lowering of the ethical standard by which a patient's records can be obtained without consent. The debate about My Health Record has illustrated that the public have strong views about the confidentiality of medical records and the ability of third parties to access their records without their knowledge or consent.

Option (1) is the best for doctors as it means that doctors are not required to provide the records but will not breach the Privacy Act and State/ Territory legislation if they choose to do so.

Section 5.2.2: Referral to another entity at or following preliminary assessment

24. Should Part 8 Division 5 of the National Law be amended to clarify the powers of a National Board following preliminary assessment, including a specific power to enable the National Board to refer a matter to be dealt with by another entity?

The AMA agrees that achieving good regulatory outcomes is often a co-operative effort: by the government, amongst regulators, the regulated, and the broader community. The Organisation for Economic Co-operation and Development (OECD) Best Practice Principles for Regulatory Policy state that

Governance arrangements for regulators can be important to foster such co-operative efforts and build the legitimacy of any necessary, strong enforcement action. For these reasons, governance arrangements require careful consideration to ensure they promote, rather than hinder, the efficient achievement of policy objectives and public confidence in the operations of regulatory agencies.

The AMA also supports a system that provides clarity and certainty for practitioners in terms of how their practices are governed and regulated. Best practice regulators should be underpinned by legislation, that empowers them to co-operate with other agencies and bodies in pursuit of the regulator's objectives. This should allow regulators to simplify their dealings with business and other entities through delegation, information sharing, joint regulation, and co-regulation.

The AMA supports the ability of the National Boards to have discretion to deal with an issue, in a way that applies the minimum regulatory burden, whilst meeting the objectives of the scheme.

The AMA supports the development of a detailed analysis which identifies the targeted entities and outlines appropriate co-ordination mechanisms, so the full gamut of this proposal can be appropriately evaluated by stakeholders. An amendment to the National Law that could further clarify that a National Board may, in the case of a notification about a medicolegal assessment that does not identify any performance, impairment or conduct issues, inform a court or tribunal that a notification was made and that the National Board intends to take no further action on the notification, should be considered in this more detailed process.

The AMA would expect that this analysis would specify the entities where referral from AHPRA is relevant. The AMA would also expect the development of guidance and education material so that the pathways for referral are clearly outlined to health practitioners.

Section 5.3.1: Production of documents and the privilege against self-incrimination

25. Should the provisions of the National Law about producing documents or answering questions be amended to require a person to produce self-incriminating material or give them the option to do so?

If so:

- **Should this only apply to the production of documents but not answering questions or providing information not already in existence?**
- **What protections should apply to the subsequent use of that material?**
- **Should the material be prevented from being used in criminal proceedings, civil penalty proceedings or civil proceedings?**
- **Should this protection only extend to the material directly obtained or also to anything derived from the original material?**

26. Should the provisions be retained in their current form? What are your reasons?

The privilege against self-incrimination is a basic and substantive common law right which is fundamental to the Australian legal system. The privilege only applies to individuals. Accordingly, it does not apply to employers or companies that hold relevant information.

As noted by the Australian Law Reform Commission:⁹

Although broadly referred to as the privilege against self-incrimination, the concept encompasses three distinct privileges:

- *a privilege against self-incrimination in criminal matters;*
- *a privilege against self-exposure to a civil or administrative penalty (including any monetary penalty which might be imposed by a court or an administrative authority, but excluding private civil proceedings for damages); and*
- *a privilege against self-exposure to the forfeiture of an existing right.*

A person may also choose to waive this privilege. No change to the National Law is required to effect this. One reason why a person may choose to waive privilege is because a court may choose to draw a negative inference, if a person later seeks to rely on something which they did not disclose when initially questioned.

Where a person chooses to waive privilege, the standard position is that what they say or choose to produce will be admissible in later proceedings. This provision is reflected in the uniform *Evidence Act 1995*.

⁹ <https://www.alrc.gov.au/publications/15.%20Privilege%3A%20Other%20Privileges/privilege-respect-self-incrimination-other-proceedings>

Changing this position in the National Law is likely to be confusing for practitioners and courts and lead to complex arguments about the source of particular evidence and the ability of the

court to consider it. For example, is a document admissible in later proceedings if the police obtain it from another source but only became aware of it because it was provided under the proposed exception to the National Law?

Recently the government proposed amendments to section 106B of the Health Insurance Act 1973, which had the potential to impact on practitioners' privilege against self-incrimination. The Supplemental Explanatory Memorandum noted that:

The first amendment would omit an amendment that was proposed to Part VAA of the Health Insurance Act. Section 106B deals with the power of a Professional Services Review Committee to summons a person to attend a hearing and give evidence. The AMA identified that the change may have the unintended consequence of subjecting a practitioner to both disqualification to billing Medicare and a possible criminal prosecution for failing to attend in accordance with a summons. This was not the intention of the proposal, but to avoid doubt the Government proposes removing the relevant provision.

Similarly, the AMA cannot find reasons that AHPRA and the National Boards want to remove this basic common law right and/ or create an alternative regime for admissibility of evidence.

The AMA does not support this proposal and will strongly contest its development and implementation.

Section 5.4.1: Show cause process for practitioners and students

- 27. Should the National Law be amended to enable a National Board to take action under another division following a show cause process under s. 179?**
- 28. Should the National Law be amended to provide a statutory requirement for a National Board to offer a show cause process under s. 179 in any circumstance where it proposes to take relevant action under s. 178?**

Medical practitioners who have been the subject of notifications have reported the process as being unclear, overly complex and unreasonable in the timeframes for responses. They report having difficulty obtaining clear, concise information about the nature of the notification and the particulars of the allegations against them, so they may present their case. They report being subject to lengthy investigations with unreasonable response timeframes. The AMA notes the work that AHPRA and the Medical Board has done to address these issues and improve the efficiency and reduce the negative impact of the notification process – but more can be done.

Accordingly, the AMA supports increased flexibility and clarity in dealing with practitioners who have received a notification from AHPRA. The AMA also supports AHPRA having the ability to ensure that the outcome from any notification process, is commensurate with the misconduct.

The AMA supports these proposals on the assumption they will be used to increase the efficiency of the process for practitioners and reduce their duration, stress and mental anguish. But the AMA also supports a practitioners' right to appeal or at the very least access a show cause process for each major step undertaken in the notification process.

Section 5.4.2: Discretion not to refer a matter to a tribunal

- 29. Should the National Law be amended to empower a National Board to decide not to refer a matter to the responsible tribunal for hearing when the board reasonably forms the view that there are no serious ongoing risks to the public? If not, why? If so, then why and what constraints should be placed on the exercise of such discretion?**

Because an investigation can affect the ongoing practice of the doctor, and their livelihood, inquiry by the Medical Board is stressful for the medical practitioner. The AMA has supported increased transparency and efficiency throughout the notifications processes since the NRAS was established. Responding to demands for documentation is time consuming and can be stressful when the practitioner is not confident that they are appropriately satisfying the demand.

Accordingly, the AMA supports the proposal for the National Law to be amended to empower a National Board to decide not to refer a matter to tribunal for hearing. The AMA believes that this is a common-sense approach where there are no ongoing risks to the public. The AMA calls on AHPRA to develop the guidelines that would support this discretionary power in consultation with practitioners.

Section 5.4.3: Settlement by agreement between the parties

- 30. Should the National Law be amended to provide flexibility for National Boards to settle a matter by agreement between the practitioner, the notifier and the board where any public risks identified in the notification are adequately addressed and the parties are agreeable? What are your reasons?**

The National Law provides for the establishment of a regulatory scheme for health practitioners. It does not, nor ever was intended to establish a complaint handling mechanism whereby members of the public can have their complaints resolved. The AMA is firmly of the belief that the activities of the regulator should remain within the scope defined by the legislation and that taking on the position of the dispute resolver with members of the public is problematic.

According to OECD best practice regulatory principles¹⁰, role clarity is required to achieve effectiveness in regulating. Clear objectives are needed to promote trust and transparent relationships between the regulator, and in this case, health practitioners. Attempting to marry the roles of health complaints ombudsman and regulator will undermine effectiveness and reduce trust to the detriment of the scheme.

¹⁰ OECD Best Practice Principles for Regulatory Policy: The Governance of Regulators 2014

If AHPRA and the Boards were required to take on the role of complaints handler, this could lead to a change in the role of the notifier to one of complainant, could result in an increase in advocacy for the notifier/complainant which would lead to a heightened the perception that the system is biased against practitioners.

Section 5.4.4: Public statements and warnings

- 31. Should the National Law be amended to empower a National Board/AHPRA to issue a public statement or warning with respect to risks to the public identified in the course of exercising its regulatory powers under the National Law? What are your reasons?**
- 32. If public statement and warning powers were to be introduced, should these powers be subject to a 'show cause' process before a public statement or warning is issued? What are your reasons?**

The AMA does not support this proposal. Again, the AMA finds this section of the document lacking in evidence and analysis concerning any problem that exists. This makes it impossible to provide considered discussion.

However, on the limited discussion provided in the consultation document, the AMA does not support any changes. The example provided on p50 resulted in the practitioner being referred to the police and when a warrant was executed at the practitioner's premises, this attracted significant media attention, ensuring that the public was fully informed, even before guilt was determined.

The AMA does not support the Medical Board or AHPRA being able to issue a public warning before a tribunal has completed its actions. To do so would imply guilt and is likely to ruin a practitioner's reputation. A public warning is a severe and non-retractable step and should be undertaken only after a health practitioner has been shown to have breached a code of conduct or convicted of a relevant offence. Under the current circumstances the Medical Board is able to issue a media statement at the conclusion of the tribunal process, which the AMA believes is entirely appropriate especially in the absence of evidence that this system is not working.

Section 5.5.1: Power to disclose details of chaperone conditions

- 33. Should the National Law be amended to empower a National Board to require a practitioner to disclose to their patients/clients the reasons for a chaperone requirement imposed on their registration? What are your reasons?**

The AMA sees this as a particularly important issue as it impacts on a medical practitioner's privacy. The benefit to patients/clients in being made aware of the reasons why a practitioner requires a chaperone, must significantly outweigh a doctor's right to keep that information private. Additionally, providing this information to patients may reduce the quality of the patient-doctor relationship and impact negatively on health outcomes.

This is more important where a chaperone is being used as an interim measure and there is no proven finding against the medical practitioner in question.

34. Should the National Law be amended to provide powers for a National Board to brief chaperones as to the reasons for the chaperone? What are your reasons?

The AMA supported the recommendations of the *Independent review of the use of chaperones to protect patients in Australia* (the Paterson review) which was published in February 2017. This included the recommendation that chaperones should be fully informed about the nature of the allegations against the practitioner, what their role is and what behaviour they should be watching for.

However, the AMA does not believe that further changes are required to the National Law and believes this is already adequately dealt with in policy.

Section 5.5.2: Power to give notice to a practitioner's former employer

35. Should the National Law be amended to enable a National Board to obtain details of previous employers and to disclose to a practitioner's previous employer(s) changes to the practitioner's registration status where there is reasonable belief that the practitioner's practice may have exposed people to risk of harm? If not, why? If yes, then why and what timeframe should apply for the exercise of these notice powers?

This is another area where there needs to be evidence presented regarding a case for change to the NRAS. The consultation document states:

AHPRA has advised that, on occasion, an investigation reveals that a practitioner, through successive workplaces, has engaged in conduct that has placed patients at serious risk¹¹.

But there is no further information about the real number or impact of the 'occasions' AHPRA believes that a power to inform previous employers may be helpful. There is absolutely no evidence supplied to extend this burden to contract, voluntary and honorary arrangements.

Accordingly, the AMA does not support this proposal in the absence of an appropriate business case, evidence or analysis.

¹¹ [Consultation paper: Regulation of Australia's health professions: keeping the National Law up to date and fit for purpose October 2018](#) p52

Section 5.6.1: Right of appeal of a caution

36. Should the National Law be amended to enable a right of appeal against a decision by a National Board to issue a caution?

The AMA has previously called on the Tranche 2 amendments process to consider adding a provision for a practitioner to seek independent review of a decision by the Medical Board to issue a caution. This is because:

- A caution can have a significant negative detrimental effect on a practitioner's career; and
- The civil, criminal and administrative legal systems in Australia generally provide avenues for appeal for decisions that have serious economic or personal consequences on individuals.

The AMA understands that the policy rationale for not allowing practitioners to “appeal” cautions is that they are not listed on the public record. However, in the AMA's experience all cautions, regardless of how “minor” or “trivial”, need to be declared to any current or future employer/credentialing hospital. In a competitive market this can have serious ongoing professional and financial implications to medical practitioners.

In addition, cautions do not appear to be removed from the practitioner's record as a matter of course. They can also attract significant media attention. The AMA fully supports this proposal and will continue to work to see it implemented.

37. Which would be your preferred option?

Option 3 – to amend the National Law into include caution as an appellable decision.

The AMA also believes that any right of appeal should not be subject to any charge to the health practitioner who have already paid for the scheme through their registration fees.

Section 5.6.2: The rights of review of notifiers

- 38. Should the National Law be amended to provide a right for a notifier (complainant) to seek a merits review of certain disciplinary decisions of a National Board? What are your reasons?**
- 39. Which would be your preferred option?**
- 40. If yes, which decisions should be reviewable and who should hear such appeals, for example, an internal panel convened by AHPRA or the National Health Practitioner Ombudsman and Privacy Commissioner, or some other entity?**

Under the NRAS, the Medical Board sets standards for the practice of medicine and regulates the practice of individuals who are found to have departed from those standards.

The process of receiving notifications ensures that departures from practice are brought to the attention of the Medical Board, which then acts as appropriate but with a view to keeping medical practitioners in the workforce, by remediating their practice, perhaps with appropriate supervision until the practitioner can again practice independently. The Medical Board acts to protect the broader public from harm, not to resolve individual grievances.

The AMA is firmly of the belief that as a health practitioner regulatory scheme, it must be confined to regulating the practice of health practitioners in this way.

It should not seek to offer consumers a resolution for their individual matter, or a punitive solution, such as removing a practitioner from practice so “it never happens to anyone again”.

This is what distinguishes a regulatory scheme from a health care complaints process. Consumers can have their grievance heard and seek a resolution to their particular circumstance, via internal complaints processes (required for accreditation of health service providers) and state-based Health Complaints Entities or Commissioners.

Section 6.1: Title protection: surgeons and cosmetic surgeons

- 41. Should the National Law be amended to restrict the use of the title ‘cosmetic surgeon’? If not, why? If so, why and which practitioners should be able to use this title?**
- 42. Should the National Law be amended to restrict the use of the title ‘surgeon’? if not, why? If so, why and which practitioners should be able to use such titles?**

The process for recognition of medical specialties is not the same as recognition of non-medical specialties. For medicine, the Australian Medical Council (AMC) accredits education and training programs for medical specialties according to world leading standards. Given that the accreditation bodies for the other health professions are relatively young (most having been set up at the time the national scheme commenced) they are yet to mature to the extent that they can now recommend specialties for their respective practitioner groups.

Accordingly, the AMA supports the proposal to protect the title of surgeon. In particular the AMA does not support the use of the title podiatric surgeon as such practitioners are not registered with the Medical Board of Australia, have only limited access to Medicare and cannot claim rebates for surgical services. For similar reasons the AMA does not support the title Cosmetic Surgeon as the practitioner is not recognised as a surgical specialist under current recognition arrangements and does not commensurate training and experience that identifies current surgeons. Patients should not be misled by the term ‘cosmetic surgeon’ into believing they are dealing with a practitioner who has formal surgical qualifications when they do not.

The AMA supports the AMC as the accreditation authority for the medical profession, including setting standards for medical education and training, and in its role of providing advice on the recognition of new and amended specialties under the National Law. The title surgeon (in human health care) should be reserved for medical practitioners who have obtained a Fellowship of an AMC accredited specialist medical college whose training program includes a surgical component relevant to their field of expertise.”

The AMA agrees that specialist fields can be supported further with regulation that better reflects a medical practitioner’s scope of practice, ensuring minimum standards are met and patients receive quality care and are kept safe. Accordingly, the AMA supports changing the National Law making it mandatory for a health practitioner to only use a title that is identical with their AHPRA category of registration.

Section 6.2: Direct or incite offences

- 43. Are the current provisions of the National Law sufficient to equip regulators to deal with corporate directors or managers to direct or incite their registered health practitioner employees to practice in ways that would constitute unprofessional conduct or professional misconduct?**
- 44. Are the penalties sufficient for this type of conduct? Should the penalties be increased to \$60,000 for an individual and \$120,000 for a body corporate, in line with the increased penalties for other offences?**
- 45. Should there be provision in the National Law for a register of people convicted of a ‘direct or incite’ offence, which would include publishing the names of those convicted of such offences?**
- 46. Should the National Law be amended to provide powers to prohibit a person who has been convicted of a ‘direct or incite’ offence from running a business that provides a specified health service or any health service?**

The AMA does not understand what problem if any this section is proposing to address. There is no evidence the AMA is aware of that similar powers held at the state level have been used recently, nor have any cases been put forward to support a need for such provision. The AMA also believes that, for medical practitioners, the proposed offences fall under the aegis of the

Professional Services Review (PSR). The legislation governing the PSR has recently been amended and will come into effect on 1 July 2019. The amendments will:

introduce fairer approaches to address corporate billing reflecting the reality that large practices, corporations and hospitals increasingly undertake billing on behalf of individual practitioners and should share responsibility if that billing is incorrect¹².

Given the financial aspect has been dealt with via amending the legislation governing the PSR, with AMA support, the issues outlined in the consultation document appear to have already been addressed.

But the AMA does not support undue influence/pressure being exerted on medical practitioners, especially early career doctors. Medical practitioners need to operate free from any coercion and in the best interests of their patients. The AMA is happy to work with AHPRA on identifying the issues further and working out how they can be addressed in order to protect the practitioners.

Section 6.3.1: Prohibiting testimonials in advertising

- 47. Is the prohibition on testimonials still needed in the context of the internet and social media? Should it be modified in some way, and if so, in what way? If not, why?**
- 48. Which would be your preferred option?**

The AMA does not believe the prohibition on testimonials should be changed at this point. The AMA does not believe these issues are adequately policed by AHPRA creating a disproportionate outcome for practitioners who strive to obey the exact letter of the current regulations.

The AMA believes it is important, that the current practice whereby health practitioners are not held liable for unsolicited testimonials on social media sites out of their control is maintained.

The AMA does believe that the area of testimonials and the use of social media is an area that should be monitored vigilantly, as changes in technology and use are likely to continue to impact in this area in the foreseeable future. In particular, the AMA would like to see more work done by AHPRA to address the issues raised previously by the AMA regarding 'third party' website testimonials.

¹² [Health Legislation Amendment \(Improved Medicare Compliance and Other Measures\) Bill 2018](#)

Section 6.3.2: Penalties for advertising offences

- 49. Is the monetary penalty for advertising offences set at an appropriate level given other offences under the National Law and community expectations about the seriousness of the offending behaviour?**

Again, there is little background information provided in order to be able to make an informed decision. The AMA would like to understand how often these provisions are currently used and for what type of offences. In the absence of this information, the AMA does not see how a rise from \$5,000 for an individual and \$10,000 for a body corporate, to \$60,000 for an individual and \$120,000 for a body corporate can be justified.

The consultation paper notes that the penalties for advertising offences in the National Law, are much lower than penalties for false or misleading advertising that apply under the Australian Consumer Law¹³. However, the current National Law amounts are comparable with the fines imposed under the Australian Regulatory Guidelines for Advertising Therapeutic Goods, which in 2017-18 will result in fines of \$2,520 for an individual and \$12,600 for an incorporated body for non-compliant advertising¹⁴.

In the absence of evidence that would support change, the AMA supports maintaining the penalties at their current levels (status quo) but is happy to discuss this issue further.

Section 7.1: Information on the public register

- 50. Is the range of practitioner information and the presentation of this information sufficient for the various user groups?**
- 51. Should the National Law be amended to expand the type of information recorded on the national registers and specialist registers?**
- 52. What additional information do you think should be available on the public register? Why?**

The primary objective of the National Law is to establish a national registration and accreditation scheme for the regulation of health practitioners and students. The AMA acknowledges that the objectives also allow for the scheme to, “facilitate access to services provided by health practitioners in accordance with the public interest”. The use of the register to inform the public about:

¹³ [Regulation of Australia’s health professions: keeping the National Law up to date and fit for purpose. A consultation paper 2018](#) p 62

¹⁴ [Australian Regulatory Guidelines for Advertising Therapeutic Goods \(ARGATG\). Guidance for advertisers. 1 July 2018](#)

- *safety – to protect the public by allowing consumers to check that a practitioner is registered, whether they have conditions on their registration and whether they are complying with those conditions;*
- *planning – to provide data for workforce planning purposes for public authorities and employers;*
- *locating a practitioner or specialist in their area;*
- *confirming a practitioner’s qualifications, including specialist qualifications; or*
- *checking whether there are any conditions or restrictions on the practitioner’s registration (to be in a position to check whether they are complying with those conditions)¹⁵.*

fits within this primary objective.

However, the consultation paper also canvasses the ability for the register to be expanded to be used by consumers for:

- *choice – to provide information to consumers to assist them to make informed decisions about locating and choosing a practitioner;*
- *quality – to inform and educate consumers and health service providers about the standard of practice achieved by registered practitioners with different types of registration;*
- *service delivery – to serve as a master index for use in e-health systems;*
- *locating a practitioner in another area or state – for example, on behalf of an elderly or sick relative or friend*
- *locating a particular type of practitioner – for example, a practitioner of a particular gender or one who speaks a language other than English.*

There is very real potential for this proposal to have unintended harmful impacts. A number of professional bodies and private providers already run their own directories which would be rivalled by an expanded NRAS register. Further, how would AHPRA manage the unfair prioritisation that would come about no matter how such a register would be organised (i.e. alphabetically etc.).

The AMA also argues that as the scheme is funded by health practitioners, this money should be used to streamline and improve the NRAS processes, reducing mental health impact on health practitioners first and foremost. The limited funding pool of AHPRA should not be diverted to funding the development of a complex information register of dubious benefit, to suit the desires of consumers (especially when this is already being carried out by the private sector). If Health Ministers’ want AHPRA to develop a register aimed at satisfying consumer interests – this should be funded from the public purse, not by practitioners.

¹⁵ [Regulation of Australia’s health professions: keeping the National Law up to date and fit for purpose. A consultation paper 2018 p65](#)

It is entirely inappropriate for the regulator to be engaged in work that is already being done by the private sector. This work should be left to the specialist organisations and the market – where it is already currently being addressed.

53. Do you think details, such as a practitioner’s disciplinary history including disciplinary findings of other regulators, bail conditions and criminal charges and convictions, should be recorded on the public register? If not, why not? If so:

- **What details should be recorded?**
- **What level of information should be accessible?**
- **What should be the threshold for publishing disciplinary information and for removing information from a published disciplinary history?**

The AMA has been very vocal regarding its concern about the potential for medical practitioners to suffer discrimination as a result of being named in a previous tribunal proceeding, particularly where:

- There was no finding against the practitioner;
- The issue was relatively minor;
- The issue occurred some years ago;
- The medical practitioner or their practice complied with the tribunal’s recommendations; and
- Other safeguards have been introduced to protect patients.

The AMA was relieved when the Medical Board announced that it would remove the entirely unfair provision to link tribunal proceedings, where there was NO finding against the practitioner. But this one change does not address the rest of the issues.

In many cases the public will not read the linked information, but will assume that, because it has been linked by a reputable regulatory body, it is serious and of ongoing relevance.

The AMA finds it difficult to comprehend that medical practitioners, who are named in a tribunal procedure, are offered less protection from discrimination than a person who has served a prison term. For example, Commonwealth spent convictions legislation, prohibits republication of information about persons who have been convicted of no more than 30 months imprisonment. And yet, medical practitioners who have committed a minor transgression (even when they have taken steps to ensure the issue can never occur again), will have links to the disciplinary process listed against them in perpetuity. This is palpably unfair – especially when this standard is not applied to other professional groups.

The AMA also believes that this move is counterproductive to the broader work being carried out by AHPRA and the Medical Board. This work aims:

- To minimise the stress and stigma for doctors receiving a notification;
- Understand and address the impact of vexatious complaints on practitioners; and
- Balance the critical rights of a patient while still being mindful of the potential negative effects on a doctor's mental wellbeing.

The AMA calls on this consultation process to seriously reconsider this unfair and entirely punitive position. The AMA is strongly of the view that the concerns of the Medical Board regarding transparency and public confidence in the regulator, must be balanced carefully against the negative stigma and stress which result from having unwarranted practitioner tribunal results listed in perpetuity.

The AMA believes that this issue will have substantial negative impacts on medical practitioners and strongly opposes any such amendment. We will continue to ensure the well-being of our members remains the utmost priority.

54. Should s. 226 of the National Law be amended to:

- 1) broaden the grounds for an application to suppress information beyond serious risk to the health or safety of the registered practitioner?**
- 2) require or empower a National Board to remove from the public register the employment details (principal place of practice) of a practitioner in cases of domestic and family violence?**
- 3) enable National Boards not to record information on, or remove information from, the public register where a party other than the registered health practitioner may be adversely affected?**

The AMA supports this initiative.

Section 7.2: Use of aliases by registered practitioners

- 55. Should the National Law be amended to provide AHPRA with the power to record on the public registers additional names or aliases under which a practitioner offers regulated health services to the public?**
- 56. Should the public registers be searchable by alias names?**
- 57. Should the National Law be amended to require a practitioner to advise AHPRA of any aliases that they use?**
- 58. If aliases are to be recorded on the register, should there be provision for a practitioner to request the removal or suppression of an alias from the public register? If so, what reasons could the board consider for an alias to be removed from or suppressed on the public register?**

- 59. Should there be a power to record an alias on the public register without a practitioner's consent if AHPRA becomes aware by any means that the practitioner is using another name and it is considered in the public interest for this information to be published?**

The AMA understands that there are medical practitioners, that for a range of benign reasons, adopt a different name to their birth certificate or the public register. The AMA supports the recognition that there are legitimate reasons for this and therefore, supports the proposed use of aliases in these instances.

The AMA does acknowledge that health practitioners could potentially attempt to use an alias to hide previous convictions, or disciplinary actions imposed by a National Board or other body with similar standing. The AMA does not support this use and believes that the AHPRA should have the ability to take appropriate action to prevent such actions.

Section 7.3: Power to disclose identifying information about unregistered practitioners to employers

- 60. Should the National Law be amended to enable a National Board/AHPRA to disclose information to an unregistered person's employer if, on investigation, a risk to public safety is identified? What are your reasons**

The AMA is supportive of this proposal. The AMA believes that for the most part unregistered people are likely to be a risk to public safety would be expected not to have appropriate medical qualifications (and some may have no qualifications). The AMA does not support any person 'holding out' to be a medical practitioner and therefore does not oppose their employer being informed of the person's registration status.

Additional Issues

Vexatious complaints

A vexatious complaint has the power to hurt and disrupt another person's life in such a way that their career can be torn to shreds and may result in psychological injury¹⁶.

The AMA has long received anecdotal information regarding vexatious complaints, that is health practitioners lodging a complaint against another health practitioner for personal or professional gain, or to bully another practitioner. The AMA welcomed the research released by AHPRA earlier this year, as it provided the first Australian academic research on this topic.

The AMA also welcomed the finding of the report that;

The report found that the number of vexatious complaints dealt with in Australia and internationally is very small, less than one percent, but they have a big effect on everyone involved¹⁷.

Last year AHPRA received 11,009 notifications¹⁸. Even at a figure of less than one percent that is around 100 health practitioners per year that could be the recipient of a complaint that “is groundless and made with the intent of causing distress or harm to the subject of the complaint” Associate Professor Bismark¹⁹.

The AMA understands that the Medical Board has taken on board the outcomes of this report and the focus placed on vexatious complaints by the Senate Committee, as part of the Senate Community Affairs References Committee for inquiry and report - *The complaints mechanism administered under the Health Practitioner Regulation National Law*²⁰.

The AMA has called on AHPRA and the Medical Board to increase the effectiveness and efficiency of triaging of complaints and notifications across the NRAS, but particularly with an aim of increasing ‘vetting’ of vexatious complaints.

The AMA welcomes the inclusion of a new section on vexatious complaints in the recently released *Draft revised Good medical practice: A code of conduct for doctors in Australia*²¹ but calls on the Medical Board to ensure that a strong focus is directed to removing these malicious and damaging complaints from the system as quickly as possible.

¹⁶ [Vexatious Bullying Complaints are Workplace Harassment - iHR Australia](#)

¹⁷ [Australian Health Practitioner Regulation Agency - Vexing not vexatious: Report finds more risk in not reporting](#)

¹⁸ [Australian Health Practitioner Regulation Agency - AHPRA in Numbers](#)

¹⁹ [Australian Health Practitioner Regulation Agency - Vexing not vexatious: Report finds more risk in not reporting](#)

²⁰ [Complaints mechanism administered under the Health Practitioner Regulation National Law – Parliament of Australia](#)

²¹ [Draft revised Good medical practice: A code of conduct for doctors in Australia](#)

Notification Process

The AMA has always called for improvements in the notification process and notes with concern that the last annual report stated:

AHPRA and the National Boards aim to have no more than 15% of investigations open for longer than 12 months. At 30 June 2017, 25.5% of investigations exceeded 12 months, up from 20% the previous year. Strategies to improve these results are being refined.

The AMA believes these results are unacceptable.

We have supported the development of a triaging process being trialled by AHPRA and the MBA and call on this to be fully supported and rolled out across Australia as soon as practicable. We have also supported the work done by AHPRA and the MBA to increase early clinical input and therefore close notifications where there is little substance in an expeditious manner.

But this is not being reflected in the timelines facing practitioners. The average time to close matters in assessment increased from 82 days in 2015/16 to 84 days in 2016/17. Whilst the time taken to complete assessment and move to another stage increased from 48 days to 51 in the same period. Considering the negative impact this has on health practitioner well being and mental health, the AMA does not understand how completing these processes more efficiently has not been a key priority of the NRAS.

The AMA again points out that this review provided an opportunity to really evaluate the effectiveness of the NRAS, to examine how these core processes and timeframes could be substantially improved. In the absence of any analysis of the effectiveness of the scheme, using the significant wealth of case information that would now be available – we believe this opportunity has been squandered.

Medical Board Professional Performance Framework (which includes health checks for doctors aged over 70).

The AMA has supported the progressive implementation of the Medical Board's Professional Performance Framework, including the continuing professional development largely in place, but other also other components, such as a regular review of doctors aged 70 and over, needing further consultation and development.

The AMA has specifically supported the Medical Board in its decision to commission clinical advice on what constitutes a practical and effective health check, for doctors aged 70 years and over to ensure this is an evidence-based approach. The AMA also supports the Medical Board's final position that the outcomes of this check should not be reported unless there is an issue of significant concern. The AMA looks forward to working with the Medical Board to ensure that the proposed health and screening checks are evidence based and implemented in a way that guarantees they are fair and consistent and not overly onerous.

Mandatory Reporting

The 2017 AMA National Conference were unanimous in their request to have the mandatory reporting requirements under the National Law amended, so as to not dissuade medical practitioners from seeking necessary medical treatment or assistance.

It is well known that doctors are at greater risk of suicidal ideation and death by suicide. In the time this issue under the National Law has been debated we have lost more colleagues to suicide - a situation that the AMA finds unacceptable.

While there are a wide range of factors involved in suicide, we know that early intervention is critical to avoiding these tragic losses. Unfortunately, the reality is that there are significant barriers, real and perceived, that prevent some doctors from seeking access to formal healthcare. The AMA is committed to changing this situation and is currently working with the Medical Board to establish accessible and robust doctors' health services across the country.

But as stated publicly on many occasions, one of the key barriers that the AMA has identified to accessing care is mandatory reporting. Mandatory reporting for doctors was introduced in NSW in 2008 and then into the National Law for all practitioners in 2010. The intention of the legislation was to ensure the protection of the public by requiring doctors (and other health practitioners) to report colleagues under defined circumstances. The legislation intentionally created a very significant bar for reporting in recognition that only matters of grave significance should be reported to the regulator.

One of the requirements for mandatory reporting is to report on health and impairment. This obligation applies to both colleagues and treating doctors. The AMA, medical colleges and the medical defence organisations have been concerned for some time that this provision creates a barrier to health professionals in accessing healthcare, particularly in relation to mental illness. The lived experience of doctors' health advisory services across the country confirms these fears.

An extensive study of over 12,000 doctors undertaken by Beyondblue in 2013 revealed that one of the most common barriers to seeking treatment for a mental health condition were concerns about the impact of this on medical registration (34.3%).

The Western Australian Government recognised this concern and after dogged, persistent and forceful representation from AMA (WA) over many months created a provision in their legislation to exempt treating practitioners from the requirements of the Act.

While it has been difficult to collect clear evidence of the impact of the mandatory reporting provisions on doctors seeking treatment, the AMA, doctors' health services, medical colleges and the medical defence organisations receive feedback from doctors regarding their fears about seeking medical treatment. It is very clear that some doctors are actively avoiding medical care where possible out of fear of the mandatory reporting obligations.

The Western Australian exemption has not made a material difference to the rate of mandatory notifications in that jurisdiction. The Independent Review of the National Registration and Accreditation Scheme for health professions commissioned by the COAG Health Council in 2014 listened to the concerns of the medical profession and other groups, recommending that the National Law to be amended to reflect the same mandatory notification exemptions for treating practitioners established in the Western Australian law.

As health practitioners, we know the dangers of delaying access to medical treatment or of only providing limited information. This risk is particularly pronounced with mental illness where delaying treatment can result in a person ending up with a far greater level of impairment. As such, we believe the current legislative arrangements are not protecting health practitioners and, equally importantly, they are failing to protect the public.

The AMA has called for the expansion of the exemption under the WA law, or the 'WA lite' to the National Law and does so again in this, the 2018 review of the National Law.

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