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By email: nras.review@health.vic.gov.au

Dear Mr Snowball

National Registration and Accreditation Scheme

Thank you for the opportunity to provide a submission in relation to National Registration and Accreditation Scheme. The *Review of the National Registration and Accreditation Scheme for health professions: Consultation paper August 2014* (the ‘Consultation Paper’) seeks feedback from stakeholders in relation to a number of issues detailed below.

Established in 1925, MDA National is one of Australia’s leading providers of medical defence and Medico-Legal advocacy services. With over 25,000 members, it works in close partnership with the medical profession on a wide range of issues which have the potential to adversely impact upon the practice of our Members, and the medical profession as a whole. In addition to its advocacy and advisory services, MDA National’s insurance subsidiary (MDA National Insurance) offers insurance policies to MDA National’s members which provide cover for the cost of investigations of professional misconduct and for claims for compensation by third parties. The MDA National insurance policy provides medical practitioners with $20 million of civil liability cover as well as a range of other professional risk covers.

MDA National supports the National Scheme however; we have significant concerns regarding a number of issues primarily revolving around the timeliness, delays and lack of consistency in relation to the approach taken at the assessment phase of a notification and the outcomes of investigations. This lack of consistency can result in the profession losing confidence and a perception that they are not being accorded procedural fairness.

**Complaints and notifications**

The Consultation Paper seeks feedback on a number of issues regarding the handling of complaints and notifications focusing on inadequate communication and responsiveness, time delays and lack of transparency and accountability.

‘Information made available on the public register’: MDA National would strongly oppose any endeavour to include historical disciplinary information on the public register. Once registrants have been disciplined and have discharged the requirements of any disciplinary action taken, they have done what is necessary to
remediate and return to practice. The prejudice of having historical disciplinary action recorded would far outweigh any genuine public disclosure argument based on informed decisions and public protection.

In Queensland in relation to impaired registrants, the approach taken is to usually record the fact that undertakings have been given or conditions imposed but not include the details thereof on the public register. As it is often a term of the undertaking or condition that an employer be notified of the undertaking/condition, we would submit that any recording of the existence of the undertaking/condition on the public register is unnecessary and, in the interests of privacy, should be removed.

MDA National supports the introduction of KPIs for particular purposes accompanied by published performance data. The data should be published in a form that would identify issues in each jurisdiction.

11. Should there be a single entry point for complaints and notifications in each State and territory?
MDA National supports a ‘single point of entry’ for lodgement of all complaints/notifications we maintain this would is definitely a positive approach, this has the potential to reduce confusion for the consumer/complainant/notifier, but also from the perspective of reducing duplication (for example, registrants under previous processes in Queensland were often required to provide multiple responses (ie to different agencies) in respect of the same circumstances).

12. Should performance measures and prescribed time frames for dealing with complaints and notifications be adopted nationally?
Yes, MDA National submits that is essential that there be national consistency in relation to complaints and notifications there should be statutory prescribed timeframes for particular processes and mandatory conditions that must be satisfied to extend a statutory timeframe. The time frames must be realistic. By way of contrast, many of the timeframes in the Health Ombudsman Act 2013 QLD are simply too short to be consistently met.

13. Is there sufficient transparency for the public and for notifiers about the process and outcomes of disciplinary processes?
MDA National does not consider that it is the role of AHPRA to appease notifiers and the public. AHPRA is responsible for regulating the health professions. The primary role of the National Boards is to protect the public and set standards and policies that all registered health practitioners must meet.

MDA National does not support any proposal to permit increased communication to complainants/notifiers regarding out comes at the discretion of the AHPRA staff. We submit that the only information that could be provided to a notifier is that which is available on the National Board’s register. A complainant/notifier may have an agenda of their own which is unrelated to the regulatory process. In these circumstances the provision of any additional information to the complainant/notifier could cause considerable detriment to a registrant. We submit that the current approach by AHPRA staff to ask a registrant’s consent to disclose their submission and or further details of an investigation or outcome enables disclosure of information to occur where the motivation is genuine and constructive.
14. Should there be more flexible powers for National Boards to adopt alternative dispute resolution, for instance to settle matters by consent between the Board, the practitioner and the notifier?
MDA National strongly supports the use of Alternative Dispute Resolution processes.

15. At what point should an adverse finding and the associated intervention be recorded against a practitioner be removed?
MDA National does not consider that a prescribed period of time should be imposed the maximum time should be one year.

**Mandatory notifications**

Notifiable conduct is defined in s 140 of the National Law and means 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.

‘Impairment’ is defined in s 5 of the National Law as a person who has ‘a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect the person’s capacity to practice the profession’.

Exemptions to the requirement to report colleagues are provided to practitioners who are:
- employed or otherwise engaged by a professional indemnity insurer; or
- a member of a quality assurance committee, council or other body approved or authorised under an Act, and unable to disclose the information because the Act prohibits disclosure.

Also, in Western Australia only, practitioners are exempted from the reporting requirements in the course of providing health services to other health practitioners or students under s 141(4) (da) of the National Law.

In Queensland practitioners are not required to make a mandatory notification when their reasonable belief is formed as a result of providing a health service to a health practitioner, where the practitioner providing the service reasonably believes that the notifiable conduct relates to an impairment which will not place the public at substantial risk of harm and is not professional misconduct. It is important to note that the Queensland legislative amendment to the National Law does not actually represent any change from the existing requirements under the National Law. The National Law requires reporting of impairment only when the practitioner’s practice of the profession has placed the public at risk of substantial harm. Therefore, the wording of the exemption in Queensland with respect to impairment simply mirrors the current requirements under the National Law.
The Consultation Paper summarises the data on mandatory notifications published in the AHPRA Annual Report 2012/13. In view of the small number of reports, it is difficult to identify if any of the variation in the rate of mandatory reports between states and from the previous AHPRA Annual Report 2011/12 are of any significance. Indeed, in the absence of any information about the rates of reporting of practitioners prior to the introduction of the National Registration and Accreditation Scheme it is not possible to identify if the legislation has introduced significant change. Unfortunately, the Annual Report does not indicate the percentage of reports which have been made by treating doctors. However a recent study published in the Medical Journal of Australia involving a retrospective review of health practitioners reported to AHPRA between 1 November 2011 and 31 December 2012 revealed that 8% of the mandatory notifications were made by treating practitioners. Again, there is no further analysis of this data to indicate if there are variations in the rates between Western Australia and other states.

Of concern to MDA National is the fact that in 55% of the mandatory notification cases closed in 2012/13 (and 59% of cases in 2011/12), the relevant Board determined that no further action was required. This suggests that the mandatory reports that have been made were not appropriate in that they did not meet the high threshold for mandatory notification, where the public was being placed at substantial risk of harm. In view of the high threshold for reports, it would be expected that there would have been further action taken by the relevant Board in all of these cases.

MDA National’s anecdotal experience has been that many doctors who are suffering from a mental health condition, such as depression or anxiety, are very reluctant to seek their own treatment for fear of being reported to the board and potentially losing their ability to practise. This is of particular concern to junior doctors and doctors who are seeking employment or entry to a training scheme because any conditions on their medical registration means that they are less likely to be offered employment or training in the increasingly competitive employment market for medical practitioners. In one case, a severely depressed patient, who was a proceduralist medical practitioner, was reported to AHPRA by his psychiatrist, despite the doctor having already stopped work due to his illness. The patient then discontinued his treatment with the reporting psychiatrist and refused to seek specialist care from another psychiatrist, culminating in the doctor’s death by suicide. The therapeutic relationship breakdown which occurred as a result of the breach of confidentiality and trust between the treating doctor and doctor-patient in this situation is understandable. Another severely depressed doctor hid his illness and did not seek medical care and treatment, citing his fear of mandatory reporting in his suicide note. It is of great concern that a profession that is dedicated to providing the best possible medical care to others may then be deprived of this same care because of their fear of being reported and losing their ability to work if they become unwell.

It is extremely difficult to alleviate a doctor’s concern that they will be reported if they divulge their symptoms and fears to their treating doctor, especially if they are impaired. The legislation creates a punitive atmosphere that fosters a culture of fear. Changing these perceptions and behaviours is not easily achieved, especially in the absence of the Western Australia exemptions for treating doctors.

MDA National’s anecdotal experience is echoed by the findings of beyondblue’s National Mental Health Survey of Doctors and Medical Students October 2013 which found that stigmatising attitudes regarding the
competence of doctors with mental health conditions and their opportunities for career progression persist in the medical community. The most commonly identified reason for doctors being unwilling to seek treatment for depression or anxiety was fear of lack of confidentiality or concerns about privacy (52.5%). The third most common barrier to seeking treatment was the impact on registration and right to practice, reported by a further 34.3% of the doctors.

The Consultation Paper states that mandatory reporting obligations are a 'common feature of many international regulatory regimes'. However, it is MDA National's understanding that few other overseas jurisdictions have introduced mandatory notification requirements. Limited mandatory reporting exists in some areas of Canada and only seven states in the US.\(^1\) The United Kingdom has no mandatory reporting requirements and is instead introducing a five year cycle of revalidation for medical practitioners, by peer and public review, as a means of ensuring professional competence.

The Consultation Paper seeks feedback from stakeholders on the effectiveness of the mandatory reporting provisions in meeting the objectives of the National Scheme. Further, the Consultation Paper asks if having inconsistencies in provisions across jurisdictions is a problem and, if so, what are the impacts of this.

The Consultation Paper outlines the options for mandatory notification as follows:
1. maintain the current arrangements across Western Australia, Queensland and other jurisdictions;
2. amend the National Law to include provisions similar to those in WA or Queensland that provide an exemption for treating practitioners.

MDA National submit that Option 2 is the most appropriate course of action. The Western Australian legislative amendment for treating practitioners should be introduced across Australia to minimise the perception (and, at times, the reality) that medical practitioners should be fearful of seeking their own health care. Importantly, this will also bring consistency in the National Law across Australia and make it a genuinely National Scheme.

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

MDA National strongly supports the Western Australian legislative amendments to the National Law in relation to the mandatory reporting provisions. The provision in Queensland should not be adopted.

Public protection-protected practice, advertising, cosmetic procedures and a national code of conduct

Advertising
The use of advertising is a recognised part of a business' strategy. Its purpose is to attract customers to either buy a product or a service. The advertising of healthcare services is governed by the National Law, Competition and Consumer Act 2010 and relevant state and territory legislation. AHPRA / National Boards

have produced Guidelines for Advertising Regulated Health Services ("The Guidelines") as well as a Social Media Policy to provide a framework for practitioners when advertising their healthcare service.

We submit that the framework and the approach of the Guidelines serve to confuse rather than assist providers. Understandably, the Guidelines need to be as broad as possible to cover the wide variety of health care services available. Instead, this may act as a constraint on the appropriate use of advertising by healthcare providers as it does not allow for the needs of different providers. For example, when comparing the services of a cosmetic medicine provider with a general practitioner, there is a substantial difference in the purpose of advertising each would adopt.

We submit that Option 2 amending the provision regarding testimonials will provide greater clarity to practitioners and consumers about when comment is permissible.

16. Are the legislative provisions on advertising working effectively or do they require change?
Cosmetic medicine providers use advertising to attract well consumers who wish to undergo ‘treatment’ or a procedure for subjective purposes and only occasionally as a treatment option for a recognised disorder / disease. In this instance, the Guidelines are in keeping with the intent of the National Law to protect consumers. Conversely, a GP clinic is likely to rely on advertising on the basis of promoting health and wellbeing and providing care and treatment when people are unwell. In this case, the Guidelines have limited relevance.

The Guidelines and Social Media Policy also appear to be out of date with current trends in the use of online marketing. Marketing / advertising agencies encourage the use of social media platforms, websites etc. Some also recommend that the business ‘own’ their online presence, use social media to engage with consumers, encourage feedback and respond accordingly, even on third party rating sites. On the whole, anecdotal feedback indicates that medical practitioners are confused about the provisions, particularly with regards to testimonials and differentiating between ‘health care and service provisions i.e. treatment / care provided by a register health care professional and the service of the reception, administrative staff.

Therefore, while the intent of the legislative provisions are acceptable, there may need to be some amendments or clearer statements made about the Guidelines for services that are ‘cosmetic’ in nature and further clarification about comments made by patients as opposed to those about treatment / care provided by a regulated health care professional.

MDA National proposes that providing an initial and immediate response to the practitioner. This could serve to:
   a. be a visible action by the National Boards to encourage compliance with the National Law and Guidelines.
   b. serve as a timely and effective response to breaches instead of existing processes which can be protracted and serve little purpose by the time of resolution.
17. How should the scheme respond to differences in States and Territories in protected practices? 
Where there are inconsistencies in protected practice, then the National scheme could be amended to either: 
   a. Refer the practitioner back to the relevant state laws; 
   b. Include statement/s which clarifies the operation of both state/territory requirements and National Scheme and give examples that may help to reduce the conflict; 
   c. Refer the issue of conflict back to the relevant Board for consideration and development of Scope of Practice documents. 

**Proposed changes to the National Law**

MDA National agrees with the amendment proposed to afford protection to registrants who report serious offences to police. We submit that clarity is required in relation to what constitutes a ‘serious offence’ and the amendment clearly indicates it is not mandatory for practitioners to report such offences to the police. 

MDA National supports the proposed amendment to the National Law to enable a National Board to revoke a suspension. In Queensland MDA National has observed problems in other provisions of the National Law eg ss125 to 127. Where those provisions do not enable the Board to revoke or amend a decision regarding action within a review period. In one instance, the parties were unable to avoid the considerable cost in the continuance of a review proceeding (appeal) before the Tribunal despite the parties being agreed as to the outcome.

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

MDA supports one point of entry for consumers and a consistent and early triage system which may provide for quicker resolution of notifications. Medical practitioners are frequently prejudiced as they are not always provided with medical records, expert opinion and relevant background material which would ensure they can provide an informed response. Further, the length of time before an investigation is concluded can cause significant stress and financial hardship for practitioners.

**Issues in relation to Queensland**

The main criticism of the complaints and notification system in Queensland relates to timeliness and delays. The delays that most affect the Queensland registrants involve the time taken for a matter to come before the relevant Committee of the Medical Board of Australia, ie once a submission is made, and the length of time it takes for an investigation to be concluded.

Registrants have also consistently been frustrated by the time taken for a matter to be referred to a Panel or the Tribunal once a decision is made to do so. In some cases, it has been years before the registrant has been served with the requisite notice of allegations (in the Panel referral process) or referral notice in the Tribunal process.
Issues in relation to Western Australia

In Western Australia Section 146 provides for verbal notifications to be made however subsection (3) simply adds that if the notification is verbal, the National Agency must make a record of the notification.

MDA National submits that there should be further information obtained from the notifier before submitting to the practitioner where notifications are vague, lacking in detail or information or evidence – The role of the / case manager / investigator should include obtaining all relevant, specific information prior to notifying the practitioner to ensure merit and ultimately enable a considered, informed response in a timely manner.

Anonymous notifications should not be progressed with as practitioners are prejudiced in responding to vague complaints where sometimes even the relevant patient cannot be identified. Further, there are difficulties in investigating such complaints and obtaining further evidence as the notifier is unknown.

Similarly, at the preliminary assessment level, where notifications are vague or lack detail, MDA National has experienced on a number of occasions a request to our practitioners to provide a response and thereby effectively fill in the missing gaps to the factual matrix. Practitioners should not be expected to go through the time consuming task of attempting to work out the nature of the complaint, rather at this preliminary assessment level, AHPRA should obtain further information from the notifier and identify specifically what issues are to be investigated and then provide them to the practitioner for a response.

Section 151 -“no further action” decisions should be available at all stages of the investigation to prevent matters being prolonged when it is evident that there is no case to answer.

Generally, where AHPRA obtains expert evidence regarding a practitioner’s conduct and relies upon that evidence to make a decision, that expert evidence should be disclosed to the practitioner. Where expert opinions are obtained by the Board, greater care should be attributed to gaining the most appropriate and comparable expert to the practitioner – this will avoid unnecessary progression of unsubstantiated matters and limit the complaint process from becoming litigious and prolonged.

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

MDA National does not support the adoption in all states and territories of the co-regulatory system which was recently introduced in Queensland; it is too early to draw any definitive conclusions regarding this system. There have been considerable concerns expressed regarding the Director of Proceedings reporting directly to the Health Ombudsman. We submit that independence of the Director of Proceedings is essential in order to ensure procedural fairness and independent decision making. The Director of Proceedings should not be subject to the direction or control of the Health Ombudsman in relation to dealing with a complaint or other matter.
MDA National prefers the NSW model of the Health Care Complaints Commission, the NSW Health Care Complaints Act 1993 provides that the Director of Proceedings Is independent, does not report to the Health Care Complaints Commissioner and has functions that enable the Director to have discretion to refer back to the Commission. The NSW model ensures procedural fairness and independent decision making.

Our view is that if a co-regulatory approach is to be realistically considered by AHPRA that it would be best to draw what can be learned primarily from the NSW model/arrangements and then to supplement that knowledge (cautiously) with the early performance information being received in Queensland. We remain concerned, and are yet to properly see the operation of, the management of disciplinary processes across two agencies.

If a decision was made to consider the Queensland model it is our view that some early impressions might be drawn from the performance data, there have only been two Performance Data reports released for the months of July and August 2014, be considered. MDA submits that this data should be treated cautiously (as there will always be some ‘teething issues’ experienced with any new system). Specifically, what is apparent from the data released thus far is that the Office of Health Ombudsman is still likely to be criticised for ‘time delays’ unless further resources are committed to meeting the level of complaints/notifications received. Further, where action has been taken to try and resolve complaints, eg by local resolution, there are also problems meeting the designated time frames under those processes.

There also remains a considerable amount of uncertainty regarding the handling of complaints and disciplinary processes (in particular, the exercise of the immediate action power). In the first two months of the Office of Health Ombudsman operation they only issued one show cause notice with respect to the potential exercise of the immediate action power.

MDA National welcomes the opportunity to provide further submissions and feedback in relation to the National Registration and Accreditation Scheme.

Yours sincerely

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