Regulation of Australia’s health professions: keeping the National Law up to date and fit for purpose

A consultation paper 2018
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Executive summary

This consultation paper seeks your views on a number of potential reforms to the Health Practitioner Regulation National Law (‘the National Law’).

The National Law established the National Registration and Accreditation Scheme for health professions (the ‘National Scheme’), which has been in operation since 2010, and is delivered by 15 National Boards, supported by the Australian Health Practitioner Regulation Agency (AHPRA). The National Scheme now regulates more than 700,000 health practitioners and ensures that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered. The scheme is overseen by the Council of Australian Governments Health Council, which comprises health ministers from every state and territory and the Commonwealth.

Following the Independent Review of the National Registration and Accreditation Scheme (‘the NRAS Review’) in 2014, health ministers began a staged implementation of its response to the review’s recommendations.

In 2017 a first stage (or tranche) of amendments were made to the National Law. This first stage of legislative reform will be completed with commencement of the provisions in the Health Practitioner Regulation National Law and Other Legislation Amendment Act 2017 (‘the Tranche 1 Amendment Act’). The Tranche 1 Amendment Act will introduce the national regulation of paramedics, as well as changes to strengthen complaints management and the disciplinary and enforcement powers of AHPRA and the National Boards.

In March 2017 health ministers requested some further urgent reforms to the National Law in relation to strengthened penalties and interim prohibition orders and, in August 2017, ministers requested urgent advice on nationally consistent mandatory reporting provisions under the National Law. Preparation of drafting instructions to progress an amendment Bill is currently underway.

Responses to this consultation paper will inform the next stage of reforms (Tranche 2) requested by health ministers. The issues and proposals under consideration were included in Tranche 2 to allow sufficient time for thorough consideration, research and discussion with key stakeholders and entities within the National Scheme.

This paper also addresses some issues and concerns that have arisen since the NRAS Review and reflects national priorities such as the role of the National Scheme in supporting the achievement of health and wellbeing for Aboriginal and Torres Strait Islander Peoples. There are also proposals that canvass opportunities to streamline the work of AHPRA and the National Boards, and to make the National Scheme more efficient. Where appropriate, the work of other health regulators has also been considered to inform the policy proposals. Other recent reviews and inquiries regarding the National Scheme, such as the Independent review of the use of chaperones to protect patients in Australia, have also informed this consultation paper.

It is acknowledged that since the NRAS Review some regulatory and systems failures have occurred where the public were harmed. Proposals for reform are intended to learn from and address these failures in order to minimise the risk of serious harm occurring again.

It is important that the National Scheme is efficient, fair and responsive for both health consumers and practitioners. This consultation paper is intended to foster debate about whether the National Law remains up to date and fit for purpose, or whether further reforms are needed to deliver a stronger, fairer National Scheme and safe health workforce for all Australians. It is expected that any legislative reforms

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1 On 19 October 2017 health ministers announced the appointment of the inaugural Paramedicine Board of Australia.
2 Registration of paramedics is expected to commence from late 2018 (Paramedicine Board of Australia 2017).
progressed after this consultation will contribute to increased consumer and practitioner confidence in the National Scheme.

Not every issue or concern canvassed in this paper will need a legislative solution – in some cases, an administrative solution may be preferable or it may be determined that no action is required. The proposals presented or views expressed in this paper are presented for discussion purposes only and do not represent a final position. Health ministers are committed to the continuous improvement of the National Scheme. Feedback captured in this consultation will also inform ministers of any outstanding issues or future opportunities for reform.

Your views are important and welcome.
Consultation arrangements

Information
This consultation is being conducted under the auspices of the Australian Health Ministers’ Advisory Council on behalf of state, territory and Commonwealth health ministers.

Further information on this consultation is available from the NRAS Review Implementation Project Secretariat <NRAS.consultation@dhhs.vic.gov.au>

or

NRAS Review Implementation Project Secretariat
Health and Human Services Regulation and Reform Branch
Department of Health and Human Services
GPO Box 4057
Melbourne VIC 3001

Copies of the consultation paper

If you are unable to access the paper on the website, please email NRAS Review Implementation Project Secretariat <NRAS.consultation@dhhs.vic.gov.au> to request a copy.

Submissions
Written submissions may be sent to NRAS Review Implementation Project Secretariat <NRAS.consultation@dhhs.vic.gov.au>

or

NRAS Review Implementation Project Secretariat
Health and Human Services Regulation and Reform Branch
Department of Health and Human Services
GPO Box 4057
Melbourne VIC 3001

Submissions are due by: midnight Wednesday, 31 October 2018.

To assist you in preparing your submission, a response template can be downloaded at COAG Health Council <www.coaghealthcouncil.gov.au>.

Note: All submissions will be considered public documents and may be posted on the website of the COAG Health Council above, unless marked ‘private and confidential’. Further information in relation to the publishing of submissions, privacy and confidentiality is also available at COAG Health Council <www.coaghealthcouncil.gov.au>.
1 Introduction

1.1 Background

What is the National Registration and Accreditation Scheme?

The National Registration and Accreditation Scheme for the health professions (the ‘National Scheme’) began operation in July 2010 following:

- the Council of Australian Governments (COAG) signing an Intergovernmental Agreement in March 2008

The National Scheme was established under state and territory (rather than Commonwealth) legislation using the ‘adoption of laws’ mechanism – except in Western Australia where complementary legislation has been enacted, and in South Australia where the amendments are made by regulation. It now regulates more than 678,000 health practitioners (AHPRA 2017a).

The National Law establishes and/or empowers the following statutory entities:

- 15 National Boards that register and regulate health practitioners from 16 regulated health professions (comprising 24 health occupations) (see Table 1)
- the Australian Health Practitioner Regulation Agency (AHPRA) and its Agency Management Committee – the administrative agency for the National Scheme
- the National Health Practitioner Ombudsman and Privacy Commissioner (NHPOPC)
- the Council of Australian Governments Health Council (‘the COAG Health Council’ or ‘Ministerial Council’), and
- the Australian Health Workforce Advisory Council.

Further information about the National Scheme including its origins, scope, principles, objectives and operations is available on the COAG Health Council website <www.coaghealthcouncil.gov.au/NRAS>.

The National Scheme provides a single, trusted source of information for consumers, employers and governments on practitioners who are registered in a regulated health profession. This information is publicly available via an online, searchable register of health practitioners that is maintained by AHPRA <www.ahpra.gov.au>. To be registered, health practitioners must meet the registration standards developed by the National Board and approved by Ministerial Council. Practitioners are able to register once in a profession and practise anywhere in Australia. The scheme provides mechanisms for detecting and responding to practitioners whose health, conduct or performance poses risks to the public. The

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3 The National Scheme commenced in Western Australia in October 2010.
4 The Council of Australian Governments (COAG) is the peak intergovernmental forum in Australia.
5 The Intergovernmental Agreement for a National Registration and Accreditation Scheme for the health professions was signed in March 2008 by the heads of all state, territory and Commonwealth governments. It is available at the Australian Health Practitioner Regulation Agency website <http://www.ahpra.gov.au/About-AHPRA/Ministerial-Directives-and-Communications.aspx>.
6 The Tranche 1 Amendment Act provides for the recognition of nursing and midwifery as two separate professions regulated by one National Board. Paramedicine will become the sixteenth regulated health profession, with health ministers announcing the appointment of the inaugural Paramedicine Board of Australia in October 2017 and registration expected to begin in late 2018.
7 Under s. 5 of the Health Practitioner Regulation National Law (as amended in September 2017 by the Health Practitioner Regulation National Law and Other Legislation Amendment Act 2017 (Qld)), the ‘Ministerial Council’ is defined as the COAG Health Council or a successor of the COAG Health Council, noting that when the COAG Health Council makes decisions under the National Law, this involves only Ministers of the governments of the participating jurisdictions (Australian Capital Territory, New South Wales, Northern Territory, Queensland, South Australia, Tasmania, Victoria and Western Australia) and the Commonwealth with portfolio responsibility for health. Throughout this document, for simplicity and alignment with the National Law, the COAG Health Council is referred to as the ‘Ministerial Council’ where appropriate.
scheme also provides powers to prosecute people who pretend to be qualified or registered to practise in a regulated health profession when they are not, or who carry out reserved practices that only registered health practitioners from specified professions are legally authorised to carry out.

**Table 1: National Boards**

<table>
<thead>
<tr>
<th>Name of board</th>
<th>Health profession</th>
<th>Division</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal and Torres Strait Islander Health Practice Board of Australia</td>
<td>Aboriginal and Torres Strait Islander Health Practice</td>
<td></td>
</tr>
<tr>
<td>Chinese Medicine Board of Australia</td>
<td>Chinese medicine</td>
<td>Acupuncturist, Chinese herbal medicine practitioner, Chinese herbal dispenser</td>
</tr>
<tr>
<td>Chiropractic Board of Australia</td>
<td>Chiropractic</td>
<td></td>
</tr>
<tr>
<td>Dental Board of Australia</td>
<td>Dental</td>
<td>Dentist, Dental therapist, Dental hygienist, Dental prosthetist, Oral health therapist</td>
</tr>
<tr>
<td>Medical Board of Australia</td>
<td>Medical</td>
<td></td>
</tr>
<tr>
<td>Medical Radiation Practice Board of Australia</td>
<td>Medical radiation practice</td>
<td>Diagnostic radiographer, Nuclear medicine technologist, Radiation therapist</td>
</tr>
<tr>
<td>Nursing and Midwifery Board of Australia</td>
<td>Nursing</td>
<td>Registered nurse (Division 1), Enrolled nurse (Division 2)</td>
</tr>
<tr>
<td>Midwifery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy Board of Australia</td>
<td>Occupational therapy</td>
<td></td>
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<tr>
<td>Optometry Board of Australia</td>
<td>Optometry</td>
<td></td>
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<tr>
<td>Osteopathy Board of Australia</td>
<td>Osteopathy</td>
<td></td>
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<tr>
<td>Paramedicine Board of Australia</td>
<td>Paramedicine</td>
<td></td>
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<tr>
<td>Pharmacy Board of Australia</td>
<td>Pharmacy</td>
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<tr>
<td>Physiotherapy Board of Australia</td>
<td>Physiotherapy</td>
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<tr>
<td>Podiatry Board of Australia</td>
<td>Podiatry</td>
<td></td>
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<tr>
<td>Psychology Board of Australia</td>
<td>Psychology</td>
<td></td>
</tr>
</tbody>
</table>
How are changes made to the National Law?

The Intergovernmental Agreement (Clause 13) sets out how changes to the National Law are to be agreed by the Ministerial Council. Proposed amendments to the National Law must be approved by the Ministerial Council, with decisions made by consensus.

When the Ministerial Council approves changes to the National Law, Queensland, as the host jurisdiction for the National Law, then 'takes all reasonable steps to secure the passage of the bill and bring it into force in accordance with a timetable agreed by the Ministerial Council' (Clause 13(3)(b) of the Intergovernmental Agreement). Once enacted, the changes automatically apply in other states and territories, except in Western Australia and South Australia.

1.2 Scope of this consultation paper

This consultation paper aims to seek views and foster debate about whether the current legislative arrangements are fit for purpose, or whether further reforms are needed to the National Law. The consultation also will consider:

- findings and recommendations from the December 2014 Independent Review of the National Registration and Accreditation Scheme for health professions (‘the NRAS Review’)
- findings and recommendations from other inquiries regarding the National Scheme, with a view to improving the National Scheme for consumers and practitioners
- opportunities to strengthen system linkages, facilitate the early detection of impaired or poorly performing practitioners, and minimise the risk of regulatory failure, for the protection of the public.

This paper canvasses issues and concerns that have been raised by interested parties and outlines some areas for possible reform. In some areas, options for reform are presented for consideration.

Not every issue or concern canvassed in this paper will need a legislative solution – in some cases, an administrative solution may be preferable or it may be determined that no action is required.

Questions throughout this paper are intended as a guide to assist respondents in providing feedback. A quick response form is provided.

Any proposals presented or views expressed in this paper are presented for discussion purposes and do not represent a final position.

Queensland and New South Wales (NSW) are co-regulatory jurisdictions. It is noted that the provisions in Part 8 (Health, performance and conduct) of the National Law do not apply in NSW. As such, the proposals in this paper relating to complaints handling (matters relating to a practitioner’s health, performance and conduct) are not relevant to NSW.

1.3 COAG regulatory assessment process

COAG requires that a regulation impact statement be prepared and published whenever a ministerial council is considering introducing new regulation that would encourage or force businesses or individuals to pursue their interests in ways that they might not have otherwise done. The impact statement process aims to maximise the efficiency of new or amended regulation and to avoid unnecessary compliance costs and restrictions on competition.

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8 In Queensland, complaints (referred to as ‘notifications’ under the National Law) are assessed by the Office of the Health Ombudsman to determine which complaints will be managed by AHPRA (on behalf of the National Boards) and which will be managed by the Ombudsman. In NSW the health professionals councils work with the Health Care Complaints Commission to assess and manage concerns about practitioners’ conduct, health and performance.
This paper has been prepared in accordance with COAG guidelines on best practice regulation (COAG 2007). These guidelines help ensure that regulatory processes in all Australian jurisdictions are consistent with the COAG principles of best practice regulation listed in Box 1.

**Box 1: COAG principles of best practice regulation**

1. Establishing a case for action before addressing a problem.
2. A range of feasible policy options must be considered, including self-regulatory, co-regulatory and non-regulatory approaches, and their benefits and costs assessed.
3. Adopting the option that generates the greatest net benefit for the community.
4. In accordance with the Competition Principles Agreement, legislation should not restrict competition unless it can be demonstrated that:
   - (a) the benefits of the restrictions to the community as a whole outweigh the costs
   - (b) the objectives of the regulation can only be achieved by restricting competition.
5. Providing effective guidance to relevant regulators and regulated parties in order to ensure that the policy intent and expected compliance requirements of the regulation are clear.
6. Ensuring that regulation remains relevant and effective over time.
7. Consulting effectively with affected key stakeholders at all stages of the regulatory cycle.
8. Government action should be effective and proportional to the issue being addressed.

### 1.4 Consultation arrangements

This consultation is being undertaken under the auspices of the Australian Health Ministers’ Advisory Council (AHMAC).[^9]

The project team is located within the Regulation and Reform Branch of the Victorian Department of Health and Human Services and is responsible for managing this consultation in conjunction with the NRAS Review Implementation Project Legislation Committee. AHMAC is overseeing the work of the project team.

The expected timetable for this review process is:

<table>
<thead>
<tr>
<th>Event</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public consultation paper available</td>
<td>Mid-2018</td>
</tr>
<tr>
<td>National and state/territory stakeholder consultation forums</td>
<td>Second half of 2018</td>
</tr>
<tr>
<td>Ministers to consider advice and recommendations arising from the consultation process</td>
<td>First half of 2019</td>
</tr>
<tr>
<td>Preparation of a draft amendment Bill if required</td>
<td>Second half of 2019</td>
</tr>
</tbody>
</table>

[^9]: AHMAC is the advisory body to the COAG Health Council and comprises the heads of each of the Australian Government, state and territory health departments.
2 Context for this consultation

2.1 Independent Review of the National Registration and Accreditation Scheme

In 2014 the COAG Health Council commissioned an independent review of the National Scheme (‘the NRAS Review’). The NRAS Review involved an extensive consultation process that included consultation forums in each capital city, with more than 230 written submissions received.

The final report of the NRAS Review (‘NRAS Review final report’) acknowledged the significant achievements made by the National Scheme and National Law, including:

- ensuring that the community can have confidence that health practitioners providing treatment and care in Australia meet a national standard based on safe practice
- consolidating 74 Acts of Parliament and 97 separate health profession boards across eight states and territories into a single National Scheme
- increasing the mobility of health practitioners working in Australia by removing the necessity for them to be separately registered in each jurisdiction
- improving protection to the health system by ensuring that any health practitioner who has been found to have committed misconduct can no longer practise undetected in another jurisdiction
- enabling significant improvements to health workforce information and planning due to the availability of accurate data on each of the 14 professions operating within it.


The implementation of the COAG Health Council’s response to the independent review is occurring in a number of stages or ‘tranches’:

**Tranche 1:** This first stage will be completed when the provisions in the Health Practitioner Regulation National Law and Other Legislation Amendment Act 2017 (‘the Tranche 1 Amendment Act’) commence. Section 2.2 of this consultation paper provides further information about the Tranche 1 reforms.

**Tranche 1A:** In March 2017, health ministers requested some additional reforms to the National Law, in relation to strengthened penalties and interim prohibition orders. In August 2017, ministers requested urgent advice on nationally consistent mandatory reporting provisions under the National Law, to be progressed in advance of the Tranche 2 process.

**Tranche 2:** This second stage began with the release of this consultation paper. As well as implementing the remaining key reform proposals arising from the NRAS Review that were not addressed in the Tranche 1 Amendment Act, the Tranche 2 process also includes:

- additional issues and proposals raised by ministers, jurisdictions, AHPRA, the NHPOPC and external stakeholders, which have been agreed for consideration
- recommended legislative reforms arising from other inquiries and reviews (see section 2.4 of this paper for more information)
- issues that arose during the consideration of the Tranche 1 Amendment Act.
Any agreed amendments to the National Law arising from this process are expected to be progressed in accordance with the timetable outlined in section 1.4 of this paper. Other NRAS Review reform projects that are currently underway or are yet to be finalised and/or released are:

- the Independent Review of Accreditation Systems
- the Review of NRAS Governance.

2.2 Health Practitioner Regulation National Law and Other Legislation Amendment Act 2017

The Tranche 1 Amendment Act received assent on 13 September 2017. It is the first time that the National Law has been amended since it was enacted in all states and territories in 2009–10.

The details of the reforms are set out in the Explanatory Notes to the Act.\(^\text{10}\)

Key reforms enacted included:

- national registration for the profession of paramedicine
- a new power for the COAG Health Council to change the structure of National Boards by regulation
- recognition of nursing and midwifery as separate professions
- strengthening notifications management and disciplinary and enforcement powers to improve their effectiveness and administration, and better protect the public
- technical and miscellaneous amendments to improve the efficiency and effectiveness of the National Law

While some of these amendments came into effect in September 2017, staged commencement of others will occur through to late 2018.

The provisions of the Tranche 1 Amendment Act apply automatically in all states and territories except Western Australia, which must pass its own legislation, and South Australia, where regulations must be made to amend the National Law. On 10 April 2018 the Western Australian Parliament passed the Health Practitioner Regulation National Law (WA) Amendment Bill 2017, and on 19 April 2018 it received Royal Assent. On 19 December 2017 South Australia made a regulation to commence those amendments that were proclaimed by the Queensland Government to come into effect on assent or 28 days after assent. South Australia will make further regulations as required to commence the remaining provisions, following staged commencement in Queensland. In addition, the changes relating to Part 8 of the National Law (concerning the health, performance and conduct powers of National Boards) do not apply in NSW.

2.3 Independent Review of Accreditation Systems

Parts 5 and 6 of the National Law set out the powers and functions of National Boards and accreditation entities in delivering ‘accreditation functions’. Box 2 lists the accreditation functions from s. 42 of the National Law.

Box 2: National Law accreditation functions

(a) developing accreditation standards for approval by a National Board;

(b) assessing programs of study, and the education providers that provide the programs of study, to determine whether the programs meet approved accreditation standards;

\(^{10}\) Available at the Queensland Parliament website <https://www.parliament.qld.gov.au/work-of-committees/committees/HCDSDFVPC/inquiries/past-inquiries/NationalLaw>
(c) assessing authorities in other countries who conduct examinations for registration in a health profession, or accredit programs of study relevant to registration in a health profession, to decide whether persons who successfully complete the examinations or programs of study conducted or accredited by the authorities have the knowledge, clinical skills and professional attributes necessary to practise the profession in Australia;

(d) overseeing the assessment of the knowledge, clinical skills and professional attributes of overseas qualified health practitioners who are seeking registration in a health profession under this Law and whose qualifications are not approved qualifications for the health profession;

(e) making recommendations and giving advice to a National Board about a matter referred to in paragraph (a), (b), (c) or (d).

The NRAS Review examined these accreditation functions and concluded:

- The delivery of these functions was expensive and subject to ‘little or no scrutiny’.
- The different approaches to accreditation across the respective bodies were ‘confusing for educators and left little capacity to streamline processes between professions’ (AHMAC 2014a, p. 49).

The NRAS Review final report proposed a range of short-term measures to improve the accountability of Accreditation Authorities and proposed further analysis of the Australian accreditation system against the United Kingdom’s (UK) approach. Health ministers accepted in principle that changes to accreditation arrangements were needed and requested a more detailed review of accreditation functions.

AHMAC commissioned the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions (‘the Accreditation Systems Review’), engaging Professor Michael Woods as the independent reviewer in October 2016.

As part of the terms of reference, the independent reviewer was asked to consider:

- the cost-effectiveness of the regime for delivering the accreditation functions
- governance structures including reporting arrangements
- opportunities for streamlining accreditation including consideration of the other educational accreditation processes such as those available through the Tertiary Education Quality Standards Agency and the Australian Skills Quality Authority
- the extent to which accreditation arrangements support educational innovation in programs including clinical training arrangements, use of simulation and interprofessional learning
- opportunities for increasing consistency and collaboration across professions to facilitate integrated service delivery.

In February 2017 a discussion paper was released that canvassed issues for consideration and debate about the current accreditation systems for health professions. The discussion paper formed part of a national consultation process that invited written submissions and included stakeholder forums in each state and territory.

A draft report was released in September 2017, and further submissions were invited.

Professor Woods submitted the final report of the Accreditation Systems Review to AHMAC on 30 November 2017.

### 2.4 Other relevant inquiries and reviews

A number of other ongoing and completed inquiries and reviews regarding the National Scheme are:
• the AHMAC-commissioned review of the governance arrangements for the National Scheme is under consideration by AHMAC and its committees at the time of release of this consultation paper

• the report of the Australian Senate Community Affairs References Committee Inquiry 2015–16, titled Medical complaints process in Australia (Senate Community Affairs References Committee 2016)

• the report of the Australian Senate Community Affairs References Committee Inquiry 2016–17 titled Complaints mechanism administered under the Health Practitioner Regulation National Law (Senate Community Affairs References Committee 2017)

• the report commissioned by the Medical Board of Australia/AHPRA titled Independent Review of the use of chaperones to protect patients in Australia (Paterson 2017)


Further details about the findings of these inquiries and reviews, where available, are set out in Appendix 1.
3 Governance of the National Scheme

3.1 Objectives and guiding principles – referencing cultural safety for Aboriginal and Torres Strait Islander Peoples

When the National Law was drafted its objectives were framed more broadly than in earlier health practitioner regulation laws in the states and territories. While these earlier registration laws specified the principal objective of regulation being to protect the public, the National Scheme is expected to give effect to broader objectives such as to facilitate access to services and enable a flexible, responsive and sustainable health workforce.

Section 3 of the National Law sets out the objectives and guiding principles of the National Scheme. These provide the foundation for the scheme and guide all regulatory decision making by entities under the scheme. They are listed in Box 3.

Box 3: Objectives and guiding principles of the National Scheme

The objectives of the National Scheme are:

(a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and

(b) to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and

(c) to facilitate the provision of high quality education and training of health practitioners; and

(d) to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and

(e) to facilitate access to services provided by health practitioners in accordance with the public interest; and

(f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and enable innovation in the education of, and service delivery by, health practitioners.

The guiding principles of the National Scheme are:

(a) the scheme is to operate in a transparent, accountable, efficient, effective and fair way;

(b) fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme;

(c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.

The National Scheme has an important role to play in supporting health outcomes for Aboriginal and Torres Strait Islander Peoples by enabling a health workforce that is culturally safe, accessible and responsive through its regulatory framework for health practitioners.

The concept of cultural safety is outlined in the national Cultural respect framework for Aboriginal and Torres Strait Islander health 2016–2026. As part of its definition of cultural safety, the framework recognises that ‘health consumers are safest when health professionals have considered power relations, cultural differences and patients’ rights’ (AHMAC 2016, p. 18). The framework also notes that
providing culturally-safe care is always determined by the recipient of care and not by the caregiver. The framework’s full definition of cultural safety is provided at Appendix 2. For health practitioners in Australia, culturally-safe practice includes the aspects of cultural competence, skills, knowledge and attitudes when working with Aboriginal and Torres Strait Islander Peoples, and the ability to reflect on their own cultural assumptions, practices and beliefs in their practice. A health practitioner working in a culturally-safe way recognises the effects of colonisation and racism on Aboriginal and Torres Strait Islander Peoples’ wellbeing (AHMAC 2016, p. 18). For the Australian health system, cultural safety also includes the ability to address institutional and system governance affecting Aboriginal and Torres Strait Islander Peoples’ health.

The AHPRA Aboriginal and Torres Strait Islander Health Strategy Group has suggested building on the definition of cultural safety in the framework by emphasising that cultural safety is a critical component of clinical and patient safety and that embedding cultural safety in health care is an important strategy to address racism and discrimination where it is present in the health system (AHPRA Aboriginal and Torres Strait Islander Health Strategy Group 2017, p. 1).

This consultation provides the opportunity to canvass views on whether the National Law objectives and guiding principles should be amended to make this expectation explicit. The following amendments are proposed:

- Amend s. 3 to include an additional guiding principle of the National Scheme being to foster cultural safety for Aboriginal and Torres Strait Islander Peoples.
- Amend s. 3 to include an additional objective of the National Scheme being to address health disparities between Indigenous and non-Indigenous Australians.

The rationale for these reforms is as follows:

- Aboriginal and Torres Strait Islander health remains a significant national health challenge. As set out in the 2017 and 2018 Prime Minister’s reports on Closing the Gap targets (Commonwealth of Australia 2017; 2018), slow progress to address the health disparities between Indigenous and non-Indigenous Australians is being made and the nation is not on track to meet many of the recognised targets. The framework suggests that embedding cultural respect principles into health systems will help deliver quality, culturally safe and responsive care to Aboriginal and Torres Strait Islander Peoples and contribute to progress in achieving Closing the Gap targets (AHMAC 2016, pp. 1 & 9).
- Under-representation of Aboriginal and Torres Strait Islander Peoples in the health workforce is a contributing factor to the lower rates of Aboriginal and Torres Strait Islander Peoples accessing health services comparative to need (Congress of Aboriginal and Torres Strait Islander Nurses and Midwives 2016). Building the Aboriginal and Torres Strait Islander health workforce is integral to improving access and providing culturally-appropriate health services, including the ongoing development of the Aboriginal and Torres Strait Islander health practitioner workforce.
- Improving Aboriginal and Torres Strait Islander health requires more than building a capable Aboriginal and Torres Strait Islander workforce. It also requires health practitioners who are not of Aboriginal and Torres Strait Islander origin embedding culturally-safe practices in the health services they provide.
- Increasing the likelihood of culturally-safe clinical care may make a considerable contribution to health improvement for Aboriginal and Torres Strait Islander Peoples, as suggested by peak Aboriginal and Torres Strait Islander health bodies (Laverty, McDermott & Calma 2017, p. 15). In response, Laverty et al. have suggested embedding cultural safety in accreditation standards and standards for clinical professionalism and quality to help achieve these health outcomes for Indigenous patients (Laverty, McDermott & Calma 2017).

Amendments to the objectives and guiding principles for the National Scheme to foster cultural safety for Aboriginal and Torres Strait Islander Peoples in accessing health services would make explicit that all
regulatory decision making in the National Scheme must give due consideration to the effects on the health and wellbeing of Aboriginal and Torres Strait Islander Peoples. It must also ensure that cultural safety is embedded in registration and accreditation standards for each health profession to help address the health disparities between Indigenous and non-Indigenous Australians.

Questions to assist with submissions:

- 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?
- 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?
- 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?

3.2 Chairing of National Boards

Eligibility for appointment to chair a National Board

Under s. 33 of the National Law, a member is appointed to a National Board as either a ‘practitioner member’ or a ‘community member’. Section 33(9) provides that the chairperson of the National Board must be a health practitioner (a practitioner member) and, therefore, cannot be a community member.

The NRAS Review consulted on the question of whether there should be flexibility to make merit-based appointments to the position of chairperson of a National Board (AHMAC 2014b, p. 42). Recommendation 26 of the NRAS Review final report recommended that s. 33 of the National Law be amended to enable the Ministerial Council to appoint either a practitioner member or a community member as chairperson of a National Board (AHMAC 2014a, p. 8). In August 2015, when releasing the NRAS Review final report, health ministers accepted this recommendation.

Further submissions were received on this proposal during framing and consultation on the Tranche 1 Amendment Bill. There was strong opposition to this proposal from some professional groups. These groups expressed the view that the chairperson of a National Board is a particularly challenging role and the person should have specialist knowledge, skills and expertise in the relevant profession. In response, health ministers agreed to defer this proposal and reconsider it during the Tranche 2 reform process to enable further consultation with stakeholders.

Strong and effective leadership is key to good governance of National Boards. Chairpersons must:

- demonstrate strong leadership, acting confidently and decisively to drive reform and facilitate change
- engage externally to advocate for the scheme and build and maintain stakeholder relationships
- chair meetings and processes effectively, facilitate input from all members, build consensus and resolve conflict.

Chairpersons may also be called upon from time to time to communicate publicly or through the media on professional matters. A chairperson who is a practitioner member is generally in a position to make authoritative statements about clinical matters. When making such statements, they would be expected to have the trust of the profession and the public.

However, there have been a number of occasions since the National Scheme began where no sitting practitioner member has been willing or able to nominate for the role of chairperson and a presiding member has been appointed. These boards have continued to operate effectively.
There are also precedents for effective chairing of registration boards by community members. Prior to
the National Scheme, for instance, Victorian legislation required practitioner members to be appointed to
leadership roles on registration boards unless the minister considered it ‘necessary for the good
operation of the board’ (Health Professions Registration Act 2005 (Vic) s.123 (2)) to recommend a
member who was not a registered health practitioner. While this power was exercised very rarely, the
Chinese Medicine Registration Board of Victoria operated effectively from 2000 to 2012 with a non-
practitioner as chair. This board had in place protocols for ensuring appointment of an appropriate
spokesperson to deal with media enquiries and for other circumstances where clinical expertise was
required.

This consultation provides a further opportunity to canvass views on whether there should be an
amendment to the National Law to provide flexibility for the Ministerial Council to appoint either a
practitioner member or a community member to chair a National Board. There are three options for
reform:

Option 1: No change – only a practitioner member may be appointed to the role of chairperson of
a National Board.

Option 2: Amend the National Law to remove the requirement for the chairperson to be a
practitioner member, allowing either a practitioner member or a community member to fill
the role. Under this option, each National Board would be responsible for ensuring
spokespeople have the necessary clinical expertise to speak authoritatively on the
board’s behalf when necessary.

Option 3: Amend the National Law to provide that the Ministerial Council must appoint a
practitioner member as chairperson, unless it is necessary for the good governance of
the board that a community member be appointed. Under this option, the Ministerial
Council would be required to appoint a practitioner member to chair a National Board,
except where there are extenuating circumstances – for instance, where there are no
practitioner members willing to carry out the role.

The options suggested would affect National Boards only. State and territory based boards would not be
impacted as the National Law does not provide for the membership of these boards.

Questions to assist with submissions:

- Which would be your preferred option regarding the appointment of chairpersons to National Boards?
  What are your reasons?
- 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?
- 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?

3.3 System linkages

Responsibility for quality assurance and quality improvement in the health sector is shared among a
myriad of individuals, agencies and institutions, including regulators, insurance providers, education
providers and health services.

Box 4 shows some of the laws that directly or indirectly interact with the National Law and national
regulators to influence safety and quality in health care. The focus of this consultation is on proposals for
change to the National Law. Reforms that require changes to other laws are beyond the scope of this
consultation.
Box 4: Range of laws that directly or indirectly influence safety and quality in health care

- Tort, contract and criminal laws (including the law of negligence)
- Health complaints laws
- Health service licensing laws (such as for private hospitals and day procedure centres)
- Public health laws
- Mental health and disability laws
- Coroners’ laws
- Health records laws
- Freedom of information, privacy, ombudsman and whistleblower laws
- Consumer protection laws
- Therapeutic goods and drugs and poisons laws
- Community pharmacy laws
- Health insurance laws
- National codes of conduct and code-regulation laws

Jurisdictions overlapping is inevitable to a certain degree and brings with it challenges such as:

- multiple avenues of complaint, with agencies sometimes undertaking separate investigations into the same incident
- constraints on agency interaction or coordination and disclosure of relevant information
- limitations of data linkages that might otherwise facilitate detection of patterns of poor practice or clinical governance failures.

A key challenge is for the various agencies and institutions to work together effectively to ensure that quality and safety of health service delivery is assured. To achieve this:

- complaints mechanisms must work effectively to ensure that though there may be multiple avenues to make a complaint, the right complaints body receives and manages the complaint in a timely manner
- patterns of unexpected adverse health outcomes must be identified and addressed as quickly as possible
- there must be effective information sharing between agencies, and joint consideration processes and protocols must be in place where there is jurisdictions overlap.

Jurisdictional inquiries that have followed major systems failures, such as that which occurred at Djerriwarrh Health Services in Victoria, have identified deficiencies in the capacity of the system to detect and appropriately respond to clinical governance failures. They have highlighted the need to strengthen the system’s capacity for continuous improvement in the safety and quality of health care (Duckett 2016).

The Tranche 1 Amendment Act included a range of measures to strengthen systems linkages, including:

- strengthened obligations on practitioners who are under investigation to disclose all of their places of employment to the National Board
- strengthened powers to inform a practitioner’s places of practice that the practitioner is under investigation
- streamlined powers of referral of matters between National Boards and regulators in co-regulatory jurisdictions
- strengthened powers to share information with Commonwealth, state and territory governments where a risk to health or safety is identified.
In addition, administrative mechanisms such as Regulatory Compacts and Alert Protocols have been established between AHPRA and some jurisdictional health departments to strengthen information sharing and system linkages.

A number of proposals in this consultation paper have the potential to strengthen information sharing and system linkages, thereby strengthening overall quality assurance. These include:

- Section 3.1: Objectives and guiding principles – referencing cultural safety for Aboriginal and Torres Strait Islander Peoples
- Section 4: Registration functions
- Section 4.4: Reporting of professional negligence settlements and judgements
- Section 4.5: Reporting of charges and convictions for scheduled medicines offences
- Section 7.1: Information on the public register
- Section 7.3: Power to disclose identifying information about unregistered practitioners to employers

This consultation provides the opportunity to canvass views about whether there are any other measures that might improve coordination, cooperation and information sharing between regulators, and strengthen the linkages between the registration regime and other legislative and non-legislative mechanisms of quality assurance. The aims are to:

- better detect at-risk practitioners so that preventive measures may be taken to protect patients
- enable use of data from Part 8 notifications about individual practitioners or practitioner groups to detect the early signs of clinical governance failures in the health system
- better coordinate service delivery, quality and safeguarding across health and community services
- 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.

This consultation is an opportunity to consider whether the linkages are working effectively between the National Scheme and other national and state/territory standard setting and regulatory mechanisms such as: the Australian Health Services Safety and Quality Accreditation; Commonwealth, state and territory licensing of providers of health, aged care and disability services; health service credentialling and clinical privileging; consumer protection regulators; the police; immigration; insurers providers, both public and private; public health regulation such as infectious diseases; and regulation of drugs and poisons and therapeutic goods.

A further example is that with the establishment of the National Disability Insurance Scheme (NDIS), effective system linkages will be needed between AHPRA and the statutory agencies that are responsible for administering the NDIS National quality and safeguarding framework, including with respect to administering NDIS worker screening for those disability workers who are also registered health practitioners.

Not every problem or issue with these interfaces will need a legislative solution – in some cases, an administrative solution may be preferable, or amendments to other state or territory laws may be indicated, or it may be determined that no action is required.

Questions to assist with submissions:

- 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?
- Are the current linkages between National Boards, AHPRA and other regulators working effectively?
- 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?
3.4 Name of the Agency Management Committee

The respective roles and responsibilities of the statutory entities established under the National Law are set out in Parts 2–5 of the National Law. These provisions establish the governance arrangements for the National Scheme, specifying the powers and functions of the COAG Health Council, AHPRA Agency Management Committee, the National Boards and their respective Accreditation Authorities. The accreditation functions are set out in Part 6 of the National Law. Parts 10 and 11 of the National Law and the Health Practitioner Regulation National Law Regulation set out the governance arrangements for the NHPOPC.

Figure 1 presents these arrangements in diagram form.

Figure 1: Statutory entities established under the National Law

*For the purposes of the National Law, the COAG Health Council is constituted by Ministers of the governments of the participating jurisdictions and the Commonwealth with portfolio responsibility for health*

Section 29 of the National Law establishes AHPRA’s Agency Management Committee. Section 30 sets out the committee’s functions, which include:

- to decide the policies of AHPRA
- to ensure that AHPRA performs its functions in a proper, effective and efficient way
- any other function given to the committee under the National Law.
The Agency Management Committee is, in effect, AHPRA’s governing body, and its role is to oversee AHPRA’s operations and set the strategic direction for the National Scheme.

While the functions set out in the National Law make it clear that the Agency Management Committee is responsible for overseeing AHPRA’s affairs, sometimes stakeholders are unclear about its role and about the lines of accountability and reporting. This may be, in part, because the name of the Agency Management Committee does not adequately convey the nature of its functions – these being comparable to those of the governing board of a statutory authority.

The chairperson of AHPRA’s Agency Management Committee has written to governments to request that the name of the Agency Management Committee be changed via legislative amendment to a name that more properly reflects its functions as the governing board for AHPRA. This request was made on the basis of feedback that its current name can create confusion regarding the committee’s role and accountability in the National Scheme.

This consultation provides the opportunity to consider whether the AHPRA Agency Management Committee should be retitled as the AHPRA Board. To change its name, amendments would be required to ss. 5, 29 and 30 of the National Law.

This proposed name change would not affect any of the Agency Management Committee’s functions.

**Question to assist with submissions:**

- 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?
4  Registration functions

An essential role of AHPRA and the National Boards is to protect the public. One of the ways they do this is by making sure that only those with the skills and qualifications to provide safe and competent care to the Australian community are registered to practise in a regulated health profession.

Part 7 of the National Law sets out the powers of AHPRA and the National Boards with respect to registration – the types of registration and endorsements on registration available; the qualifications and other requirements for registration; the application process; renewal of registration requirements; and the reporting obligations placed on registered practitioners.

AHPRA and the National Boards have a range of powers available to monitor the compliance of health practitioners with registration requirements (including any restrictions placed on their registration) and to ensure practitioners remain fit to practice. These powers are exercised at the initial registration stage, at the time of annual renewal of registration, during the registration period in response to reporting by the practitioner or other parties, and via the receipt and investigation of complaints notifications (complaints). Further details about these powers are set out in Appendix 3.

This consultation provides the opportunity to canvass views on key proposals to improve the administration of the registration functions.

4.1  Registration improperly obtained – falsified or misleading registration documentation

On occasion, AHPRA has become aware, after an application for registration has been processed and registration has been granted, that falsified documentation (such as proof or identity or qualifications for the profession) has been used in the application. When this occurs, two courses of action are available to the National Board:

- to deal with the matter under Part 7 of the National Law as a registration matter by refusing to renew the practitioner’s registration under s. 112 – however, this can only happen during the renewal period, or
- to deal with the matter under Part 8 of the National Law as a conduct matter.

Part 8 includes powers for a National Board to:

- take immediate action under s. 156, where a ‘registered health practitioner’s registration was improperly obtained because the practitioner or someone else gave the National Board information or a document that was false or misleading’, or
- refer the matter to the responsible tribunal under s. 193, where ‘the practitioner’s registration was improperly obtained because the practitioner or someone else gave the Board information or a document that was false or misleading’.

In practice, AHPRA usually becomes aware of these circumstances at a time other than the registration renewal period and must rely on the Part 8 provisions of the National Law. In many cases, referral to a tribunal is necessary before the person’s registration can be cancelled, since National Boards do not hold the power to cancel a person’s registration. Referral to a tribunal is usually a lengthy process, can incur significant costs for all parties concerned, and can result in an extended period of uncertainty for employers, practitioners and their patients.

This consultation provides the opportunity to canvass views on whether the National Law should be amended to empower a National Board to withdraw the registration of a person under Part 7, where the registration was improperly obtained.

In particular, it is proposed that the National Law be amended to:
• empower the National Board to withdraw the registration of a person where it has established that their application relied on false or misleading documentation (rather than relying on the provisions of Part 8)
• provide for a ‘show cause’ process before a National Board exercises this power
• provide a right of review for a person whose registration is withdrawn in such circumstances.

Question to assist with submissions:

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?

4.2 Endorsement of registration for midwife practitioners

Endorsement of registration is a mechanism by which a registrant who has additional qualifications and expertise recognised by a National Board can be identified on the public register. An endorsement of registration acknowledges that the registrant has an extended scope of practice in a particular area of practice because they have an additional qualification approved by the National Board. An endorsement authorises a registered practitioner to carry out certain roles or activities that a person without the endorsement is not authorised to, subject to any related jurisdictional legislation.

Appendix 4 provides details of how the endorsement function operates under the National Law and data on the types of endorsements granted.

Section 96 of the National Law makes provision for the Nursing and Midwifery Board to endorse the registration of a registered midwife, the effect being to authorise the midwife to practise as a ‘midwife practitioner’. Section 113 restricts use of the title ‘midwife practitioner’ only to those who hold an endorsement under s. 96.

When the National Law was being framed, the Nurses Act 1991 (NSW) provided for registration of midwife practitioners. At the commencement of the National Scheme in 2010, one midwife registered in NSW held this type of registration and was transitioned to national registration with an endorsement as a midwife practitioner. Since the National Law commenced:

• no further endorsements of this type have been granted by the Nursing and Midwifery Board
• the Nursing and Midwifery Board has not sought Ministerial Council approval of a registration standard to enable further endorsements of this type to be granted
• there are no approved programs of study that qualify midwives for endorsement as a midwife practitioner.

This consultation provides the opportunity to canvass views on whether s. 96 of the National Law that empowers the Nursing and Midwifery Board to grant an endorsement as a midwife practitioner should be repealed, since there does not appear to be a workforce need for such an occupational group. However, if this endorsement is repealed, this may decrease workplace flexibility if there are changes to the health system or workforce that would benefit from endorsement to separately identify an advanced practice class of midwives.

If s. 96 is repealed, then a transition provision would be required to enable the sole NSW midwife practitioner to continue to hold and renew their endorsement as a midwife practitioner and to continue to use the title, should they so choose.

No other changes are envisaged – the title ‘midwife’ would continue to be a protected title under the National Law.

Question to assist with submissions:
4.3 Undertakings on registration

Under ss. 155 and 178 of the National Law, a National Board can seek and accept from a practitioner an undertaking to limit the practitioner’s practice in some way, if this is necessary to protect the public. When a practitioner gives an undertaking to the National Board, it means the practitioner agrees to do, or to refrain from doing, something in relation to their practice of the profession.\(^{11}\)

Under s. 225, any undertaking that is currently in force is published on the public register against the practitioner’s name. When a National Board or adjudication body decides an undertaking is no longer required to ensure safe practice, it is revoked and removed from the public register. Where an undertaking relates to a practitioner’s health, the fact that an undertaking is in place is published, but the details of the undertaking are not published.

Conditions on registration are different from undertakings in the following ways:

- An undertaking is entered into voluntarily, whereas a condition is imposed on a practitioner’s registration by the National Board.
- A National Board or an adjudication body can impose a condition on the registration of a practitioner or student, or on an endorsement of registration (a condition restricts the practitioner’s practice in some way to protect the public).
- A condition may be placed on a practitioner’s registration for disciplinary reasons such as because a National Board has found that a practitioner has departed from accepted professional standards.
- A condition may also be placed on a practitioner’s registration for reasons that are not disciplinary, such as for a practitioner who is returning to practice after a break.

As applies for undertakings, conditions that restrict a practitioner’s practice of the profession are published on the register of practitioners. When a National Board or adjudication body decides a condition is no longer required to ensure safe practice, it is removed from the practitioner’s registration and no longer appears against their name on the public register.

4.3.1 Power to accept an undertaking at first registration and at renewal (instead of imposing a condition)

Under s. 83 of the National Law, a National Board has the power to grant registration subject to any condition the board considers necessary or desirable in the circumstances. Similarly, under s. 112, the board may renew a practitioner’s registration subject to a condition. Section 81 sets out the process that the board must follow if it intends to refuse application for registration or impose a condition. This includes giving a minimum of 30 days’ notice to the applicant and giving them the right to make a submission before the decision is made.

The board does not have the power to accept an undertaking by a practitioner when granting an application for registration. This means that a decision to grant registration where a condition is to be imposed by the board can take longer because the board must follow a ‘show cause’ process.\(^{12}\) Delays in processing registration applications could be avoided if the board had the power to accept an

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\(^{11}\) Note that that NSW is a co-regulatory jurisdiction and undertakings are not available as a regulatory action under the NSW National Law.

\(^{12}\) The ‘show cause’ process applies under section 81 of the National Law and requires a National Board to provide an applicant with written notice of a proposal to refuse application for registration or impose a condition, and to invite the applicant to make a written or verbal submission about the proposal.
undertaking from an applicant for registration in lieu of imposing a condition. Practitioners may prefer to give an undertaking rather than to have a condition imposed on their registration.

This consultation provides the opportunity to canvass views on whether ss. 83 and 112 should be amended to empower a National Board to accept an undertaking from a practitioner at first registration or at renewal of registration.

There is no provision in the NSW National Law allowing for undertakings. Therefore, if the National Law were to be amended to allow undertakings to be accepted at registration and renewal, consideration would need to be given to how the power would apply to practitioners whose principal place of practice is NSW, or in circumstances where a practitioner who has given an undertaking moves to NSW.

4.3.2 Failure to comply with an undertaking – impact on renewal of registration

In the course of a disciplinary process under Part 8, a National Board may decide to accept an undertaking from a practitioner that they will limit their practice in some way. In such circumstances, an undertaking may be the best way of facilitating a fair and timely outcome to a notification while also protecting the public.

In some parts of the National Law, undertakings and imposed conditions are treated similarly; for example, the failure to comply with a condition or an undertaking may be grounds for a National Board to take ‘immediate action’ under Part 8. However, in Part 7, in the case of renewal of registration, failure to comply with a condition and failure to comply with an undertaking are not afforded the same weight in the decision to renew a practitioner’s registration.

Section 112 of the National Law sets out the provisions that govern decisions about applications for renewal of registration. Under s. 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. However, there is no similar power to refuse to renew a practitioner’s registration in circumstances where the practitioner has failed to comply with an undertaking, even though the seriousness of the breach may be the same.

For example, a National Board may be notified that a practitioner is suspected of having a problem with substance use that is affecting their ability to practise safely. During the notification assessment process, the board proposes to impose a condition on the practitioner’s registration that they submit for regular drug testing. In considering the practitioner’s response to the proposal, the board instead agrees to accept an undertaking from the practitioner that they will complete a rehabilitation program and submit to routine drug testing as an alternative to imposing a condition. The board accepts the undertaking on the grounds that this will meet the public protection imperative while also enabling a timely settlement of the notification. However, it is subsequently discovered, around registration renewal time, that the practitioner has not complied with the requirements of the rehabilitation program and has missed a drug screen.

If the board had imposed the condition and the practitioner did not comply, then the board could propose to refuse to renew the registration of the practitioner. However, having accepted an undertaking instead, the board cannot propose to refuse to renew the registration and must initiate further disciplinary action under Part 8 of the National Law to suspend the practitioner. This can be a lengthy process for the practitioner, patients, employers and the board.

Under Part 7, a board may refuse to renew a practitioner’s registration because they are not a ‘fit and proper’ person to hold registration; however, failure to comply with an undertaking would not necessarily meet the threshold for this action in the absence of substantial other evidence of poor character, particularly if the practitioner has an impairment.

13 Note: Part 8 of the National Law does not apply in NSW. As such, any proposed amendments to Part 8 would not apply in NSW.
Therefore, while the requirements specified in a condition or undertaking may be identical, in the event of noncompliance, the powers available to the board at renewal of registration are not comparable.

This consultation provides the opportunity to canvass views on whether s. 112 of the National Law should 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. 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.

Questions to assist with submissions:

- 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?
- 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?

4.4 Reporting of professional negligence settlements and judgements

Background

Section 130 of the National Law requires that a registered health practitioner or student must, within seven days after becoming aware that a ‘relevant event’ has occurred, give the responsible National Board written notice of the event. The list of ‘relevant events’ includes charges for offences punishable by imprisonment of 12 months or more, convictions for offences punishable by imprisonment, withdrawal of clinical privileges, and other matters.

There are increasing expectations (from governments and the community) that National Boards monitor and intervene early where a practitioner's practice presents a risk to public health and safety. It is important that National Boards have at their disposal the most up-to-date and responsive set of regulatory tools to monitor professional practice and detect and respond to poorly performing practitioners, before patients suffer harm.

There have been calls for stronger disclosure obligations in this area (Scott & Armitage 2016), including a request from health ministers in April 2016 for advice on options for reform to strengthen system linkages, facilitate early detection of impaired or poorly performing practitioners, and minimise the risk of regulatory failure (COAG Health Council 2016).

In some other jurisdictions, the reporting obligations imposed on registered health practitioners include an obligation to disclose to their registration board any professional negligence settlements and judgements. In others, the obligation is imposed on the insurance providers.

National and international comparisons

United States of America

In the United States, the Code of Federal Regulations governs the reporting of medical malpractice payments. Regarding who must report, s. 60.7(a) of the code states that:

*Each entity, including an insurance company, which makes a payment under an insurance policy, self-insurance, or otherwise, for the benefit of a health care practitioner in settlement of or in satisfaction in whole or in part of a claim or a judgment against such health care practitioner for medical malpractice, must report information ... to the National Practitioner Data Bank (NPDB) and*
to the appropriate state licensing board(s) in the state in which the act or omission upon which the medical malpractice claim was based occurred (45 CFR § 60.7).

The type of information that must be reported under section 60.7(b) of the code includes:

- a description and amount of the judgement or settlement and any condition attached
- a description of the acts or omissions or injuries or illnesses upon which the action or claim was based.

Section 60.7(d) of the code provides clarification regarding the interpretation of information, stating that, ‘A payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred’.

The NPDB is an electronic information repository created by Congress. It contains information on medical malpractice payments and certain adverse actions related to healthcare practitioners, entities, providers and suppliers. Federal law specifies the types of actions reported to the NPDB, who must submit the reports, and who may obtain copies of the reports. Organisations must be authorised according to federal law to submit reports to NPDB or access the database. Organisations authorised to access these reports use them to make licensing, credentialling, privileging or employment decisions. An individual and organisation that is the subject of a report also has access to their own information. The reports are confidential and not available to the public (US Department of Health & Human Services 2017).

Ontario, Canada

The College of Physicians and Surgeons of Ontario (CPSO) regulates the practice of medicine in Ontario. In that province, all medical practitioners are required to declare to the CPSO any ‘offences, findings and settlements’ incurred in the previous year as part of their annual registration renewal. For the purposes of the CPSO registration renewal process the following definitions are used:

**Finding** means any judgement or decision made against a medical practitioner by a court in relation to any lawsuit involving a patient. This includes, but is not limited to, a finding of negligence, malpractice or battery. It also includes findings in which the practitioner has been found by the court to be liable for the acts of others, including the practitioner’s employees or agents, in a lawsuit involving a patient.

**Settlement** means an agreement to resolve a lawsuit involving a patient at any time during the proceeding. A settlement may or may not include payment made on your behalf to the patient or other parties in the lawsuit. You do not need to report a lawsuit that has been dismissed, discontinued, or withdrawn unless the lawsuit against you was dismissed, discontinued or withdrawn but included any payment of costs, admission of liability, and/or payment of money on behalf of the defence (CPSO 2017a).

In 2017 the CPSO registration renewal applications were required to answer the following questions:

- [In the previous year], has a court made a finding against you in any lawsuit involving a patient or someone acting on behalf of a patient, the facts of which you have not previously disclosed to the College?
- [In the previous year], have you made a settlement of any lawsuit involving a patient or someone acting on behalf of a patient, the facts of which you have not previously disclosed to the College?

If a registrant answers yes to either of these questions they are asked to provide an explanation, and the college may contact the registrant for further information.

The college is required by legislation to enter in the public register current charges and guilty findings (made on or after 1 June 2015) under the Criminal Code of Canada or Health Insurance Act, as well as every finding of professional negligence or malpractice, unless the finding is reversed on appeal.
Information relating to the settlement of any lawsuit is not made public; however, physicians are required to declare any settlement to the college. The college may follow up with the physician to request further information and, depending on the circumstances, may initiate an investigation.

**United Kingdom**

The General Medical Council (GMC) is responsible for registering doctors to practise in the UK. The GMC requires medical practitioners to complete a declaration of fitness to practice when:

- applying for registration with a licence to practise
- restoring their licence to practise
- restoring their name to the register
- relinquishing their registration.

As part of a ‘fitness to practise declaration’ (GMC 2017a), the GMC requires medical practitioners to disclose any settlements as a result of a medical malpractice or negligence claim. Specifically, practitioners are asked if they have ever entered into a settlement as a result of a medical malpractice or negligence claim, and to disclose if the claim was proven or disputed. Practitioners may also be asked for documentary evidence of the nature of the settlement including the nature of the medical malpractice/negligence.

**Australian state and territory laws prior to July 2010**

Prior to the National Scheme in 2010, five states had legislation that imposed an obligation on registered practitioners to report to the responsible registration board certain information about medical negligence settlements and judgements.

Victoria (*Health Professions Registration Act 2005* (Vic) s. 34), Queensland (*Health Practitioners (Disciplinary Proceedings) Act 1999* (Qld) s. 385B), South Australia (*Medical practitioners Act 1983* (SA) s. 72), Western Australia (*Medical Practitioners Act 2008* (WA) s. 61) and Tasmania (*Medical Practitioners Registration Act 1996* (Tas) s. 68) had legislative provisions that required a health practitioner to advise the relevant board where a court ordered the practitioner to pay damages or other compensation in relation to a claim for alleged negligence committed in the course of practising their profession.

In Queensland, South Australia, Western Australia and Tasmania, practitioners were also required to advise the relevant board where they agreed to pay a sum of money in settlement of a claim. In Queensland, an exemption applied to any settlement of proceedings under an agreement reached in conciliation under another relevant Act or interstate law.

In Victoria, an exemption applied where the court ordered the terms of the settlement be confidential. Generally settlements included a non-disclosure clause and, therefore, it was rare for a board to receive information of this nature under the Victorian provision (*Health Professions Registration Act 2005* (Vic) s. 34). Also, Victorian registration boards had a power to issue guidelines setting the amount below which reporting was required. This was to enable the boards to take account of ‘drop hands’ settlements (that is, settlements for small amounts of money where no liability had been admitted and the insurer considered it is less expensive to settle than contest the case).

**Discussion**

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.

The Oregon Medical Board (2017) notes that ‘a payment in settlement of a medical malpractice action does not create a presumption that professional negligence has occurred’. Settlements occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the health practitioner. As noted above, employers and insurers often settle claims where they consider it is less expensive to settle than to contest the matter. In some cases, the final decision to settle a matter may be outside the control of the health practitioner. So even though there is a finalised professional negligence claim, no disciplinary action may be warranted.

However, large settlements, where it is clear that professional negligence has occurred, may raise serious clinical matters and may be indicative of a more serious issue with the practitioner’s competence or conduct.

The laws that applied in some states prior to 2010 provided registration boards with an additional source of information which, when used in conjunction with other information, was intended to better equip the board to identify those practitioners whose practice might be placing the public at risk of harm. In dealing with data of this nature, boards would take into account that some types of clinical practice are inherently more risky than others and have a higher claims profile – and develop expertise in interpreting the data reported to judge when further regulatory action may be needed. While it is recognised that the information in settlements disclosed to a board cannot be definitively assessed and weighted, it may assist in providing a broader understanding of the nature and extent of issues related to a practitioner (for example, if multiple settlements were received regarding the same issue/procedure).

A proposal to include reporting requirements regarding medical negligence claims was canvassed during the consultation to establish the National Scheme (AHMAC 2008a), but consensus was not achieved across jurisdictions at that time. To introduce a new reporting obligation of this nature would represent a regulatory burden for which an impact assessment may be required under the COAG Best Practice Regulation requirements.\(^\text{14}\)

A series of tragic events at Djerriwarrh Health Services in Victoria between 2013 and 2014 created an imperative to search for better tools to help regulators to detect practitioners whose practice poses a risk to the public. In response to the Djerriwarrh events, AHPRA commissioned an independent review of its systems and processes for managing notifications in Victoria. This review recommended greater transparency and information sharing in the public interest with actions in five main areas:

- **Better risk assessment**: the need to embed a more systematic, data-informed approach to risk-assessing notifications not only taking account of the information that is outlined in the notification but also factors such as a practitioner’s history of notifications, their practice context and who made the notification.
- **Management of high-risk matters**: to more intensively apply resources to higher-risk notifications so these cases are investigated thoroughly but quickly.
- **Greater transparency**: to interpret and use the National Law flexibly, not narrowly, to support information sharing in the public interest and promote greater understanding and transparency of what AHPRA does.
- **Culture**: to address perceptions of being pro-practitioner and shift this perception through cultural change, with a greater emphasis on service. And for AHPRA to drive an open and transparent

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organisational culture with a clear balance between the interest of patients, public safety and the practitioner to ensure its service culture balances the rights and needs of all stakeholders.

- **Performance**: to continue to critically evaluate the causes of delays, especially for high-risk and complex cases (AHPRA 2016a).

For professional indemnity insurance claims that involve employees, individual practitioners may not be named in the claim where the action is taken against the employer (for example, where the state or a private company employs the practitioner).

### Options for reform

This consultation provides the opportunity to canvass views on whether the National Law should be amended to impose an obligation to report about professional negligence settlements and judgements made against a registered practitioner. The following options for reform differ as to who would be subject to such an obligation to report to the National Board and when.

**Option 1: No change – rely on the existing notifications process and practitioner credentialling to detect at risk practitioners**

Under this option, no changes would be made to the National Law. Instead, hospitals and other health services would continue to be responsible for credentialling of practitioners and might seek information from practitioners about professional negligence settlements and judgements as part of this process. Existing monitoring powers would continue to apply – for instance, the annual return completed at registration renewal, the obligation to report relevant events during the registration period and the mandatory reporting obligations on practitioners and on employers.

The National Law provides for mandatory reporting by employers and registered practitioners of conduct that placed the public at risk of harm because the practitioner practised in a way that constituted a significant departure from accepted professional standards. For any adverse event that results in a professional negligence settlement or judgement, the practitioner’s conduct may also meet the threshold for notifiable conduct under s. 140 of the National Law and trigger an obligation on the employer or registered practitioner to make a mandatory report.15 Also, when a practitioner’s conduct is subject to an investigation or performance assessment, the investigator may request that the practitioner provides details of their claims history.

This option does not preclude:

- reforms to the mandatory reporting obligations of employers as outlined in section 6.1 of this paper
- strengthening community and patient education about the notifications process to increase the likelihood that such matters are brought to the attention of the responsible National Board.

**Option 2: Practitioner obligation to disclose during a disciplinary process**

Under this option, a new provision would be inserted in Part 8 of the National Law to empower a National Board to require a practitioner who is the subject of a notification to provide the National Board with details of their claims history. This could be done either as part of the preliminary assessment of the notification, or as part of an investigation under Part 8 Division 8 or a performance assessment under Part 8 Division 9. As noted above, where another registered health practitioner, employer or education provider reasonably believes that a registered health practitioner or student has behaved in a way that constitutes notifiable conduct, they are already under a mandatory obligation to notify AHPRA.

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15 Sections 140–143 of the National Law set out the mandatory reporting obligations that apply to registered health practitioners, employers and education providers. Where a health practitioner (unless an exemption applies), an employer or an education provider reasonably believes that a registered health practitioner or student has behaved in a way that constitutes notifiable conduct, they must notify AHPRA of the conduct.
Option 3: Practitioner obligation to report

Under this option, the definition of ‘relevant event’ in s. 130(3) of the National Law would be amended to impose an obligation on all registered practitioners to report to the responsible National Board details (including amounts) of any professional negligence settlements or judgements against them. This would have to happen during the registration period and within seven days of the settlement or judgement. Failure to comply with the reporting obligation would be unprofessional conduct for which the board could decide to take disciplinary action under Part 8.

Option 4: Insurer obligation to report

Under this option, the National Law would be amended to impose a statutory requirement for all indemnity insurance providers to report to AHPRA details of any professional negligence settlement or judgement in relation to a registered practitioner. Failure to comply with this reporting obligation could be an offence (with provision for corporate penalties) or might result in the entity being named publicly for the compliance failure.

Alternatively, the obligation on insurers to report might apply in statute only where:

- an insurer decides to withdraw or refuses to renew the practitioner’s professional indemnity insurance, or
- there is a judgement and court-ordered settlement against the practitioner, or
- the responsible National Board requires details of the practitioner’s claims history to be provided by the insurer in the context of a Part 8 investigation of a notification.

If an obligation to report professional negligence settlements or judgements was introduced, it may also be appropriate to require information regarding whether the claim was proven or disputed, as occurs in the UK.

Questions to assist with submissions:

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

4.5 Reporting of charges and convictions for scheduled medicines offences

As outlined above, s. 130 of the National Law requires registered practitioners and students to give written notice to their National Board within seven days of a ‘relevant event’ occurring. A ‘relevant event’ includes that the practitioner or student has been charged with, or convicted of, an offence punishable by imprisonment, whether in a participating jurisdiction or elsewhere (ss. 130(3)(a)(i) and (ii)) and (b)(i) and (ii)). This requirement is intended to ensure that AHPRA and the National Boards have the earliest possible notice of events that may bring a practitioner’s suitability to practise into question, and that therefore require a timely regulatory response to protect the public.

However, the requirement that only those offences that are punishable by imprisonment be reported means that some unlawful conduct that may present a serious risk to health and safety may not need to be reported, even though it may warrant an urgent regulatory response. In particular, the current wording of s. 130 may not require a practitioner who is charged or convicted of unlawfully possessing a controlled or restricted drug to report it because, under drugs and poisons legislation, such offences are generally punishable by a fine only, rather than a term of imprisonment.

For example, offences under Queensland’s drugs and poisons legislation, the Health (Drugs and Poisons) Regulation 1996 (the HDPR), are punishable by a fine of up to 80 penalty units. Action can be
taken under the HDPR by either the Queensland Police Service or the Queensland Department of Health. Between January 2015 and April 2017, the Queensland Police Service charged 81 health professionals with offences under the HDPR. The majority of these offences related to the unlawful possession of restricted drugs.

In November 2016 in a report titled *Investigation report: undoing the knots constraining medicine regulation in Queensland* (Office of the Health Ombudsman 2016), the Queensland Health Ombudsman discussed the risk that drug-impaired practitioners may present to themselves or the health and safety of members of the public. The Health Ombudsman noted that:

- A practitioner is not required to notify the relevant National Board under s. 130 that they have been charged with, or convicted of, an offence under the HDPR. The National Law only requires that the practitioner notifies the relevant National Board either at the time they apply to renew their registration (s. 190(b)) or at such time as their authorisation to access controlled drugs under a jurisdiction’s drugs and poisons legislation is cancelled or restricted (s. 130(3)(a)(vi)).
- As a result there may be a significant delay between a person being charged or convicted under a drugs and poisons law and the National Board/AHPRA becoming aware of the matter. This delay may prevent the National Board or AHPRA from taking timely regulatory action to limit or manage a practitioner’s access to controlled drugs.

To address this regulatory gap, the Queensland Health Ombudsman has recommended that s. 130 of the National Law be amended to require practitioners to also notify the responsible National Board if they been charged or convicted of any offence under a drugs and poisons law, whether in a participating jurisdiction or elsewhere.

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. However, it is expected that in accordance with s. 178 of the National Law, a National Board would assess and determine what, if any, action is appropriate to take in relation to a ‘relevant event’ disclosed by a practitioner under s. 130.

This consultation provides the opportunity to canvass views on whether the National Law should be amended to strengthen the powers to deal with practitioners who have been charged with or convicted of an offence under a state or territory’s drugs and poisons legislation.

**Question to assist with submissions:**

- 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?

### 4.6 Practitioners who practise while their registration has lapsed

On occasion, a National Board becomes aware of a practitioner who has continued to practise after their registration has lapsed and this is disclosed when the practitioner reapplies for registration. If a practitioner continues to practise when their registration has lapsed, they may be committing an offence under the holding out provisions or practice restriction provisions in Part 7 of the National Law. In such circumstances, as the practitioner was not registered when the conduct took place, the way the National Law is currently framed, the matter cannot be dealt with as a disciplinary matter under Part 8.

If the National Board decides that further regulatory action is required, it must deal with the matter under Part 7. For example, the board has the option to re-register the practitioner with a condition placed on

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16 Note that as this proposal relates to the powers and functions under Part 8 of the National Law, this proposal does not apply to NSW.
their registration, or to prosecute the practitioner through the courts for the offence of using a reserved professional title or carrying out a reserved practice.\(^{17}\)

However, some of these matters are not considered suitable for prosecution due to factors such as the short time periods involved and a lack of intent to break the law on the part of the practitioner. For example, there have been cases where a practitioner has changed email addresses, has failed to update their details with AHPRA and then missed the reminders to renew their registration.

In such cases, particularly where this is the first occasion that the practitioner has failed to renew on time but continued to practise, placing a condition on their registration or prosecuting for an offence under the National Law may not be the most appropriate regulatory tools. Also, under Part 8, the majority of matters of this nature would not be of sufficient seriousness to meet the threshold for professional misconduct, nor would referral to a tribunal be an optimal outcome. The preferable course of action might be to re-register the practitioner and to issue a caution for failing to renew their registration on time.

The following case study of a practitioner who practised while their registration had lapsed illustrates the issues raised and the discretion sought by the National Boards.

**Case study**

Ms J is a physiotherapist who was registered with the Physiotherapy Board of Australia (the Board) (and had been registered with the state board for 10 years prior to the National Scheme). She suffered a major motor vehicle accident where the hospital admission and subsequent rehabilitation took an extended period of approximately eight months. During this period, Ms J’s registration had lapsed and correspondence that AHPRA sent to remind her to renew had not been received.

As a strategy to re-enter the workforce, she re-joined the private practice where she had a job before her accident, undertaking a graduated return to full clinical duties – some of these were administrative, while some were clinical in nature. During this time, she remained unregistered, although her patients could have reasonably understood her to be a registered health practitioner. At the point where she was returning to full clinical duties (approximately 12 months since her accident), Ms J decided to seek re-registration with the Board. On application, she fully disclosed the circumstances that led to the period without registration, and the work she had undertaken.

The Board considered her application for registration, noting:

- the period without registration (approximately 10 months)
- the reasons for her registration lapsing
- the disclosure that Ms J had undertaken practice while not registered
- there were no impairment issues that needed to be assessed and further considered
- Ms J’s previous registration history (and criminal history) had not indicated any issues of concern prior to her registration lapsing.

The Board considered that the short period without registration was not suitable for prosecution to be pursued. Further, given that health assessments had not identified any ongoing impairment issues that would restrict Ms J’s practice, that conditions placed on her registration by way of Part 7 provisions would not be an appropriate tool for addressing these concerns.

A more appropriate approach would be to manage any outstanding matters as a disciplinary matter under Part 8 as a practitioner who is eligible to hold registration but found to be practising without registration for a restricted period of time. In this case, an action such as a caution by the Board would have been potentially an appropriate outcome.

\(^{17}\) See Part 7 Division 10 for details of these offences.
This consultation provides an opportunity to canvass views on whether a National Board should have the discretion to deal with a practitioner who has practised while unregistered for a short period of time (and in doing so breaches the title protection or practice restriction provisions in the National Law), by applying disciplinary powers under Part 8 s. 178. For example, the board could issue a caution or refer the matter to a panel hearing as appropriate. The option to prosecute the practitioner for an offence under the National Law would still be available to deal with serious matters.

Question to assist with submissions:

- 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?

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

Under the National Law, a registered health practitioner may apply to a National Board to renew their registration (s. 107). Typically, a period of registration is 12 months, although the period of registration is decided by each National Board. In most cases, the registration renewal date is the same date for all practitioners in a particular profession, so all of the registrations in the profession end on the same date. If a practitioner applies for registration up to two months before a registration renewal date, registration may be approved for a longer period (up to 14 months).

To renew registration, a registered practitioner must apply for renewal to the National Board within one month after the practitioner’s period of registration ends. The practitioner remains registered until the National Board advises the applicant of its decision about their application for renewal. Under section 109 of the National Law, when a practitioner applies to renew their registration, they are required to make declarations about their suitability to practise.

These declarations include that they continue to meet registration standards designed to protect public safety and ensure continuing competence, such as the recency of practice, professional indemnity insurance arrangements, criminal history, and continuing professional development standards. Failure to meet these registration standards provides grounds for the relevant National Board to refuse to renew the practitioner’s registration or to renew the registration with conditions.

Under section 130 a registered practitioner must also, within seven days after becoming aware that a ‘relevant event’ has occurred, give written notice of this event to the National Board that registered the practitioner. ‘Relevant events’ include being charged with an offence punishable by 12 months imprisonment or more, or being convicted of an offence punishable by imprisonment.

Under the National Law, a practitioner’s registration may be suspended as a result of health, performance or conduct matters. There are several decisions that could result in suspension:

- a decision by a National Board to take immediate action under section 156 of the National Law, while a matter is being dealt with under Part 8 of the National Law
- a decision by a health panel to suspend a practitioner’s registration under section 191(3)(b) of the National Law, because of a health impairment
- a decision by a tribunal under section 196(2)(d).

Under section 225(l), the National Register must include that a practitioner’s registration is suspended and the period during which the suspension applies.

Note that whilst Part 8 of the National Law does not apply in New South Wales (as a co-regulatory jurisdiction), similar suspension provisions are still in operation in New South Wales.
Section 207 of the National Law provides that if a practitioner’s registration is suspended, the practitioner is taken not to be registered under the National Law for the period of the suspension, other than for the purposes of Part 8 (health, performance and conduct). As the requirement for a practitioner to renew their registration is included in Part 7 of the National Law (s.107), a suspended practitioner cannot apply for their registration to be renewed because section 207 expressly restricts registration to applying for the purpose of Part 8 only.

In practice, the suspended practitioner remains on the National Register with a record of the suspension until the suspension ends, is revoked on appeal, or is revoked by the National Board, a health panel19 or Tribunal. AHPRA and National Boards consider that the effect of section 207 is that the registration of a suspended practitioner is ‘put on hold’ or ‘frozen’. This means that although the registration cannot be renewed, it neither lapses nor expires under section 108 of the National Law. Instead, it continues only for limited purposes under Part 8 (health, performance and conduct).

If a suspension continues past a scheduled registration renewal date, and the suspension is subsequently lifted or expires, the National Law does not clearly empower a National Board to require a practitioner to make the declarations that they would have made at the scheduled renewal date, had their registration not been suspended. Therefore, the National Board may be unaware of matters that a National Board would usually be able to consider before deciding whether to renew a practitioner’s registration, such as a practitioner who has committed a criminal offence or does not have suitable professional indemnity insurance. Given that the suspended practitioner has been registered (although only for the purposes of Part 8) longer than the usual 12 month period (after which a practitioner would have been expected to make the usual declarations for their suitability to practice) it may be appropriate to ensure they remain eligible and suitable to practise between their return to practice and the next scheduled renewal.

As the suspended practitioner’s registration is treated as ‘put on hold’ or ‘frozen’ during a suspension it could be argued that once the suspension ends, the practitioner should be able to continue as a registered health practitioner for the remainder of the period of registration they would have been registered for if not for the suspension. It could also be argued that once a practitioner’s suspension ends, all of the practitioner’s rights and privileges as a registered health practitioner are ‘revived’ (along with their obligations), and so the practitioner should not be required to undergo an additional process to demonstrate their suitability to practise (such as registration renewal).20

Case study

A hypothetical case study illustrates these issues.

- In October 2017, a practitioner is suspended by a National Board taking immediate action in response to a notification.
- In May 2018, the relevant National Board completes an investigation of the practitioner and refers the matter to a tribunal for hearing.
- In January 2019, after a tribunal hearing, a tribunal decides to suspend the practitioner’s registration for a further 12 months.
- The practitioner’s usual registration renewal date (30 November) has passed twice, but the practitioner has not renewed their registration because their registration is suspended.
- In January 2020, the suspension expires and the practitioner’s registration is restored.

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19 A National Board may establish a health panel if it decides it is necessary or appropriate to do so and believes that a registered practitioner or student has, or may have, an impairment. Further information on health panels can be found at <https://www.ahpra.gov.au/Notifications/Further-information/Guides-and-fact-sheets/Panel-hearings.aspx>

20 It is noted that the NSW National Law contains provisions providing that when a practitioner’s suspension ends, all the practitioner’s rights and privileges as a registered health practitioner are revived.
The practitioner is not required to renew their registration until 30 November 2020. In January 2020, the practitioner last renewed their registration in November 2016, over three years earlier. Since the last renewal in 2016, the practitioner has made no declarations that would normally be required of a practitioner annually when they renew their registration. This includes declarations that they continue to meet registration standards designed to protect public safety and ensure continuing competence, such as the recency of practice, professional indemnity insurance arrangements, criminal history, and continuing professional development standards. The practitioner also has not been required to give notice to the National Board of ‘relevant events’ under section 130, such as criminal charges or convictions.

This consultation provides an opportunity to canvass views on whether the National Law should be amended to clarify whether a practitioner returning from suspension, whose suspension has passed one or more renewal dates, should be required to apply to renew their registration so that the National Board may consider their suitability to practise. The objective would be to ensure that when a practitioner recommences practice, they have made all the relevant declarations that would be required of any other practitioner for the upcoming period of registration.

If the National Law was amended to require a practitioner returning from suspension, whose suspension has passed one or more renewal dates, to apply to renew their registration it is acknowledged that a number of potential impacts would need to be considered during the renewal process. This includes appropriate registration fee adjustments, recency of practice requirements, and continued professional development requirements.

Consideration of appropriate administrative arrangements for adjusted registration fees would be required noting that the guiding principles of the National Law require that the scheme operate in a fair way and that any fees required to be paid must be reasonable and have regard for the efficient and effective operation of the scheme.

It is acknowledged that a practitioner who is seeking to return to practice following a suspension may not meet some registration standards, such as the recency of practice requirements or continued professional development requirements, particularly if their period of suspension was lengthy. The recency of practice registration standard is specific to each National Board and the requirements depend on the profession and the length of absence from the field. Where a practitioner declares that they do not meet this standard, the National Board can take appropriate steps and/or regulatory actions (such as imposing a condition) to ensure that the practitioner is fit to practise. Similarly, if a practitioner has not completed required continued professional development requirements due to their suspension, a National Board could consider arrangements to allow the practitioner to return to practice with appropriate arrangements in place (such as undertakings or conditions on registration) to protect the public until the practitioner has completed the continued professional development that would meet the standard expected in their profession.

Questions to assist with submissions:

- 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?
- 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?
5 Health, performance and conduct

Part 8 of the National Law sets out the powers of AHPRA and the National Boards to receive and investigate notifications (complaints) about registered health practitioners and formerly registered health practitioners.

This consultation provides the opportunity to canvass views on whether the provisions in Part 8 are working as intended, or whether any improvements are needed.

Key proposals for reform are set out below.

5.1 Mandatory notifications by employers

Sections 140–143 of the National Law set out mandatory reporting obligations that apply to registered health practitioners, their employers and education providers. The mandatory reporting obligations are intended to protect the public by increasing the likelihood that AHPRA, the National Boards and co-regulatory complaints bodies will be made aware of practitioners who may be placing the public at risk of harm and can take necessary action to protect the public, such as by placing conditions on or suspending the practitioner’s registration.

Section 142(1) of the National Law states, ‘If an employer of a registered health practitioner reasonably believes the health practitioner has behaved in a way that constitutes notifiable conduct, the employer must notify the National Agency of the notifiable conduct’.

Notifiable conduct is defined under s. 140 to mean that the practitioner has either:

- practised the practitioner’s profession while intoxicated by alcohol or drugs
- engaged in sexual misconduct in connection with the practice of the practitioner’s profession
- placed the public at risk of substantial harm in the practitioner’s practice of the profession because the practitioner has an impairment, or
- 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.21

Impairment is defined in s. 5 of the National Law to mean the person 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 practise the profession.22

In addition, where a practitioner’s right to practise at a hospital or other facility is withdrawn or restricted, the National Law places an obligation directly on the practitioner to advise their National Board:

- Under s. 109(1)(c), a registered health practitioner must provide to the board details of any withdrawal or restriction of their right to practice, in the annual statement submitted with an application for renewal of registration.
- Under s. 130, a registered health practitioner must give written notice to the board, within seven days, if the practitioner’s right to practise at a hospital or another facility is withdrawn or restricted because of the practitioner’s conduct, professional performance or health.

The question is whether these provisions, when taken together, are sufficient to ensure that the National Boards/AHPRA/co-regulatory complaints bodies are informed as early as possible of any practitioner whose practice may pose a risk, and can take appropriate action.

21 Section 140 of the National Law
22 Section 5 of the National Law
AHPRA has implemented administrative mechanisms to address this problem such as the 2015 ‘Know your obligations when employing health practitioners’ campaign for employers (AHPRA 2017d). Guidelines for mandatory notifications are also set by the National Board for each profession.

However, even with this education campaign and the additional guidelines developed by boards, AHPRA has reported a number of cases where a health service has identified safety and quality concerns with a person’s practice and withdrawn their clinical privileges, but has not advised AHPRA. AHPRA has subsequently become aware of such information, where other concerns about the performance of the practitioner have been reported to AHPRA from other sources such as through a notification from a second employer or a patient. The failure of the first employer to notify AHPRA when the practitioner’s clinical privileges were withdrawn delayed AHPRA’s ability to assess whether regulatory action was required to protect patients and the public. In these cases it would appear some employers were uncertain whether the mandatory notification provisions applied or whether the withdrawal of privileges met the threshold for mandatory reporting.

This consultation provides the opportunity to canvass views on whether the National Law should be amended to clarify the obligation of an employer to make a mandatory report of ‘notifiable conduct’ in circumstances where a practitioner’s right to practise has been withdrawn due to their conduct, performance or health.

A specific obligation to report in these circumstances could be included in s. 142. Alternatively, a note could be included in s. 142(1) to give guidance that the withdrawal of a practitioner’s right to practise may meet the threshold for reporting. The note could state that the termination of a registered practitioner’s practise by a recognised delegate of a health service may be grounds for a mandatory notification to a National Board under s. 140(c) or (d).

An amendment of this nature would be expected to:

- remove uncertainty and provide a clear requirement for employers to report when they withdraw a practitioner’s clinical privileges due to concerns about patient safety
- enhance the monitoring powers of National Boards to detect at-risk practitioners at an earlier stage, particularly where a practitioner practises across multiple facilities, and has had their clinical privileges withdrawn at one facility but not others.

**Question to assist with submissions:**

- 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?

5.2 Preliminary assessment of notifications

Division 5 of Part 8 of the National Law sets out the provisions governing preliminary assessment of a notification.

This consultation provides an opportunity to canvass views on whether the preliminary assessment process is working effectively for the benefit of notifiers and practitioners. A number of specific proposals for reform are outlined below.

5.2.1 Access to clinical records during preliminary assessment

During the preliminary assessment stage, unless a notification has been made by a patient (and therefore patient consent to access their medical records has been obtained), AHPRA is generally

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23 Note that as this proposal relates to the powers and functions under Part 8 of the National Law, this proposal does not apply to NSW.
unable to access relevant clinical (patient) records, unless the National Board has taken the step to refer the matter for formal investigation under Part 8 Division 8. This may result in notifications that could have been assessed and finalised without a formal investigation taking longer to be completed.

In NSW, under s. 21A of the **Health Care Complaints Act 1993** (NSW), the Health Care Complaints Commission has the power to obtain information, records and evidence from a person during the assessment stage of a complaint. Section 21A(2) provides that information and documents may be provided to the commission in compliance with this section despite any other Act or law, and s. 21A(3) requires the person to comply with a request for information unless they have a reasonable excuse not to do so.

This consultation provides the opportunity to canvass views on whether Part 8 Division 5 of the National Law (preliminary assessment) should be amended to mirror the NSW legislation, requiring a practitioner to provide information and records if requested to do so during the preliminary assessment stage of a notification, without risk of breaching their privacy obligations.

Such an amendment would be expected to reduce the number of occasions a National Board must invoke its formal investigation powers under Part 8 Division 8, thereby improving the timeliness of managing notifications to the benefit of both the practitioner and the notifier. Matters relating to patient consent, retention of records and sharing of patient information would be treated the same as information sought and obtained during an investigation under Part 8 of the National Law, noting that this may include access to a patient’s records without the patient’s consent. Under the powers of investigators in Schedule 5, investigators may require a person to provide information, and it is an offence for a practitioner to fail to provide requested information without a reasonable excuse.

**Question to assist with submissions:**

- 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?

### 5.2.2 Referral to another entity at or following preliminary assessment\(^{24}\)

As outlined above, Division 5 of Part 8 of the National Law deals with preliminary assessment of notifications. In particular:

- Section 149 provides that a National Board must conduct a preliminary assessment of a notification within 60 days after receipt.
- Section 150 sets out the arrangements for joint consideration with the responsible health complaints entity (HCE) if the subject matter of a notification would also provide a ground for referral to the HCE.
- Section 151 sets out when a National Board may decide to take no further action on a notification.

There is some lack of clarity with respect to the outcomes of the preliminary assessment process, the timeframe for completing the process and the powers of the responsible National Board. For instance:

- While s. 151(1)(e) provides that a ground for taking no further action on a notification is that the subject matter can be dealt with by another entity, there is no specific head of power for a National Board to make such a referral to another entity (with the exception of an HCE) until after an investigation has been completed – and not all matters will require an investigation.
- The Tranche 1 Amendment Act included a new provision (s. 151(1)(e)(ii)) that enables a board to take no further action when the subject matter of the notification has been referred by the board.

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\(^{24}\) Note that as this proposal relates to the powers and functions under Part 8 of the National Law, this proposal does not apply to NSW.
to another entity to be dealt with by that entity. However, the board is still constrained to either take no further action under s. 151, or to deal with the matter by way of investigation, despite when there might be another appropriate agency to deal with the matter. This reduces the efficiency of the preliminary assessment process.

Defining with greater precision the actions available to a National Board at the preliminary assessment stage would:

- assist practitioners and notifiers to understand the range of outcomes from a preliminary assessment of a notification and the expected timeframe
- ensure AHPRA has the power to refer notifications to the right entity as soon as practicable, in the interests of the notifier, AHPRA and the entity receiving the referral
- improve the accountability and transparency of reporting by AHPRA and National Boards on the process and outcomes of the preliminary assessment stage of the notifications handling process.

This consultation provides an opportunity to canvass views on how the effectiveness, timeliness and transparency of the preliminary assessment process may be improved. Specifically, views are sought on a proposal to amend the National Law to specify that, after assessing a notification, a National Board may decide to:

- take no further action (for reasons set out in s. 151), or
- refer the matter to another entity, such as a health service, a court (in the case of an expert witness in court proceedings) or an employer, if the National Board reasonably believes that it is better dealt with by that entity, or
- take further action under another division in Part 8.

If the National Board refers the matter to another entity, it is proposed that it also have the power, at any later time, to ask that entity for information about how the matter was dealt with and any action taken by that entity. For example, such information may become relevant if further notifications or information come to AHPRA regarding that practitioner.

### Notifications regarding a medico-legal assessment

Courts, tribunals and statutory authorities often appoint health practitioners to conduct assessments and provide independent medico-legal reports to inform decision making. On occasion, a party to a proceeding of this nature may be aggrieved about some aspect of the medico-legal report and may decide to make a notification under Part 8 of the National Law about the practitioner’s conduct or performance in preparing the report. In some cases, it may be appropriate for a notification to be dealt with through the usual National Board process, where the matter involves a genuine complaint about the standard of report prepared by a health practitioner. However, there may also be cases where the notification process is being used to influence or intimidate a practitioner about the independent evidence they have provided to a court, tribunal or statutory authority or as an abuse of process. The risk of such notifications is that health practitioners may refuse or be reluctant to undertake such independent health assessment work. Concerns of this nature were also raised through the 2016–17 inquiry into the life insurance industry.

In some cases, it may be more appropriate for the issue about the health professional’s report to be dealt with in the court or tribunal proceedings, rather than through the notifications process. For example, it may be more appropriate for the person concerned to obtain their own independent advice from another health practitioner to provide as evidence in the proceedings. In such a case, it would be up to the court or tribunal to weigh the evidence of the experts to make a judgement about the relative merits of the person’s case. In these cases it may be appropriate for a National Board, if it believes the issue raised in the notification does not identify any conduct, performance or health issues, to refer it to
Regulation of Australia’s health professions: keeping the National Law up to date and fit for purpose

There have been some calls for inclusion of a further ground for taking no further action on a notification if it relates to a medico-legal assessment, report or evidence given in a legal proceeding (Avant Mutual Group 2017). A National Board already has sufficient powers to take no further action where the notification relates to a medico-legal assessment or court report. However, an amendment to the National Law could further clarify that a National Board may, in the case of a notification about a medico-legal 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.

Question to assist with submissions:

• 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?

5.3 Investigation powers: production of documents and the privilege against self-incrimination

The National Law requires a person to give information or documents or answer questions as part of an investigation into a health practitioner or if an inspector reasonably believes an offence against the National Law has been committed (see ss. 1, 2, 9 and 10 of Schedule 5 and ss. 1, 2, 9 and 10 of Schedule 6). The powers assist investigators and inspectors appointed by AHPRA to collect information or evidence needed to take disciplinary action against practitioners or to be used in proceedings for offences against the National Law. Similar provisions are included in most legislative schemes that provide investigative and enforcement powers.

These provisions apply unless a person has a reasonable excuse for not complying. The National Law specifies that it is a reasonable excuse not to give information or documents or answer a question if to do so would tend to incriminate a person (see ss. 2(3) and 10(3) of Schedule 5 and ss. 2(3) and 10(3) of Schedule 6). These provisions reflect the common law privilege against self-incrimination.

The practical effect of the current provisions is that practitioners being investigated are entitled to refuse to handover relevant documents or answer questions if to do so would provide evidence against them. Although a practitioner may wish to provide documents or information to assist in finalising an investigation, the practitioner may be reluctant to do so for fear that anything they disclose could be used against them in criminal or civil proceedings.

To overcome these issues, some legislative schemes require a person to produce documents or answer questions, even if it would incriminate them. However, such legislation is generally accompanied by protections against the use of the documents or information in subsequent criminal, civil penalty or civil proceedings. The reason for providing protections is that, generally, the privilege against self-incrimination is considered such a fundamental right of the Australian legal system that when the privilege does not apply, it must be substituted with appropriate protections.

The advantage of including a provision of this type in the National Law would be that it could encourage more frank information to be provided in the early stages of an investigation, leading to investigations being completed more quickly. However, the protections given against the use of material in subsequent criminal, civil penalty or civil proceedings could potentially affect the ability to take criminal or civil penalty action at a later time. Despite this, provided investigators use other means to obtain evidence or information, criminal or civil penalty proceedings could still be taken in appropriate cases.
This consultation provides the opportunity to canvass views about whether the provisions of the National Law that reflect the privilege against self-incrimination should be amended. The current provisions could be amended to require practitioners to produce self-incriminating documents for the purposes of disciplinary action or offences against the National Law, but with protections against the use of those documents in subsequent criminal, civil penalty or civil proceedings. If amendments of this type were made to the National Law, the provisions may also need to clarify that documents given under these provisions would be able to be used for the purposes of an investigation, subsequent health, conduct or performance action under Part 8 of the National Law or for the prosecution of offences under the National Law. The privilege against self-incrimination could be retained in relation to the requirement to answer questions or provide information not already in existence. Alternatively, the provisions could be amended to provide practitioners with the option of giving self-incriminating material, but only on the condition that the material is protected from subsequent use.

Each state and territory’s justice policies differ in some respects about what protections should apply if legislation overrides the privilege against self-incrimination. For example, in the Australian Capital Territory (ACT), s. 22(2)(i) of the Human Rights Act 2004 (ACT) enshrines protection of the right for criminal proceedings. This is reflected in ss. 2(3) and (4) of Schedules 5 and 6 of the Health Practitioner Regulation National Law (ACT), which protect self-incriminating material being used in subsequent criminal proceedings, as well as information derived from the self-incriminating material. In some states, justice policies provide protection for the use of incriminating material in subsequent criminal proceedings, while in others such protection extends to civil penalty proceedings or civil proceedings.

The NRAS Review final report noted advice from AHPRA and the National Boards as follows:

> The Health Practitioner Regulation National Law (ACT) has a variant to Clause 2 of Schedule 5 that abrogates the right against self-incrimination. It provides that any information, answer or document required to be given, answered or provided is not admissible in evidence against the individual in a criminal proceeding. The same provision applies in NSW.

> Medical Defence Organisations have advised that they consider such an approach as desirable, as their members wish to cooperate with the Boards without fear that any information provided could be used against them in criminal proceedings.

> From a practical perspective, an amendment with application across the scheme would impact on notifications timeframes where there are extant criminal processes. Further, it may enable practitioners to better defend immediate action proposals as they will be able to freely give their version of events. (AHMAC 2014a, p. 177)

This issue was also raised in the submission by the Medical Insurance Group Australia (MIGA), a medical defence organisation and medical indemnity insurer, to the Senate Community Affairs References Committee in its 2016–17 inquiry: Complaints mechanism administered under the Health Practitioner Regulation National Law (Senate Community Affairs References Committee 2017).

MIGA advised that the limited availability of protections against self-incrimination and use of evidence in other contexts under the National Law is of considerable concern. MIGA expressed the view that this situation can leave a practitioner having to choose between:

> … providing information in the context of a health care complaint, but putting themselves at risk of sanction or proceedings in another context, or

> declining to provide information to a health care complaint, but facing consequences which may not have occurred if the information could have been provided with appropriate protections against use elsewhere. (MIGA 2017, p.11)
MIGA argued that given the interest of the National Law complaints system in protecting the public and ensuring appropriate professional standards and public confidence, there is an interest in providing scope for full and frank information to be provided by practitioners.

This issue was further considered in the report Independent review of the use of chaperones to protect patients in Australia (‘the Chaperone Review report’). The Chaperone Review report noted that:

Health practitioners may be unwilling to provide information or produce documents during investigations because statements they make or evidence they produce may be used against them in criminal proceedings. The fear of self-incrimination in a criminal investigation or trial was identified by some submitters as a contributory factor to delays in investigations of allegations of sexual misconduct. (Paterson 2017, p. 83)

The Chaperone Review report recommended:

Inclusion of a provision in the National Law removing the entitlement to refuse to answer a question or produce a document if the answer or production might tend to incriminate the practitioner (while still preventing its use in criminal proceedings) would likely reduce delays in investigations and provide Board committees with important information to assess the need for and appropriate level of interim action. The practitioner could be interviewed by AHPRA investigators and would be required to respond, but have the protection that any information and documents provided could not be used in the criminal proceedings.

The introduction of such a measure in the National Law may be insufficient to prevent tribunals granting a stay of the substantive disciplinary proceedings. However, removing one key barrier to speedier investigations (even if the disciplinary proceedings are not heard until after a criminal process) would enable National Boards to be better placed to assess the need for and appropriate level of interim action. (Paterson 2017, p. 83)

Questions to assist with submissions:

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

5.4 Regulatory actions available to National Boards

5.4.1 Show cause process for practitioners and students

Section 179 of the National Law sets out a ‘show cause’ process that a National Board must follow before it takes ‘relevant action’ under s. 178 in relation to a registered health practitioner or student, such as issuing a caution or imposing a condition on their registration. The show cause process is intended to

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25 Note that as this proposal relates to the powers and functions under Part 8 of the National Law, this proposal does not apply to NSW.
ensure procedural fairness for a practitioner or student who is the subject of regulatory action. The show cause process requires the National Board to give notice to the practitioner or student of the action it proposes to take, and to provide an opportunity for the practitioner or student to make a submission.

There are two proposals for amendment that relate to the show cause process.

**An express power to enable a National Board to take action under another division after considering a show cause submission**

After considering a show cause submission from a practitioner under s. 179, sometimes the National Board may wish to order that further information be collected by way of an investigation or health assessment. For example, a practitioner may provide significant new evidence during a show cause process that should be tested by obtaining further information before the board makes a determinative decision. The present construction of s. 179 does not expressly provide that a National Board can order that further information be obtained through an investigation, health or performance assessment under Part 8 of the National Law.

A practitioner may also provide information during a show cause process that leads a National Board to form a reasonable belief that the professional performance or conduct of the practitioner is more serious than previously considered and warrants referral to a performance and professional standards panel under Division 11 of Part 8 of the National Law.

It is proposed that s. 179(2)(b) be amended to the effect that a National Board, after considering a show cause submission, can decide to take action under another division of Part 8.

**Require a show cause process whenever relevant action is proposed under s. 178**

Section 179(3) provides an exemption from the show cause process in specified circumstances such as where an investigation or health assessment or performance assessment has already occurred.

However, the show cause process is important to afford the practitioner or student procedural fairness in relation to any regulatory action that is to be taken under Part 8 of the National Law. Despite the exemption from the show cause process that s. 179(3) provides, a National Board decision to take relevant action following an investigation or a health or performance assessment may be subject to challenge through judicial review proceedings if a show cause opportunity is not provided. It is therefore the current policy of AHPRA and the National Boards to afford a show cause opportunity in relation to all proposed relevant action regardless of whether the proposal follows an investigation or a health or performance assessment.

Given that the existing s. 179(3) is inconsistent with current operational practice and also may be out of step with emerging law in relation to procedural fairness in regulatory processes, it is proposed that the National Law be amended to remove the s. 179(3) exemption. This would have the effect of creating a statutory obligation, consistent with current practice, for a National Board to afford a show cause opportunity in relation to all proposals to take relevant action under s. 178.

**Questions to assist with submissions:**

- 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?
- 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?
5.4.2 Discretion not to refer a matter to a tribunal

Section 193 of the National Law provides that a National Board must refer a matter to the responsible tribunal if it reasonably believes that:

- a registered health practitioner has behaved in a way that constitutes professional misconduct, or
- the practitioner’s registration was improperly obtained because the practitioner or someone else gave the board information or a document that was false or misleading in a material particular.

Matters referred to a tribunal can result in a lengthy and costly process for the board, the practitioner and the tribunal. There have been instances where a National Board believes that a practitioner has engaged in professional misconduct or has improperly obtained registration, but there is no ongoing risk posed to the public by the practitioner, and there is no clear benefit in referring the matter to a tribunal for hearing.

Case study

A National Board investigates a dentist who allegedly committed professional misconduct by charging excessive fees for a range of dental procedures. During the course of the investigation, it is established that the dentist has a terminal illness, and the dentist tenders their registration. In these circumstances, there is little public interest in the National Board proceeding with a referral to the tribunal as the practitioner is no longer in practice, they pose no risk to the public, and the adverse consequences for the practitioner of proceeding with the referral are considered unacceptable in the circumstances.

Case study

A number of practitioners obtained certificates of good standing (also called a Certificate of Registration Status) from a fraudulent local provider. In the relevant series of cases the practitioners met all appropriate requirements for registration, had been practising in Australia for a number of years without concern and there was no evidence to support a view that the practitioners had acted improperly. Bringing these matters to a tribunal would have had significant adverse consequences for the practitioners concerned, with no public benefit.

This consultation provides an opportunity to canvass views on whether s. 193 of the National Law should be amended to permit a National Board to decide not to refer a matter to the responsible tribunal for hearing, where the board reasonably believes that there is no ongoing risk to public health and safety and it is not in the public interest to proceed with the referral. In such circumstances, the threshold for exercising this discretion should be high, given that even where a practitioner has ceased practice permanently and no longer presents a risk to the public, it may still be in the public interest for the matter to be heard so that justice is seen to be done, details of the matter are on the public record to act as a deterrent and improvements in practice can be made.

Questions to assist with submissions:

- 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, or if so, then why and what constraints should be placed on the exercise of such discretion?

Note that as this proposal relates to the powers and functions under Part 8 of the National Law, this proposal does not apply to NSW.
5.4.3 Settlement by agreement between the parties

When the National Scheme was being framed, health ministers sought a system that would ensure that public protection is paramount, maintain a high degree of transparency, and be appropriately accountable (AHMAC 2008b).

All state and territory HCEs have statutory powers to conciliate health service complaints, where this is the remedy sought by the complainant and there are no professional conduct, performance or health issues that require referral to the responsible National Board for disciplinary action. The exact division of responsibilities between the National Boards and the responsible state or territory HCE differs, depending on whether the participating jurisdiction is a ‘co-regulatory jurisdiction’ (NSW and Queensland are co-regulatory jurisdictions).

Section 150 of the National Law (except in NSW and Queensland) sets out how the National Boards and the responsible HCE jointly assess a notification or complaint that is received by one or the other but falls within both their jurisdictions. This joint consideration process provides that a matter (or part of a matter) dealt with by a National Board under the National Law can be referred to the HCE for another action, such as conciliation. The HCE may provide formal conciliation of a complaint, either at the same time it is being dealt with by a National Board/AHPRA, or following completion of the National Board’s disciplinary process.

In most cases, the earlier the matters arising from a notification are settled, the better for the notifier, the practitioner and the public. Using alternative methods of dispute resolution in the complaints process can lead to quicker settlements in less serious matters in a way that is satisfactory for the parties involved while ensuring that risks associated with the practitioner’s practice are adequately addressed. Under current arrangements, the key way to achieve both these objectives is to ‘split’ a matter, and for both the HCE and the National Board to deal with it, either in parallel, or one at a time.

The NHPOPC has advised that, in some cases, the notification process is unsatisfying for the notifier because the regulatory actions available to the National Board will not achieve what the notifier is seeking to achieve in making the notification. For example, the notifier may principally be seeking a personal apology from a practitioner or an opportunity to discuss the events that led to lodging the notification directly with the practitioner, so they can better understand the practitioner’s point of view. In some cases they may also be seeking a financial settlement or restitution. In these cases, a process that makes provision for involving the notifier in parallel with dealing with the professional conduct issues may achieve a more acceptable outcome for the notifier. However, the National Law does not provide the flexibility for National Boards to do this other than by ‘splitting’ the matter and referring it to the responsible HCE.

Settlement of a matter by agreement between the practitioner and the board, or between the practitioner, the notifier and board, was a feature of some state and territory registration schemes prior to introducing the National Scheme. For instance, both NSW and Victorian registration laws included such powers for boards, thereby, in appropriate cases, avoiding the need to refer the matter to the responsible HCE for formal conciliation. In some cases this enabled a quicker resolution (such as an apology, restitution or a replacement product) while ensuring any professional practice issues were adequately addressed. It is understood that the powers were more commonly used by those boards that regulate professions where there are strong commercial pressures to sell consumer products, such as in optometry and dentistry.

In 2012 the Victorian powers to settle a matter by agreement were repealed with full implementation of the National Law. In 2016, following public consultation, NSW amended its National Law to remove the requirement for its local regulators (NSW Councils) to encourage the complainant and the practitioner to settle the complaint by consent. The rationale for this amendment in NSW was that the National Law is a

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Note that as this proposal relates to the powers and functions under Part 8 of the National Law, this proposal does not apply to NSW.
public protection scheme, not an individual dispute resolution scheme, and that if a conciliated settlement is indicated, then this is best managed by the Health Care Complaints Commission.

The question of whether regulators should have mediation powers in the context of a ‘fitness to practise’ proceeding was examined by the UK Law Commission in its 2014 report. The Law Commission’s report noted that it will only be suitable in a limited number of cases, such as relatively minor misdemeanours where an apology is being sought, only early on in the process, and never in cases where there is a reasonable prospect of a finding of impairment.

The UK’s Department of Health and Social Care has again raised the question of the place of alternative dispute resolution in dealing with complaints about fitness to practise in its recent consultation on reforms to the regulation of healthcare professionals in the UK:

> More needs to be done to move to a more inquisitorial approach that seeks to establish the circumstances of a case rather than an adversarial approach. The government rejected the potential use of mediation as part of the fitness to practise procedures in response to the Law Commission’s recommendations. However we wish to reconsider this … Dispute resolution or mediation when dealing with enquiries and complaints that do not need a full fitness to practise investigation could help resolution of cases at an earlier stage. We would be interested in hearing views on the value of mediation as part of the system of professional regulation. (Department of Health and Social Care 2017, p. 21)

Under the National Law, National Boards already have the power to reach an agreement with a practitioner who is the subject of a notification, and to accept an undertaking from the practitioner, for example, to change the way they practise. However, this power is generally used in suitable cases to address the professional practice issues raised by a notification, rather than to secure other outcomes sought by the notifier, should these be different.

This consultation provides an opportunity to revisit the split of responsibilities between National Boards and the HCEs, and specifically whether s. 178 of the National Law should be amended to include an additional ‘relevant action’ for a National Board following a preliminary assessment or an investigation – that is, to ‘settle a matter by agreement between the practitioner, the notifier and the National Board.

On the one hand, such a power might enable a board, in the course of dealing with the professional practice issues raised by a notification, to secure an apology from the practitioner or a commitment to restitution for the notifier (for example, supplying new glasses or a replacement filling) without having to refer the matter to the HCE for a formal mediation or conciliation process following completion of the National Board’s process.

On the other hand, there is some unease that conferring on National Boards such a power might compromise the independence of the board in dealing with professional conduct matters, create unreasonable expectations from notifiers, and exacerbate confusion about the respective roles and responsibilities of the National Boards and the HCEs. For instance, if such a power were available, National Boards might be expected to use it to provide a formal mediation/conciliation process (thereby duplicating the role of the HCE), rather than simply securing an agreement through an informal process that is incidental to dealing with the disciplinary matter. The proposal also raises questions of potential conflict of interest, noting that where an entity carries out both prosecution and conciliation processes, as does the NSW Health Care Complaints Commission, there are statutory provisions that quarantine the conciliation function (the staff, the information generated) from the other disciplinary functions of the commission.

**Question to assist with submissions:**

- 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?
5.4.4 Public statements and warnings

Section 41A of the NSW Health Care Complaints Act 1993 empowers the Health Care Complaints Commissioner to issue a public warning or statement following an investigation where an unregistered health practitioner has breached a code of conduct for unregistered health practitioners or has been convicted of a relevant offence and the practitioner is considered to pose a risk to the health or safety of the public. Similarly, s. 94A of the NSW Act provides that the commissioner may decide to issue a public warning about a treatment or a health service where the commissioner believes there is a risk to health and safety.

When all states and territories have implemented the code-regulation regime (National code of conduct for health care workers) as agreed by health ministers in April 2015, it is expected that all HCEs will have powers to issue public statements and warnings.

While National Boards issue media statements from time to time, generally at the completion of a tribunal hearing, there is no specific power under the National Law for a National Board or AHPRA to issue a public statement or warning in circumstances where the National Board/AHPRA becomes aware of a risk to the health or safety of the public in the course of an investigation, prosecution or disciplinary proceeding. If such powers were available, a warning statement might be issued in relation to:

- a person who has their registration cancelled and is the subject of a prohibition order or interim prohibition order
- a person who has withdrawn their registration or let it lapse apparently in an attempt to avoid disciplinary action
- a person who has never been registered but is under investigation, charged with or found guilty of a reserved practice or holding-out offence under the National Law.

Case study

A National Board brought disciplinary proceedings against a practitioner in relation to a sexual relationship with a vulnerable patient. The practitioner’s registration was cancelled and they were disqualified from re-applying for registration for one year. Subsequent to the decision of the tribunal, an anonymous complaint was made to AHPRA that the formerly registered practitioner was holding themselves out and continuing to practice while not being registered. A warrant was executed at the practice and equipment and records were seized as evidence that suggested that the former practitioner was continuing to practise.

In such circumstances, if the powers were available, the National Board might issue a public statement naming the former registered practitioner and outlining the investigations that had established the former practitioner is not a fit and proper person to hold registration.

This consultation provides the opportunity to canvass views on whether an amendment to the National Law is needed to empower a National Board or AHPRA to issue a public statement or warning about a serious risk to the public arising from regulatory action in relation to:

- a registered health practitioner or number of registered practitioners
- a former registered health practitioner (including a practitioner who is subject to a prohibition order)
- an unregistered person or persons under investigation, charged with or convicted of an offence under the National Law.

28 For the purposes of the NSW Health Care Complaints Act 1993, a ‘relevant offence’ means an offence under Part 7 of the Public Health Act 2010 or an offence under the Fair Trading Act 1987 or the Competition and Consumer Act 2010 of the Commonwealth that relates to the provision of health services.
Whether such powers should be subject to a ‘show cause’ process before a public statement or warning is issued is also up for discussion.

It is expected that the National Board or AHPRA would use these powers in circumstances where the person is considered to pose a risk and it is determined to be in the public interest to issue a public warning, and to do so would not unduly interfere with any further process or investigation.

Questions to assist with submissions:

- 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?
- 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?

5.5 Information-sharing powers

The Tranche 1 Amendment Act included a number of modifications to information-sharing powers. As detailed in section 3.4 of this paper, some of the changes to information-sharing powers strengthen system linkages.29

This consultation provides an opportunity to canvass views on whether the information-sharing powers under the National Law should be further extended. Key proposals for reform are outlined below.

5.5.1 Power to disclose details of chaperone conditions

When a National Board receives a notification alleging that a health practitioner has engaged in professional misconduct (including sexual misconduct), the board must consider how to deal with these allegations and what, if any, action to take to protect patients while an investigation is undertaken.

In the past, when a notification regarding sexual misconduct was received about a practitioner, a board sometimes accepted an undertaking from the practitioner or imposed a condition requiring the presence of a chaperone when seeing all or certain types of patients. This was generally done as a temporary protective measure while allegations were investigated and the matter decided.

Section 216 of the National Law provides that a person who is or has been exercising functions under the National Law must not disclose protected information to another person, except in certain circumstances. Protected information is defined under s. 214 as ‘information that comes to a person’s knowledge in the course of, or because of, the person exercising functions under this Law’.

In 2016 AHPRA and the Medical Board of Australia (MBA) commissioned an independent review of the use of chaperone conditions, the Chaperone Review report (Paterson 2017) in April 2017 (see also section 5.3). The report recommended amendments to the National Law be considered to allow better information to be given to patients and chaperones in relation to the use of chaperones.30 Specifically, the report found:

29 For instance, ss. 132 and 206 of the National Law were amended to expand the definition of employer to include a broad range of different practice arrangements under which a health practitioner may be engaged, and a corresponding amendment to ensure that where health, conduct or performance action is being taken against a health practitioner, a National Board is able to inform all places at which the person practices. Section 220 of the National Law was also amended to enable a National Board to disclose information to an entity of the Commonwealth, state or territory to protect the health or safety of patients or other persons. A number of sections were amended to enable closer communication with notifiers by providing the flexibility for National Boards to inform notifiers of progress at key decision points, and by enabling more information to be communicated beyond what appears on the public register.
30 The Chaperone Review report also recommended that the term ‘chaperone’ be replaced with ‘practice monitor’ (Paterson 2017, p. 11). For the purposes of this consultation paper, these terms are considered interchangeable.
The National Law may need to be amended to allow a National Board to require a practitioner to disclose the reasons for a restriction to patients and to permit chaperones to be fully briefed as to those reasons. Unless disclosure to patients and chaperones is clearly authorised by statute, there will continue to be a gaping hole in the level of protection afforded to patients by chaperone conditions. (Paterson 2017, p. 81)

The Tranche 1 Amendment Act provided National Boards with a discretionary power to provide more information to notifiers (complainants) regarding the actions being taken in response to a notification and the reasons for taking action. However, this amendment relates only to notifiers and does not extend to patients of the practitioner.

This consultation provides an opportunity to canvass views on whether the National Law should be amended in accordance with the recommendations of the Chaperone Review report to empower a National Board to require a practitioner to disclose to their patients the reasons for a restriction requiring the presence of a chaperone (for example, where a restriction has been imposed due to alleged sexual misconduct) and to permit chaperones to be fully briefed about the reasons. One way of implementing such a proposal could be for a National Board to impose a condition on the practitioner’s registration.

Questions to assist with submissions:

- 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?
- 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?

5.5.2 Power to give notice to a practitioner’s former employer

Section 206 of the National Law requires a National Board to give notice to a practitioner’s employer of a decision to take health, conduct or performance action against the practitioner. This obligation applies only to the practitioner’s current employer or employers. The term ‘employer’ has been interpreted narrowly to mean only those in strict ‘employer–employee’ relationships.

The Tranche 1 Amendment Act made changes to s. 206 to provide that where health, conduct or performance action is being taken in relation to a health practitioner, the National Board is able to inform employers at all places at which the practitioner is practising and that s. 206 applies equally to contractual, voluntary and honorary employment arrangements.

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 risk.

However, there are currently no powers under the National Law for a National Board to require a practitioner who is under investigation to give to the board details of their previous employers. Also, even where the National Board knows of the practitioner’s previous employers, there are no powers for the National Board to notify those employers of a change in the practitioner’s registration status.

This consultation provides an opportunity to canvass views on whether the information-sharing powers in the National Law should be amended to provide a National Board with the powers to:

- obtain from a registered health practitioner details of their previous employment arrangements, including contract, voluntary and honorary arrangements
- disclose to a practitioner’s previous employer(s) and places of practice changes to the practitioner’s registration status.

A timeframe of five years prior to the date of the notification may be appropriate to exercise such a notice power, and for the power to be exercised only in circumstances where there is reasonable belief that the health practitioner’s health, conduct or performance may have exposed patients to harm.
Question to assist with submissions:

- 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?

5.6 Rights of review of National Board decisions

Division 13 of Part 8 of the National Law (ss. 199–203) sets out provisions dealing with appeals against certain decisions made under the National Law. Appeals under the National Law are generally heard by the responsible tribunal in the jurisdiction where the practitioner’s principal place of practice is located.

This consultation provides the opportunity to canvass views on whether the rights of review afforded under the National Law remain fit for purpose. Specific proposals for reform are outlined below.

5.6.1 Right of appeal of a caution

Section 178 of the National Law empowers a National Board to issue a caution to a practitioner or student. A caution is generally considered to be the minimum or least serious of the sanctions available to the National Board and is intended to act as a deterrent so the practitioner does not repeat the conduct. A caution is generally not published on the public register against the practitioner’s name, although a practitioner’s employer is advised that a caution has been issued (in accordance with s. 206 of the National Law).

Section 199 of the National Law explains ‘appellable decisions’. For instance, a practitioner may appeal a National Board decision to impose conditions on the practitioner’s registration and a decision to suspend a practitioner’s registration. The ruling of a performance and professional standards panel to reprimand a person is also appellable.

However, the issue of a caution to a registered health practitioner by a National Board is not an appellable decision. It may be open to a health practitioner who has been issued with a caution to seek judicial review of the National Board’s decision in the Supreme Court; however, this would most likely involve a review of questions of law involved in making the decision rather than a review of the merits of the decision itself. AHPRA has advised that a small number of practitioners have sought to use a judicial review process to appeal a caution.

Concerns have been raised that a practitioner is disadvantaged because, while a board advises the practitioner’s employer that the practitioner has been issued a caution, the practitioner has no right to appeal the board’s decision to issue the caution.

The NHPOPC has advised that in 2016–17 a small number of practitioners raised concerns about the lack of a right of appeal regarding the caution.

In addition, the Senate Community Affairs References Committee report Complaints mechanism administered under the Health Practitioner Regulation National Law recommended that the decision to issue a caution be an appellable decision (Senate Community Affairs References Committee 2017, p. 52). The report also notes that:

- appeals processes are important to ensure that all decisions are made properly and according to law
- all other board decisions are subject to an appeals process

Note that as this proposal relates to the powers and functions under Part 8 of the National Law, this proposal does not apply to NSW.
• the committee supported treating cautions in a consistent manner with other decisions made by the National Boards (Senate Community Affairs References Committee 2017, p. 52).

Options for reform

This consultation provides an opportunity to canvass views on whether s. 199 of the National Law should be amended to provide that a caution issued by a National Board to a practitioner following a disciplinary process be an appellable decision.

There are a number of options:

Option 1: No change

Under this option, no changes would be made to the National Law. A decision by a National Board to issue a caution would continue not to be an appellable decision. This option may be seen as reasonable, taking into consideration the cost and time for all parties of an additional appeal process, and the fact that cautions are at the lower end of seriousness of regulatory action and are not published on the public register.

On the other hand, practitioners have argued that it is unfair for their employer to be advised of a caution when the practitioner has no avenue to appeal the decision to issue the caution.

Option 2: Establish an internal review process

Under this option, an internal review process would be established to enable a practitioner to seek a review of a caution by an appropriate independent person who is appointed by the relevant National Board. Such a person would have had no involvement in the original decision to issue the caution.

The practitioner’s employer would be notified that a caution has been issued only where the appeal has been determined and if the decision is upheld.

The costs of an additional review mechanism would be borne by the professions in the form of increased registration fees. This option may be seen to strike a reasonable balance between the right of the practitioner to seek a review of a caution and the costs and administrative burden that the additional process would bring. Issues such as the powers of the reviewer (for example, whether the reviewer can substitute another decision or must refer the matter back to the original decision-maker for a fresh decision) would need to be settled.

Option 3: Amend the National Law to include a caution as an appellable decision

Under this option, the list of appellable decisions in s. 199 of the National Law would be amended to include a decision by a National Board to issue a caution, and the appeal would be heard by the responsible state or territory tribunal. As for Option 2, notice to the employer that a caution had been issued would occur only after the appeal is determined and if the decision is upheld.

Some practitioners may favour this option because it would afford a caution the same right of appeal as any other decision (relevant action) of a National Board. An additional appeal right would generate additional costs for the scheme and these would be passed on to registrants through higher registration fees.

Questions to assist with submissions:

• Should the National Law be amended to enable a right of appeal against a decision by a National Board to issue a caution?
• Which would be your preferred option?
5.6.2 The rights of review of notifiers

In managing notifications, tensions can sometimes arise between the need to ‘resolve’ the matter to the satisfaction of the complainant (the notifier) and the need to ensure the broader public interest is protected, for instance, by:

- supporting the practitioner to constructively address deficiencies in their practice (rather than punishing the practitioner for those deficiencies)
- enabling the practitioner to continue working or return to work, where the board considers it is safe for them to do so.

The public interest in keeping a practitioner working (albeit with appropriate measures in place to manage the identified risk) may be contrary to the desires of the individual complainant. It can be difficult for a notifier to accept that a National Board’s action is a measured and appropriate response to the issues raised by the complaint, particularly where there has been a death or serious injury and they or their loved one has suffered or continues to suffer the consequences.

The Tranche 1 Amendment Act made changes intended to improve communication with notifiers by providing the flexibility for National Boards to inform notifiers of progress at key decision points, and to provide reasons for decisions. The Tranche 1 amendments also removed specific limitations from the National Law on the information that can be provided to notifiers.

However, some stakeholders have expressed the view that these changes have not gone far enough. For instance, the NHPOPC has advised that complainants to her office often say they see it as unfair that a practitioner can appeal a decision of a National Board (to the tribunal), but the person who made the notification has no such right.

A notifier may lodge a complaint with the NHPOPC if they are dissatisfied with the way their notification has been handled – for example, where they consider the investigation about their notification was insufficient or where they believe the board has not given due weight to their concerns. However, the NHPOPC’s jurisdiction is limited to investigating the ‘administrative actions’ of the National Boards or AHPRA. This may include whether the board has taken account of relevant considerations and whether the board’s decision is reasonable, based on the information gathered by AHPRA during a preliminary assessment or investigation. The NHPOPC can also make recommendations to AHPRA, which might include the recommendation for a board to review a matter. However, the NHPOPC has no power to conduct a merits review of the matter or to substitute a different decision if the commissioner forms a view that the original decision was incorrect.

During the framing of the National Law, jurisdictions considered what rights the notifier should have in the disciplinary process. The policy position reflected in the National Law is that the notifier is not a ‘party’ to the disciplinary matter in that they do not have the right to be present at a hearing, to lead evidence, to cross-examine witnesses or to appeal a decision of a National Board, a hearing panel or a tribunal. While the notifier has in most cases triggered a disciplinary action by making a notification, the parties to the proceeding are the National Board and the practitioner.

Rights of review in other schemes

In some other legislative schemes there is provision for the complainant to seek a review of a decision following a disciplinary proceeding, although the process varies. Two examples are outlined below.

Under s. 41(3) of the NSW Health Care Complaints Act 1993, the Health Care Complaints Commission must review a decision taken under s. 39 of the Act if asked to do so by the complainant. The decisions available to the commission under s. 39 include: to refer the complaint to the director of proceedings (to

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32 Note that as this proposal relates to the powers and functions under Part 8 of the National Law, this proposal does not apply to NSW
consider prosecuting a complaint before a disciplinary body); to refer the complaint to the appropriate professional council (to consider taking action under the National Law such as performance assessment or impairment assessment); to refer the complaint to the Director of Public Prosecutions; or to terminate the matter. The Act is silent about the procedure for reviewing a decision under s. 41(3).

Under arrangements that applied in Victoria prior to 2010, the now repealed Health Professions Registration Act 2005 (Vic) made provision for a notifier to have a right of review for certain decisions by a board or panel to a fresh panel of reviewers who had had no previous dealings with the matter, including a nominee of the then Health Services Commissioner. The following were reviewable decisions since these were the decision points that had typically generated the most grievances:

- a decision not to conduct an investigation
- a decision to take no further action following an investigation
- a decision to refer a matter to an internally constituted ‘professional standards panel’ rather than externally to a tribunal where hearings were open to the public.

Although this additional review process incurred extra costs for the scheme, it provided an additional quality check on board decisions taken in disciplinary matters.

**Options for reform**

This consultation provides the opportunity to canvass views on whether the rights of the notifier in the disciplinary process should be strengthened, and if so, how. There are a number of options for reform:

**Option 1:** Status quo – no legislative change. Rely on administrative measures to improve the notifier experience, for example, by strengthening engagement with and education of notifiers and improving the existing pathways for administrative review through the NHPOPC.

**Option 2:** Amend the National Law to extend the powers of the NHPOPC to enable the commissioner to request that a National Board reconsider a matter in specified circumstances, for example, if the NHPOPC considers that the National Board has not given due consideration to all relevant information or if it appears that new information has come to light. The NHPOPC has advised that this would give the notifier an opportunity to communicate issues that they think may have been overlooked when their notification was first considered by the National Board and, even if the final decision does not change, the process of reconsideration may satisfy the notifier that the matters they raised have been exhaustively dealt with and that their views have been heard.

**Option 3:** Amend the National Law to provide a limited right of review for notifiers who are aggrieved by certain decisions of a National Board to a fresh panel of reviewers convened by AHPRA and that might include, for instance, a nominee of the NHPOPC.

**Questions to assist with submissions:**

- 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?
- Which would be your preferred option?
- 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?
6 Offences and penalties

The National Law includes various provisions that establish offences and penalties for unlawful conduct. Appendix 5 lists these offences and the relevant sections of the National Law.

The Tranche 1 Amendment Act made a number of changes to the offences and penalties, including an amendment to make it an offence for a person to contravene a prohibition order issued by a tribunal under s. 196(4)(b), with a maximum penalty of $30,000. Also, a new definition of ‘prohibition order’ was included in the National Law to ensure the offence applies to a prohibition order issued in any state or territory, including prohibition orders issued by co-regulatory jurisdictions.

In August 2017 health ministers agreed to progress the Tranche 1A Amendment Bill to make additional changes to the offences and penalties, specifically to:

- double the maximum monetary penalties for holding out, reserved practice and prohibition order offences to $60,000 for an individual and $120,000 for a body corporate
- introduce a custodial sentence with a maximum term of three years for holding out, reserved practice and prohibition order offences.

Drafting of an amendment Bill to progress these changes is proceeding.

This consultation provides an opportunity to canvass views on whether any further changes are needed to the offences and penalties under the National Law.

6.1 Title protection: surgeons and cosmetic surgeons

Sections 113–120 of the National Law set out offences for those who use a professional title that is reserved only for registered health practitioners, or otherwise pretend to be qualified and registered in a regulated health profession when they are not (see Appendix 6).

The Intergovernmental Agreement that underpins the National Scheme states that the primary basis for regulation is ‘protection of professional title’, with statutory offences to prevent unregistered or unauthorised people using professional titles. This means that only health practitioners who are suitably trained, qualified and fit to practise are registered and it is an offence for any other person to pretend to be qualified or registered in a regulated health profession or to use a professional title reserved for that profession when they are not so registered. It is also an offence for a person to ‘hold out’ another person as qualified and registered in a regulated health profession when they are not.

Questions have been raised about the scope of the offences that reserve professional titles and whether these provisions remain fit for purpose. There have been calls for the National Law to be amended in relation to the protection of title for surgeons and cosmetic surgeons.

The term ‘cosmetic surgery’ is used to describe a wide range of elective procedures designed to improve a person’s appearance. Cosmetic surgery procedures are performed by a range of providers including medical practitioners from various specialties (including general practice and plastic surgery), dentists and nurses as well as procedures involving lasers or intense pulsed light sources performed by beauty therapists (Australian Radiation Protection and Nuclear Safety Agency 2017). Training varies widely and there is no uniform approach to recognising qualifications or to credentialling. In addition, cosmetic surgery is discretionary – it is performed in the private sector and does not attract Medicare rebates. As a result, patients can choose to access surgery directly without a referral from a general practitioner.

There are various laws that regulate the provision of cosmetic surgery, including licensing of facilities (such as private hospitals and day procedures centres), medicines regulation, public health laws (infection control) and practitioner regulation (the National Law).
In October 2016, in response to a request from AHMAC, the MBA published the document Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures (Medical Board of Australia 2016). These guidelines aim to inform registered medical practitioners and the community about the board’s expectations of medical practitioners who perform cosmetic medical and surgical procedures in Australia.

The guidelines define ‘cosmetic medical and surgical procedures’ as:

… operations and other procedures that revise or change the appearance, colour, texture, structure or position of normal bodily features with the dominant purpose of achieving what the patient perceives to be a more desirable appearance or boosting the patient’s self-esteem. (Medical Board of Australia 2016, p. 2)

Surgery or procedures that have a medical justification are excluded from the definition.

The guidelines distinguish between ‘major’ procedures (that involve cutting beneath the skin) and ‘minor’ procedures (that do not involve cutting beneath the skin but may involve piercing the skin) (Medical Board of Australia 2016, p. 2). The guidelines also set out the board’s expectations with respect to matters such as: conflict of interest; patient assessment; provision of services to patients who are under 18 years of age; consent; patient management; provision of patient care by other health practitioners; prescribing and administering Schedule 4 (prescription-only) cosmetic injectables; training and experience; qualifications and titles; advertising and marketing; facilities; and financial arrangements (Medical Board of Australia 2016, pp. 3–6).

The MBA regulates medical practitioners who practise as specialists, in accordance with certain approvals granted by the Ministerial Council:

- Under s. 13 of the National Law, the Ministerial Council approves medical specialties and the specialist titles that may be used by practitioners who have been granted specialist registration in a recognised specialty.
- Sections 57–61 set out the powers of National Boards to grant specialist registration to suitably qualified practitioners.
- Sections 118 and 119 make it an offence for a person to hold themselves out as a specialist when they are not, to use any titles that are reserved only for practitioners in a recognised specialty or claim to be qualified to practise in a recognised specialty when they are not.
- Section 133 regulates the advertising of regulated health services, making it an offence to advertise a service in a way that is false, misleading or deceptive, that creates an unreasonable expectation of beneficial treatment, or directly or indirectly encourages the indiscriminate or unnecessary use of regulated health services.

Surgery is one of 23 medical specialities that the Ministerial Council has approved under s. 13 of the National Law. There are a number of speciality fields and specialist titles that have been approved within the medical specialty of surgery, such as:

- plastic surgery with a protected title of ‘specialist plastic surgeon’
- oral and maxillofacial surgery, with a protected title of ‘specialist oral and maxillofacial surgeon’
- general surgery, with a protected title of ‘specialist general surgeon’.

There is no recognised medical specialty or specialty field of cosmetic surgery and no protected title relating to cosmetic surgery. Therefore the MBA does not set minimum qualification requirements for those medical practitioners who use the title ‘cosmetic surgeon’.

If a medical practitioner does not hold specialist registration, it does not mean that they are not qualified or not able to perform any services within that specialty. For example, while not all medical practitioners have specialist registration in the field of surgery, many medical practitioners will undertake surgical procedures during their career. Rather, specialist registration recognises that a practitioner has met...
additional training and qualification requirements and is a specialist in a particular area. Restricting the use of specialist titles therefore helps the public to have confidence in the expertise of specialist practitioners.

In recent years, different groups have raised concerns that the use of ‘cosmetic surgeon’ misleads the public. As ‘cosmetic surgeon’ is not a restricted title, any medical practitioner can call themselves a cosmetic surgeon, regardless of their level of qualifications. There is concern that the use of the title ‘cosmetic surgeon’ can imply that the practitioner has specialist surgical registration.

However, it is understood that most practitioners who use the title ‘cosmetic surgeon’ do not hold board-approved specialist surgical qualifications. Some may be general practitioners (GPs) (that is, they hold specialist qualifications in the recognised specialty of general practice) and some medical practitioners who use the term may not hold any specialist qualifications at all.

In response to concerns about the use of the title ‘cosmetic surgeon’ by medical practitioners who do not hold a specialist surgical registration, there have been calls to amend the National Law to restrict use of the title ‘cosmetic surgeon’. Restricting the title ‘cosmetic surgeon’ may better inform consumers about the qualifications of practitioners who perform serious surgical procedures.

As such, this paper is calling for submissions on whether the National Law should be amended to restrict the title ‘cosmetic surgeon’ and, if so, which practitioners should be able to use the title.

A related issue also arises in respect of the title ‘surgeon’. Some medical practitioners, and others, use the title ‘surgeon’ despite not holding a specialist surgical registration. The use of such a title by a practitioner who does not hold specialist registration has been argued by some to be misleading.

On the other hand, as noted above, many medical practitioners will carry out surgical procedures during their careers. In addition, there are a range of other occupations who use, and have done so historically, the title surgeon, such as podiatric surgeons (and it is noted that podiatric surgery is a podiatric specialty), dental surgeons, veterinarian surgeons and tree surgeons. It is also noted that many GPs refer to their premises as ‘GP surgeries’ or ‘doctor’s surgeries’. While it is important that titles are not used in a way that can mislead the public, care also needs to be taken to ensure that title restrictions do not unnecessarily limit commonly used terms.

This paper is also seeking submissions on whether any restrictions should be placed on the use of the title ‘surgeon’.

Questions to assist with submissions:

- 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?
- 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?

6.2 Direct or incite offences

Section 136 of the National Law makes it an offence for a person to direct or incite a registered health practitioner to do anything in the course of their practice that amounts to unprofessional conduct or professional misconduct. This offence was framed to address concerns about adverse impacts associated with the increasing corporatisation of health services. The offence does not apply to a person who is the owner or operator of a public health facility, the rationale being that there are more efficient and effective ways of dealing with these issues in public facilities (for example, via the intervention ministers and departments) than prosecution through the courts.

These concerns are about the potential for corporate directors or their unregistered managerial staff to actively influence employee health practitioners to practise in ways that compromise their clinical independence and the quality of care to patients/clients, particularly with respect to:
referral patterns
consultation targets
ordering of diagnostic tests
prescription of pharmaceutical medicines, aids and equipment.

Other concerns relate to the potential for financial arrangements that are not transparent and understood by patients to influence clinical practice, or that access by patients to information in their medical records may be denied because of the sale or closure of a corporate practice.

While to date there have been no prosecutions under this section of the National Law, there is anecdotal evidence to suggest that practitioners have in the past relied on the existence of such statutory offences to protect themselves from pressure, in the context of an employment relationship, to compromise their clinical decision making for the sake of profit.

This consultation provides the opportunity to canvass views on whether the provisions of the National Law equip regulators with sufficient powers to deal effectively with direct or incite offences by practitioners who deliver regulated health services as an employee of a corporate entity, and whether the provisions are framed in a manner that maximises their potential deterrent effect.

For instance, unlike provisions that applied prior to 2010 (in now repealed statutes such as the Part 8A of the NSW Medical Practice Act 1992 and ss. 85–93 of the Victorian Health Professions Registration Act 2005) there is no provision in the National Law to:

- publish a list of practitioners who have been convicted of a ‘direct or incite’ offence under s. 136, or
- prohibit a person from continuing to provide a specified health service where the person has been convicted of an offence under s. 136 and is considered not fit and proper to own or operate a health service.

Appendix 7 sets out the ‘direct or incite’ provisions that applied in NSW for medical practitioners and in Victoria for all registered health practitioners prior to 2010. In NSW, the Director General’s prohibition order powers were never used. In Victoria, no prohibition orders were issued between 2002 and 2010 when the powers were in force. However, there was anecdotal evidence, in pharmacy, optometry and dentistry, that the provisions had an important deterrent effect in that practitioners were able to point to the provisions when, in their dealings with corporate managers, they felt pressured to make clinical decisions that they considered would compromise clinical care because they were driven by a profit motive rather than clinical need. However, as noted above, there is anecdotal evidence that the current provision in the National Law may provide a similar deterrent.

If amendments of this nature are to be progressed, a number of issues would need to be settled, including:

- the scope of the prohibition order powers – to prohibit a person from providing a specific health service, or all health services, and for a time limited period, or permanently
- who would exercise the powers – AHPRA and/or the responsible National Board, the responsible state or territory tribunal, or the courts.

**Penalties for a direct or incite offence**

Under s. 136, the offence for directing or inciting unprofessional conduct or professional misconduct has a maximum penalty of $30,000 in the case of an individual and $60,000 in the case of a body corporate.

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33 The direct or incite offence was first enacted for medical practitioners in Victoria in 2002 with amendments to the Medical Practice Act 1994 and then extended to all regulated health professions with commencement in 2007 of the Health Professions Registration Act 2005.
As outlined above, in August 2017 health ministers agreed to double the maximum monetary penalties for holding out, reserved practice and prohibition order offences to $60,000 for an individual and $120,000 for a body corporate. It is planned to progress these changes as part of the Tranche 1A Amendment Bill.

If these changes are passed by the Queensland Parliament and take effect, the penalties for direct or incite offences would be lower than for other offences under the National Law.

This consultation also provides the opportunity to canvass views on whether the penalties for direct or incite offences are at a level that reflects the seriousness of the conduct and the expectations of the community, or if they should be increased in line with the Tranche 1A amendments to the National Law.

Questions to assist with submissions:

- 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 practise in ways that would constitute unprofessional conduct or professional misconduct?
- 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?
- 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?
- 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?

6.3 Advertising offences

Section 133 of the National Law sets out the provisions that govern advertising of regulated health services. This section prohibits advertising that is either:

- false, misleading or deceptive
- offers gifts or discounts without setting out the terms
- uses testimonials or purported testimonials
- creates an unreasonable expectation of beneficial treatment, or
- directly or indirectly encourages the indiscriminate or unnecessary use of regulated health services.

Section 133 defines a ‘regulated health service’ as ‘a service provided by, or usually provided by a registered health practitioner’.

Advertising is also regulated under a number of other laws including the Competition and Consumer Act 2010 (Cwlth), the Australian Consumer Law (as applied in each state and territory) and the Therapeutic Goods Act 1989 (Cwlth) (as applied in each state and territory).

This consultation provides the opportunity to canvass views on whether the advertising offences are still fit for purpose, or whether changes are needed. Specific proposals for reform are set out below.

6.3.1 Prohibiting testimonials in advertising

With the advent of social media, there have been significant changes in the context of practice since the commencement of the National Law. Increasingly, consumers expect to express and share views about registered health practitioners and the services they provide, including on practitioner websites and social media.
The prohibition on testimonials in advertising under the National Law is more stringent than under other laws. Under the Australian Consumer Law and the Therapeutic Goods Act 1989 (Cwlth), testimonials are permitted in advertising, as long as they are not false or misleading.

The experience to date with administering this provision is that:

- Despite the prohibition on use of testimonials in the National Law, there is evidence that some practitioners are still using testimonials to advertise regulated health services.
- Practitioners are confused about their obligations and what constitutes a testimonial, particularly where a consumer makes a statement about a practitioner’s services on a consumer website and the practitioner’s website.
- Some testimonials appear to make false and misleading claims about clinical care, and others make no reference to clinical care at all.

The current prohibition on the use of testimonials in advertising presents regulatory challenges for the National Boards and AHPRA. In practice, regulatory action predominantly focuses on those testimonials that make false or misleading claims.

This consultation provides an opportunity to canvass views on whether prohibiting the use of testimonials to advertise regulated health services remains fit for purpose or should be modified.

There are two main options:

**Option 1:** Status quo – the prohibition on using testimonials to advertise regulated health services remains in place.

**Option 2:** Amend the National Law to limit the scope of the prohibition on using testimonials in advertising to apply only to advertising undertaken by the registered health practitioner or their employer. The prohibition would not apply to testimonials via means such as service directory sites or consumer blogs that are not linked to the practitioner and for which a practitioner has no control of the content. Under this option, there would be nothing to prevent a consumer publishing on a website or via social media a testimonial about a registered health practitioner or regulated health service, as long as this is not solicited by or linked to the practitioner to whom it relates.

While removing the prohibition on using testimonials altogether may seem appealing, to do so risks opening the floodgates to practitioners’ use of testimonials and making the job of regulating advertising more resource-intensive than it currently is. Limiting the scope of the prohibition on testimonials might enable National Boards and AHPRA to focus resources on breaches that involve the most risk rather than technical breaches of the prohibition on testimonials that arguably deliver only minimal public protection and are considered by some to constrain consumer information and choice.

**Questions to assist with submissions:**

- 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?
- Which would be your preferred option?

**6.3.2 Penalties for advertising offences**

Under s. 133 of the National Law, the offence for advertising breaches has a maximum penalty of $5,000 in the case of an individual and $10,000 in the case of a body corporate.

The penalties for advertising offences are much lower than for other offences such as holding out offences, restricted title offences, restricted practice offences and contravention of a prohibition order, which have a maximum penalty of $30,000 in the case of an individual and $60,000 in the case of a body corporate. It is also proposed that as part of the Tranche 1A Amendment Bill, these penalties be
increased to $60,000 for an individual and $120,000 for a body corporate (for further information, see section 6 of this paper).

The penalties for advertising offences in the National Law are also much lower than penalties for false or misleading advertising that apply under the Australian Consumer Law, where the maximum penalty for false or misleading conduct or unconscionable conduct is $1.1 million for corporations and $220,000 for individuals (Australian Competition and Consumer Commission 2017). Lesser civil penalties apply to other contraventions.

This consultation provides the opportunity to canvass views on whether the penalties for breaches of the advertising provisions are at a level that reflects the seriousness of the conduct and the expectations of the community.

There are three main options:

Option 1: Status quo – the maximum penalties for breaching advertising provisions would remain at $5,000 for an individual and $10,000 for a body corporate.

Option 2: Increase the penalties for breaching advertising provisions to $60,000 for an individual and $120,000 for a body corporate in line with the proposed increased penalties for other offences that will be introduced with the Tranche 1A amendments.

Option 3: Increase the penalties for breaching advertising provisions by another amount to more closely align with advertising breaches under the Australian Consumer Law.

**Question to assist with submissions:**

- 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?

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7 Information and privacy

Part 10 of the National Law sets out provisions governing the privacy, disclosure and confidentiality of information collected under the scheme, including provisions for publishing information on public registers. This section discusses the balance between what information should be available to the public and a practitioner’s right to privacy and right to have certain sensitive information kept confidential.

Specifically this section of the consultation paper will seek views on the following key proposals for reform.

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This consultation provides the opportunity to canvass views on whether the provisions in Part 8 are working as intended, or whether any improvements are needed.

7.1 Information on the public register

Background

Part 10 of the National Law sets out the powers of each National Board to maintain a public national register of the names and other details of all health practitioners currently registered by the board. Sections 222(2), 223(b) and 227 require each National Board to keep a public national register of practitioners whose registration has been cancelled.

Section 225 of the National Law sets out the information about registrants that is to be recorded in a public national register (see Appendix 8). In summary, this includes:

- details relating to the registrant’s registration type, including any endorsement, specialty or limitation on their registration
- details of any qualifications relied on to obtain registration or endorsement
- details of cancelled registrants including the grounds for cancellation and details of the conduct that led to cancellation (where this results from a hearing that was open to the public)
- current disciplinary sanctions in place in relation to suspension, reprimand, conditions or undertakings
- a record of decisions made by panels and tribunals
- other information the National Board considers appropriate.

There is also provision for:
• an exemption from publishing the details of conditions or undertakings relating to health impairment (s. 226(1))
• discretion not to record information in a national register or specialists register if publication would present a serious risk to the health or safety of the practitioner (s. 226(2))
• discretion to remove information on reprimands from a national register (s. 226(3)).

Section 227 of the National Law sets out the information to be recorded about practitioners whose registration has been cancelled. Also, a list of practitioners who have given an undertaking not to practise is publicly available.

Together, these public national registers provide a trusted source of timely, relevant and readily understandable information for a range of users about who is qualified to provide regulated health services, use protected titles and carry out restricted acts, and who is not.

Register information may be used for various purposes including:
• 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
• 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
• planning – to provide data for workforce planning purposes for public authorities and employers
• service delivery – to serve as a master index for use in e-health systems.

To make informed choices about their health care, consumers must have access to timely, relevant and readily accessible information. Consumers may seek to access register information to assist with:
• locating a practitioner or specialist in their area
• 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
• confirming a practitioner’s qualifications, including specialist qualifications
• 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).

Dissemination of information arising from the disciplinary process is an important vehicle to protect the public and promote professional standards.

The public register also benefits practitioners – the register is the only reliable source of information about a practitioner’s registration status. From time to time, false and malicious claims may be made about some practitioners, such as in social media, which could have the effect of unfairly damaging a practitioner’s reputation. An accurate, up-to-date public register is a means of protecting a practitioner’s professional reputation.

Recent amendments to the National Law

The Tranche 1 Amendment Act included a number of amendments to:
• empower National Boards to provide more detailed information to notifiers than that which appears on the public register
• require that the public national register of health practitioners in each health profession includes the names of all practitioners subject to a prohibition order and a copy of the order.
Also, the provisions relating to which board is required to keep which public national registers are to be shifted from the Act to the National Regulation (scheduled to commence by mid-2018).

International comparisons

A comparison of information available on the public registers in Australia and international jurisdictions has been undertaken, focusing on how each register is used (its purpose), levels of transparency regarding the information made available to the public, and the ways in which the functionality of (and ability to search) the registers enabled increased transparency and access to information.

Appendix 9 details the comparison of the public registers in Australia and international jurisdictions.

Based on the jurisdictions considered, it is evident that the public in North American jurisdictions, particularly in Ontario, has access to more information about practitioners than elsewhere. This access has also aided consumer choice through enhancements to the functionality of their online registers. Other jurisdictions, such as Australia and the UK, have taken a more cautious approach to ensure that registers do not stray from their primary regulatory purpose of indicating registration status. The College of Physicians and Surgeons of Ontario (CPSO), which has done considerable work to improve the transparency of information available to the public on its register (CPSO 2017b), maintains that providing information that helps consumers make decisions about who provides them with care has a public safety justification (CPSO 2017c) and allows them to be more accountable (CPSO 2017b). Where limited information is available, there is a concern that consumers may rely on other search engines or online practitioner directories that do not provide the up-to-date and reliable information that a practitioner register provides.

The extent to which disciplinary history and legal actions were noted on a practitioner’s record, and for what length of time, varied, but again, regulators like the CPSO have widened their scope in this area, while the UK’s General Medical Council has decided to reset the balance between transparency and proportionality to bring in time limits for publishing this information. Compared with the other regulators and jurisdictions, AHPRA appears to be providing a reasonable balance between practitioner safety and the public interest for instances where information on its register may need to be suppressed. While Australian and UK-based regulators are meeting web content accessibility guidelines, and most regulators provide consumer guidance on using their registers, there is still room for improvement in making registers more accessible to the public and easier to understand. This could include visual cues such as the ‘traffic light’ approach used by the UK’s Nursing and Midwifery Council that may help consumers with lower health literacy better understand the registration status of a practitioner.

Discussion

In determining what information should be publicly available and how this information may be accessed, the provisions of the National Law strike a balance between the public’s right to access information about a health practitioner and the practitioner’s right to privacy and to have certain sensitive information kept confidential.

There have been calls for more information to be made publicly available about registered health practitioners, in particular, for publication of more detailed disciplinary information on the public registers. On the other hand, concerns have been raised that the grounds for suppressing information about a practitioner on the public register are too narrow and could, in certain circumstances such as family violence, present a serious risk to the health or safety of a practitioner or other third party, such as a relative or friend of the practitioner.

35 Web Content Accessibility Guidelines (WCAG) 2.0, for example, available at: <www.w3.org/TR/WCAG20/>
Power to publish more information on the public register

Under current arrangements, access to register information is constrained. For instance, details of the disciplinary conditions placed on a practitioner’s registration are removed from the register either:

- when the condition expires (when evidence of compliance or successful completion has been accepted by the relevant board), or
- when the practitioner withdraws or fails to renew their registration.

This means that to find historical information about a practitioner’s disciplinary history requires a Google search or to search and read through previous tribunal decisions, with a separate search required for each state and territory. This can be complex and onerous, particularly if a practitioner has practised in multiple jurisdictions. The AHPRA website does, however, provide a link to the Australasian Legal Information Institute website (known as AustLII), which publishes decisions of courts and tribunals about registered health practitioners (AHPRA 2017c).

Other issues include the following:

- The public national registers may be searched only by entering a practitioner’s name. This means there is no public access to a single list of all practitioners who are subject to disciplinary conditions or those whose registration has been suspended. It may be argued that there is no clear public benefit in this given that if a patient is considering seeing a particular practitioner they can already search the register for that practitioner by name to see if they have any conditions on their registration.
- The register of practitioners, the list of cancelled practitioners and the list of practitioners who have given an undertaking not to practise are all separate registers that need to be searched separately.

There have been calls for more information to appear on the public register, particularly in relation to the historical details of disciplinary proceedings, and for this information to be more easily accessed. For instance, the Chaperone Review report (see section 5.3) found that:

- The ‘limited information on the register is insufficient to inform patients and the public and does not reflect a commitment to transparency. Patients should not have to resort to Dr Google to find information about a doctor’s previous disciplinary or criminal record for sexual misconduct’ (Paterson 2017, p. 10).
- While ‘the first guiding principle of the National Scheme is that “the scheme is to operate in a transparent, accountable, efficient, effective and fair way” … the national register currently contains less information than public registers in some other jurisdictions and this does not reflect a commitment to transparency’ (Paterson 2017, p. 81).

The Chaperone Review report also included the following quotes:

- ‘Part of good regulation must be helping patients to protect themselves, by making it easy for them to check the register’ (Stone, cited in Paterson 2017, p. 82).
- ‘The public has a right to know if there are conditions on a doctor’s registration or if there have been serious disciplinary or criminal offences proven against a doctor. It’s long overdue’ (chair of the MBA, Dr Joanna Flynn, cited in Paterson 2017, p. 82).

Paterson argues that restrictions on practice (with an explanation of the reasons) and full details of any disciplinary decisions that are not suppressed (with links to relevant decisions) should be available on the public register: ‘Providing such information is an important way for regulators to be transparent and accountable to the public they are charged with protecting’ (Paterson 2012, cited in Paterson 2017, p. 82).

The Chaperone Review report notes that many health regulators internationally do no better job of publishing information on the register. However, the report does acknowledge that some regulators do
make it easier for members of the public to search a practitioner’s history and notes that the Office of the Health Ombudsman in Queensland publishes practitioners’ names and immediate actions on a separate webpage.

This consultation provides an opportunity to canvass views about whether the current National Law provisions governing the public national registers and, specifically, the publication of information about registered and formerly registered practitioners whose registration has been cancelled are fit for purpose and strike a reasonable balance between the consumer’s right to know and the practitioner’s right to privacy. Issues include:

- whether a practitioner’s disciplinary history should be publicly accessible against their name on the public register
- if so, then what information should be included in a published disciplinary record – for example, the findings and decisions of tribunal and panel hearings, conditions imposed on registration, reprimands and undertakings (other than details of impairment/health-related conditions)
- whether there should be a time period after which some information (such as expired conditions and reprimands) should be removed from the register if there have been no further related notifications
- the thresholds for publishing disciplinary information on the public register – the decision not to publish information and the decision to remove information from the public register.

**Power to suppress information from the public register**

Section 226 of the National Law provides powers for a National Board to decide, on application from a registered practitioner, not to record information about the practitioner on the public register if the board reasonably believes the inclusion of the information would present a serious risk to the health or safety of the practitioner.

A number of concerns have been raised about these provisions:

- whether the grounds for suppression are too narrow because the practitioner must prove there is a serious risk to their own health and safety but not to their family or wider network
- there is no provision for a third party (a friend or relative of the practitioner) to make application to a National Board for information to be suppressed from the public register where they may be adversely affected, for example, when there is a risk of family violence.

The NRAS Review final report noted the following in relation to the issue of information on the public register:

*It is proposed that information on the public Register be limited to protect third parties who may be adversely affected (section 226). This proposal is supported. The Australian College of Nursing (ACN) noted that the National Law might also include a requirement that the public interest be considered and may override the adverse impact on one individual.* (AHMAC 2014a, p. 75)

This consultation provides an opportunity to canvass views on whether the powers to suppress information from the register are fit for purpose. In particular:

- whether the current provisions in the National Law are sufficient to capture the risk of family violence
- whether a National Board should be required, on production of evidence (for example, a court order) of domestic and family violence, to remove the principal place of practice and any employment details of the practitioner that appear on the public register
- whether a third party should be able to make an application to suppress information from the public register.
Questions to assist with submissions:

- Is the range of practitioner information and the presentation of this information sufficient for the various user groups?
- Should the National Law be amended to expand the type of information recorded on the national registers and specialist registers?
- What additional information do you think should be available on the public register? Why?
- 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?
- Should s. 226 of the National Law be amended to:
  - broaden the grounds for an application to suppress information beyond serious risk to the health or safety of the registered practitioner?
  - 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?
  - 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?

7.2 Use of aliases by registered practitioners

Some registered health practitioners practise under a different name to that which appears on the public register. There may be legitimate reasons for this, such as safety or privacy concerns, or where the practitioner has adopted and uses an anglicised name in their practice.

However, there are occasions where an applicant for registration or a registered health practitioner has used one or more aliases to avoid detection of criminal or complaints history, or to make it more difficult to identify them for the purposes of making a notification.

Some other jurisdictions have specific provisions dealing with registered practitioners using aliases. For instance, under Californian law, the Business and Profession Code states that:

… the use of any fictitious, false, or assumed name, or any name other than his or her own by a licensee either alone, in conjunction with a partnership or group, or as the name of a professional corporation, in any public communication, advertisement, sign, or announcement of his or her practice without a fictitious-name permit … constitutes unprofessional conduct. (CA Bus & Prof Code § 2285)

The Medical Board of California is empowered to issue a ‘fictitious name’ permit (The Medical Board of California 2016). The purpose of the permit is to allow the practitioner to practise under a name other than his or her own. The Medical Board of California closely monitors fictitious names to ensure that similar names are not issued. If there is a name discrepancy, the applicant is contacted to agree upon an alternative name.

If a National Board discovers aliases used by a practitioner, it does not routinely record them on the public register. Publication of aliases used by a practitioner may help the public more easily find a practitioner on the public register to review their entry.

This consultation provides an opportunity to canvass views on whether the National Law should be amended to:
• enable a practitioner to nominate one or more aliases or additional names to be recorded on the public register, with the register searchable using the alias
• empower AHPRA to record on the public register an alias used by a practitioner, whether the practitioner has applied to do so or not.

It is anticipated that the power to suppress information from the register would apply also to the use of an alias. It is not intended that shortened versions of names be considered an alias, for example, a practitioner who is registered as ‘Jennifer’ but practises as ‘Jenny’.

Questions to assist with submissions:

• 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?
• Should the public registers be searchable by alias names?
• Should the National Law be amended to require a practitioner to advise AHPRA of any aliases that they use?
• 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?
• 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?

7.3 Power to disclose identifying information about unregistered practitioners to employers

Under s. 206 of the National Law, a National Board may inform an employer of a registered health practitioner of its decision to take health, conduct or performance action against a registered health practitioner. Providing this information to an employer can be important because the employer may need to take further action to protect patients or the public.

This power to provide information to an employer does not extend to circumstances where AHPRA is investigating or prosecuting a person who is not a registered health practitioner for an offence under the National Law, even where such a person may be providing a health service and is considered to pose a risk to the health or safety of the public. While s. 220 of the National Law provides power for a National Board to disclose information to a Commonwealth, state or territory entity about a registered health practitioner and (in all states and territories except Western Australia) about any other person who provides a health service and poses a risk to public health and safety, the scope of this power does not extend to employers.

There are instances where AHPRA has received information about a person who is not registered (or who was previously registered) and considers there is a strong public interest in disclosing that information to the person’s employer or another entity. For example, if AHPRA receives information that a person who is not registered is working in a private health clinic and is using the specialist title ‘dental specialist’ when they are not a registered dental practitioner, it would investigate. On investigation of the matter, AHPRA might determine that there is a potential breach of the National Law, that the safety of the public is at risk, and that prosecution of the person may be warranted. However, AHPRA’s current powers do not allow it to inform the practitioner’s employer of this action. The employer may not be aware that the person is using a reserved title under the National Law, and if they did know, it might prompt them to take action to protect the public.

This consultation provides an opportunity to canvass views on whether the National Law should be amended to enable AHPRA or a National Board to provide information to an unregistered person’s
employer, where the person is being investigated for an offence under the National Law. Such a disclosure may assist an employer to take appropriate action to protect the safety of the public.

Questions to assist with submissions:

- 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?
8 Consolidated list of questions

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?

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?

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?

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?

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?

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

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?

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?

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?

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 practise as a midwife practitioner be repealed?
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?

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?

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?

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?

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?

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?

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?

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?
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?

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?

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?

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?

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?

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?

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?
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?

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?

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?

37. Which would be your preferred option?

Section 5.6.2: The rights of review of notifiers

38. Should the National Law be amended to enable 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?

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?

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 practise 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?

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?
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?

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?

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?

54. Should s. 226 of the National Law be amended to:
   - broaden the grounds for an application to suppress information beyond serious risk to the health or safety of the registered practitioner?
   - 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?
   - 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?

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?

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?
Appendices

Appendix 1: Findings and recommendations from other relevant inquiries and reviews regarding the National Registration and Accreditation Scheme

Senate Community Affairs References Committee inquiries 2016–17

Medical complaints process in Australia
On 2 February 2016, the Senate referred the following matter to the Senate Community Affairs References Committee for inquiry and report: Medical complaints process in Australia.

The inquiry lapsed at the dissolution of the Senate on 9 May 2016. On 15 September 2016, the Senate agreed to re-adopt the inquiry, with a reporting date scheduled for November 2016.

The predominant focus of that inquiry was the prevalence of bullying and harassment within Australia’s medical profession.

On 30 November 2016, the committee’s report was tabled in the Senate. The report contained six recommendations – five proposing actions from stakeholders to further address bullying and harassment, and a sixth recommendation for a further inquiry into the complaints mechanism in the National Scheme.

Complaints mechanism administered under the Health Practitioner Regulation National Law
On 1 December 2016, the Senate referred the following matter to the Senate Community Affairs References Committee for inquiry and report: Complaints mechanism administered under the Health Practitioner Regulation National Law.

The focus of that inquiry was the implementation and regulation of the complaints mechanism administered under the Health Practitioners Regulation National Law. It examined whether the current existing regulatory framework in the National Law provides adequate provision for dealing with medical complaints, the roles and relationships between AHPRA, National Boards and other bodies in dealing with complaints and whether amendments to the National Law are required to ensure the effective management of the complaints handling process.

On 10 May 2017, the Senate Committee’s report was tabled in the Senate. The report concluded that the independent evidence does not suggest that vexatious notifications are a widespread issue, and made 14 recommendations to improve the complaints process in the National Scheme. Some of the recommendations may require amendments to the National Law and are canvassed in this consultation paper.

State and territory inquiries

Victorian Legislative Council Legal and Social Issues Legislation Committee: Inquiry into the Performance of the Australian Health Practitioner Regulation Agency
On 23 October 2012, the Legislative Council of the Parliament of Victoria requested the Legal and Social Issues Legislation Committee to inquire into, consider and report on the performance of the Australian Health Practitioner Regulation Agency including its cost-effectiveness, its regulatory efficacy and the ability of the National Scheme to protect the Victorian public.

On 12 March 2014, the Legal and Social Issues Legislation Committee tabled its report. The report recommended a number of issues to be addressed including improved handling of complaints, greater financial transparency and further streamlining of the bureaucracy that supports the National Scheme.
A large part of the report dealt with the health complaints process under the National Scheme, which is designed to protect the public. The report concluded that there were numerous problems with the existing health complaints process in Victoria at that time including time delays, inadequate communication, confusion over the roles of AHPRA, the boards and the then Health Services Commissioner, inadequate rights of notifiers, and inadequate ministerial and parliamentary accountability and oversight.

Some of the recommendations of that inquiry have been addressed administratively by AHPRA, some have been addressed in the Tranche 1 legislative reforms, and others will be considered as part of this Tranche 2 reform process.


**Independent reviews**

**Independent review of the use of chaperones to protect patients in Australia**

In 2016 AHPRA and the Medical Board of Australia (MBA) commissioned Professor Ron Paterson, Professor of Law at the University of Auckland and Distinguished Fellow at Melbourne, to undertake a review of the ‘use of chaperone conditions as a condition of registration of a health practitioner to protect patients while allegations of sexual misconduct are investigated’.

On 11 April 2017, AHPRA and the MBA released the Independent review of the use of chaperones to protect patients in Australia (‘the Chaperone Review report’), which contained 28 recommendations for reform. These recommendations relate to the use of chaperones, improved handling of sexual misconduct cases, and better information sharing with patients.

The Chaperone Review report stated that the use of chaperone conditions in response to allegations of sexual misconduct is not an effective means to safeguard patients and is no longer consistent with community expectations. It recommends the use of chaperone conditions as an interim measure be discontinued, to be replaced by greater use of gender-based prohibitions, prohibitions on patient contact and suspensions.

The Chaperone Review report acknowledged that reforms to the National Law, which will come into effect through the Health Practitioner Regulation National Law and Other Legislation Amendment Act 2017 (the Tranche 1 Amendment Act), address some of the concerns identified in the report, including strengthened powers to require practitioners to provide to their National Board information about employers and practice locations, review periods for conditions on registration, and a public interest test for immediate action (Paterson 2017, pp. 80–81).

The Tranche 1 amendments also include additional powers for AHPRA and National Boards to inform notifiers of the reasons for a decision taken by a National Board.

However, the reviewer suggests that the following recommendations are included in the second stage of legislative reforms:

- information for patients and chaperones – the report recommends that practitioners are required to disclose the reasons for a restriction to patients and fully brief chaperones about those reasons
- more information on the National Registers – extend powers to publish a broader range of information on the public register
- better communication with notifiers to ensure that notifiers are kept informed of the progress of their complaint
- remove the right of practitioners to refuse to answer questions or produce documents if the answer or production might tend to incriminate the practitioner.
Appendix 2: Definition of cultural safety

This definition of ‘cultural safety’ is taken from the Australian Health Ministers’ Advisory Council’s Cultural respect framework for Aboriginal and Torres Strait Islander health 2016–2026.

Cultural safety:

Identifies that health consumers are safest when health professionals have considered power relations, cultural differences and patients’ rights. Part of this process requires health professionals to examine their own realities, beliefs and attitudes.

Cultural safety is not defined by the health professional, but is defined by the health consumer’s experience—the individual’s experience of care they are given, ability to access services and to raise concerns.

The essential features of cultural safety are:

a) An understanding of one’s culture

b) An acknowledgment of difference, and a requirement that caregivers are actively mindful and respectful of difference(s)

c) It is informed by the theory of power relations; any attempt to depoliticise cultural safety is to miss the point

d) An appreciation of the historical context of colonisation, the practices of racism at individual and institutional levels, and their impact on First Nations people’s living and wellbeing, both in the present and past

e) Its presence or absence is determined by the experience of the recipient of care and not defined by the caregiver. (AHMAC 2016)
Appendix 3: Monitoring powers of National Boards

Powers at registration

At the initial application for registration stage, all applicants for registration are required to meet, or commit to meeting, five mandatory registration standards:

- criminal history (applicable to health practitioners and students)
- English language skills (applicable to health practitioners applying for registration)
- professional indemnity insurance arrangements (applicants commit to having professional indemnity insurance arrangements in place for all practice undertaken during the registration period)
- continuing professional development (applicants undertake to comply with the continuing professional development registration standard)
- recency of practice (applicable to health practitioners applying for registration).

In addition, National Boards may seek Ministerial Council approval of additional registration standards and may issue codes and guidelines to provide guidance to registrants.

Before deciding an application for registration, a National Board is required to check the applicant’s criminal history (s. 79(1)). A National Board can also check an applicant’s proof of identity (s. 78). Section 80 of the National Law describes boards’ other powers before deciding an application for registration, which include that a board may:

- investigate an applicant
- require an applicant to give the board further information or a document the board reasonably requires to decide the application
- require an applicant to attend before the board to answer any questions relating to the application
- require an applicant to undergo an examination or assessment to assess the applicant’s ability to practise the health profession in which registration is sought
- require the applicant to undergo a health assessment.

Powers at annual renewal

Each time a practitioner applies to renew their registration they must make a declaration that they have met the mandatory registration standards for their profession. Section 109 of the National Law sets out the provisions relating to the annual registration renewal statement, which includes declarations about whether:

- they have an impairment that affects or could affect their capacity to practise their profession
- they have met the requirements of the National Board’s recency of practice registration standard
- they have met the requirements of the National Board’s continuing professional development registration standard
- they have practised with appropriate professional indemnity insurance arrangements in place and commit to ensuring appropriate insurance arrangements are in place if their registration is renewed
- there was any change to their criminal history that occurred during the previous registration period
- their right to practise at a hospital or another health services facility was withdrawn or restricted during the preceding period of registration due to their conduct, professional performance or health and, if so, to provide details of the withdrawal or restriction
• their billing privileges under the **Health Insurance Act 1973** were withdrawn or restricted during the preceding period of registration due to their conduct, professional performance or health and, if so, to provide details of the withdrawal or restriction

• they have had a complaint made about them to a registration authority or another relevant entity and, if so, to provide details of the complaint.

Before deciding an application for renewal of registration, a National Board may exercise a power under s. 80 of the National Law (as detailed above under **Powers at registration**) as if the application for renewal was an application for registration (s. 110).

**Powers during the registration period**

National Boards can audit registrants to check that they have met the registration standards as declared in their previous annual statement. Submitting a false declaration may result in action being taken against a practitioner’s registration.

National Boards can, at any time, require a registered health practitioner to provide evidence of their identity (s. 134(1)). They can also, at any time, obtain a written report about a registered health practitioner’s criminal history from and of the following:

- Australian Crime Commission
- a police commissioner
- an entity in a jurisdiction outside Australia that has access to records about the criminal history of people in that jurisdiction (s. 135(1)).

**Powers to deal with health, conduct or performance matters**

A National Board may take immediate action in relation to a registered health practitioner or student registered by the board if they believe that the health practitioner’s conduct, performance or health poses a serious risk to the public and that the immediate action will protect public health or safety (s. 156(1)). The Tranche 1 Amendment Act broadens the grounds on which a National Board may take immediate action to enable immediate action to be taken by a National Board if it reasonably believes the immediate action is in the public interest.

On behalf of the National Boards, AHPRA monitors health practitioners and students with restrictions (conditions or undertakings) placed on their registration, as well as those with suspended or cancelled registration. Restrictions are placed on registration through a number of mechanisms, including as an outcome of a notification, application for registration or renewal of registration.

Each monitoring case is assigned to one of the following five streams:

1. **Health**

   The practitioner or student is being monitored because they have a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that affects their ability to practise the profession or undertake clinical training.

2. **Performance**

   The practitioner is being monitored to ensure they practise safely and appropriately while demonstrated deficiencies in their knowledge, skill, judgement or care in the practice of their profession are addressed.

3. **Conduct**

   The practitioner is being monitored to ensure they practise safely and appropriately following consideration of their criminal history, or they have demonstrated a lesser standard of professional conduct than expected.
4. Suitability/eligibility

The practitioner is being monitored because they either:

- do not hold an approved or substantially equivalent qualification in the profession
- lack the required competence in the English language
- do not meet the requirements for recency of practice, or
- do not fully meet the requirements of any other approved registration standard.

5. Prohibited practitioners/student

The practitioner/student is being monitored because they either:

- are subject to a cancellation order, suspension or restriction not to practise, or
- have surrendered registration or changed to non-practising registration, in lieu of further action, under Part 8 of the National Law or suspension.

Where any noncompliance with restrictions is identified, AHPRA can act to support boards to manage risk to public safety.
Appendix 4: Endorsement functions

This section provides details about how the endorsement function operates under the National Law and data on the types of endorsements granted.

Endorsement of a practitioner’s registration is a mechanism through which particular registrant subgroups who have additional qualifications and expertise recognised by a board can be identified to the public, employers and other users of register information.

An endorsement of registration recognises that a person has an extended scope of practice in a particular area because they have an additional qualification that is approved by the National Board.

There are a number of types of endorsement available under the National Law. Some endorsements relate to the provision of certain types of services that are regulated under other Acts or regulation (either state or Commonwealth) such as Endorsement for scheduled medicines, which is set out under s. 94 of the National Law. This type of endorsement identifies registered practitioners within a profession who the National Board has determined are qualified to use (for example, supply or prescribe) medicines that are otherwise subject to restricted access because of state and territory laws that regulate drugs and poisons.

Some endorsements confer the right under the National Law to use a specific professional title that is otherwise restricted and hold themselves out as qualified to practise as a particular type of practitioner. Examples are:

- endorsement to use the title ‘nurse practitioner’, ‘midwife practitioner’ or ‘acupuncturist’, set out under ss. 95, 96 and 97 of the National Law respectively
- endorsement that identifies those practitioners who have specialty (postgraduate) training recognised by the relevant board and can hold themselves out as a specialist (for example, medical specialists).

Some endorsements identify classes of registered practitioners who hold additional qualifications in an area of practice that has been approved by the Ministerial Council. Section 98 of the National Law provides for an Endorsement for approved area of practice.

The Ministerial Council has approved areas of practice for two professions: psychology and dentistry. For psychology, the approved areas of practice are divided into ‘subtypes’ that describe additional qualifications and expertise (see Table 2). Dentistry has one approved area of practice: conscious sedation.

An endorsement can include more than one ‘subtype’. Table 2 shows which National Boards use endorsements on registration, which groups of practitioners they apply to, what the endorsement is and, in psychology and nursing and midwifery, what subtypes there are.

For registered nurses, there is an additional endorsement subtype to supply scheduled medicines (rural and isolated practice).
Table 2: Endorsements on registration (as at 31 December 2017)\(^\text{36}\)

<table>
<thead>
<tr>
<th>National Board</th>
<th>Profession/division</th>
<th>Endorsement</th>
<th>Subtype</th>
<th>Number of practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Osteopathy Physiotherapy</td>
<td>Medical practitioners Osteopaths(^\text{37}) Physiotherapists(^\text{37})</td>
<td>Acupuncture</td>
<td>Not applicable</td>
<td>MBA: 579</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>OsteoBA: 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PhysioBA: 6</td>
</tr>
<tr>
<td>Nursing and Midwifery</td>
<td>Registered nurses</td>
<td>Supply scheduled medicines</td>
<td>Rural and isolated practice</td>
<td>1,132</td>
</tr>
<tr>
<td></td>
<td>Registered nurses</td>
<td>Nurse practitioners</td>
<td>Not applicable</td>
<td>1,604</td>
</tr>
<tr>
<td></td>
<td>Midwives</td>
<td>Prescribe scheduled medicines</td>
<td>Not applicable</td>
<td>390</td>
</tr>
<tr>
<td></td>
<td>Midwives</td>
<td>Midwife practitioner(^\text{38})</td>
<td>Not applicable</td>
<td>1</td>
</tr>
<tr>
<td>Optometry</td>
<td>Optometrists</td>
<td>Scheduled medicines</td>
<td>Not applicable</td>
<td>2,929</td>
</tr>
<tr>
<td>Podiatry</td>
<td>Podiatrists</td>
<td>Scheduled medicines</td>
<td>Not applicable</td>
<td>86</td>
</tr>
<tr>
<td>Dental</td>
<td>Dental practitioner – division of dentists</td>
<td>Area of practice</td>
<td>Conscious sedation</td>
<td>96</td>
</tr>
<tr>
<td>Psychology</td>
<td>Psychologist</td>
<td>Area of practice</td>
<td>Clinical neuropsychology</td>
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<td></td>
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<td>Clinical psychology</td>
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<td>Community psychology</td>
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<td></td>
<td>Counselling psychology</td>
<td>948</td>
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<td></td>
<td>Educational and developmental psychology</td>
<td>654</td>
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<td>Forensic psychology</td>
<td>580</td>
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<td>Health psychology</td>
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<td></td>
<td>Organisational psychology</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Sport and exercise psychology</td>
<td>94</td>
</tr>
</tbody>
</table>

\(^{36}\) The AHPRA Glossary provides more information on endorsement [https://www.ahpra.gov.au/Support/Glossary.aspx#E], with statistics for endorsements on registration provided quarterly on each National Board’s website.

\(^{37}\) Chiropractors, osteopaths and physiotherapists who wish to use the title ‘acupuncturist’ must apply for registration with the Chinese Medicine Board of Australia.

\(^{38}\) Nursing and Midwifery Board of Australia statement of midwife practitioners [www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Position-Statements/midwife-practitioners.aspx]
Appendix 5: Offences and penalties under the National Law

The following sets out the provisions in the National Law that establish offences and penalties for unlawful conduct.

Section 133: Advertising

(1) A person must not advertise a regulated health service, or a business that provides a regulated health service, in a way that—

(a) is false, misleading or deceptive or is likely to be misleading or deceptive; or
(b) offers a gift, discount or other inducement to attract a person to use the service or the business, unless the advertisement also states the terms and conditions of the offer; or
(c) uses testimonials or purported testimonials about the service or business; or
(d) creates an unreasonable expectation of beneficial treatment; or
(e) directly or indirectly encourages the indiscriminate or unnecessary use of regulated health services.

Maximum penalty—

(a) in the case of an individual—$5,000; or
(b) in the case of a body corporate—$10,000.

(2) A person does not commit an offence against subsection (1) merely because the person, as part of the person’s business, prints or publishes an advertisement for another person.

(3) In proceedings for an offence against this section, a court may have regard to a guideline approved by a National Board about the advertising of regulated health services.

(4) In this section—

regulated health service means a service provided by, or usually provided by, a health practitioner.

Section 136: Directing or inciting unprofessional conduct or professional misconduct

(1) A person must not direct or incite a registered health practitioner to do anything, in the course of the practitioner’s practice of the health profession, that amounts to unprofessional conduct or professional misconduct.

Maximum penalty—

(a) in the case of an individual—$30,000; or
(b) in the case of a body corporate—$60,000.

(2) Subsection (1) does not apply to a person who is the owner or operator of a public health facility.

Section 196A: Offences relating to prohibition orders

Section 196A came into effect with the Tranche 1 Amendment Act.

(1) A person must not contravene a prohibition order. Maximum penalty—$30,000.

(2) A person who is subject to a prohibition order (the prohibited person) must, before providing a health service, give written notice of the order to the following persons—
(a) the person to whom the prohibited person intends to provide the health service or, if that
person is under 16 years of age or under guardianship, a parent or guardian of the person;
(b) if the health service is to be provided by the prohibited person as an employee—the person’s
employer;
(c) if the health service is to be provided by the prohibited person under a contract for services or
any other arrangement with an entity—that entity;
(d) if the health service is to be provided by the prohibited person as a volunteer for or on behalf
of an entity—that entity.
Maximum penalty—$5,000.

(3) A person must not advertise a health service to be provided by a prohibited person unless the
advertisement states that the prohibited person is subject to a prohibition order.

   Maximum penalty—
   (a) in the case of an individual—$5,000; or
   (b) in the case of a body corporate—$10,000.

Section 216: Duty of confidentiality

(1) A person who is, or has been, a person exercising functions under this Law must not disclose to
another person protected information.

   Maximum penalty—
   (a) in the case of an individual—$5,000; or
   (b) in the case of a body corporate—$10,000.

(2) However, subsection (1) does not apply if—

(a) the information is disclosed in the exercise of a function under, or for the purposes of, this
Law; or
(b) the disclosure—
   (i) is to a co-regulatory authority; or
   (ii) is authorised or required by any law of a participating jurisdiction; or
(c) the disclosure is otherwise required or permitted by law; or
(d) the disclosure is with the agreement of the person to whom the information relates; or
(e) the disclosure is in a form that does not identify the identity of a person; or
(f) the information relates to proceedings before a responsible tribunal and the proceedings are
or were open to the public; or
(g) the information is, or has been, accessible to the public, including because it is or was
recorded in a National Register; or
(h) the disclosure is otherwise authorised by the Ministerial Council.

Schedule 5 Part 1 s. 10: Offence for failing to produce information or attend
before investigator

(1) A person required to give stated information to an investigator under clause 1(a) must not fail, without
reasonable excuse, to give the information as required by the notice.
Maximum penalty—
(a) in the case of an individual—$5,000; or
(b) in the case of a body corporate—$10,000.

(2) A person given a notice to attend before an investigator must not fail, without reasonable excuse, to—
(a) attend as required by the notice; and
(b) continue to attend as required by the investigator until excused from further attendance; and
(c) answer a question the person is required to answer by the investigator; and
(d) produce a document the person is required to produce by the notice.

Maximum penalty—
(a) in the case of an individual—$5,000; or
(b) in the case of a body corporate—$10,000.

(3) For the purposes of subclauses (1) and (2), it is a reasonable excuse for an individual to fail to give stated information, answer a question or to produce a document, if giving the information, answering the question or producing the document might tend to incriminate the individual.

Schedule 5 Part 2 s. 10: Offences for failing to comply with requirement under clause 9 (Powers after entering places)

(1) A person required to give reasonable help under clause 9(2)(f) must comply with the requirement, unless the person has a reasonable excuse.

Maximum penalty—
(a) in the case of an individual—$5,000; or
(b) in the case of a body corporate—$10,000.

(2) A person of whom a requirement is made under clause 9(2)(g) must comply with the requirement, unless the person has a reasonable excuse.

Maximum penalty—
(a) in the case of an individual—$5,000; or
(b) in the case of a body corporate—$10,000.

(3) It is a reasonable excuse for an individual not to comply with a requirement under clause 9(2)(f) or (g) that complying with the requirement might tend to incriminate the individual.

Section 20: False or misleading information

A person must not state anything to an investigator that the person knows is false or misleading in a material particular.

Maximum penalty—
(a) in the case of an individual—$5,000; or
(b) in the case of a body corporate—$10,000.
Section 21: False or misleading documents

(1) A person must not give an investigator a document containing information the person knows is false or misleading in a material particular.

   Maximum penalty—
   (a) in the case of an individual—$5,000; or
   (b) in the case of a body corporate—$10,000.

(2) Subclause (1) does not apply to a person who, when giving the document—
   (a) informs the investigator, to the best of the person’s ability, how it is false or misleading; and
   (b) gives the correct information to the investigator if the person has, or can reasonably obtain, the correct information.

Section 22: Obstructing investigators

(1) A person must not obstruct an investigator in the exercise of a power, unless the person has a reasonable excuse.

   Maximum penalty—
   (a) in the case of an individual—$5,000; or
   (b) in the case of a body corporate—$10,000.

(2) If a person has obstructed an investigator and the investigator decides to proceed with the exercise of the power, the investigator must warn the person that—
   (a) it is an offence to obstruct the investigator, unless the person has a reasonable excuse; and
   (b) the investigator considers the person’s conduct is an obstruction.

(3) In this clause—
   obstruct includes hinder and attempt to obstruct or hinder.

Section 23: Impersonation of investigators

A person must not pretend to be an investigator.

   Maximum penalty—$5,000.
Appendix 6: Title protection offences

The following sets out the provisions in the National Law that establish the offences in relation to title protection.

Section 113: Restriction on use of protected titles

(1) A person must not knowingly or recklessly—

(a) take or use a title in the Table to this section, in a way that could be reasonably expected to induce a belief the person is registered under this Law in the health profession listed beside the title in the Table, unless the person is registered in the profession, or

(b) take or use a prescribed title for a health profession, in a way that could be reasonably expected to induce a belief the person is registered under this Law in the profession, unless the person is registered in the profession.

Maximum penalty—

(a) in the case of an individual—$30,000; or

(b) in the case of a body corporate—$60,000.

(2) A person must not knowingly or recklessly—

(a) take or use a title in the Table in relation to another person (the second person), in a way that could be reasonably expected to induce a belief the second person is registered under this Law in the health profession listed beside the title in the Table, unless the second person is registered in the profession; or

(b) take or use a prescribed title for a health profession in relation to another person (the second person), in a way that could be reasonably expected to induce a belief the second person is registered under this Law in the profession, unless the second person is registered in the profession.

Maximum penalty—

(a) in the case of an individual—$30,000; or

(b) in the case of a body corporate—$60,000.

(3) Subsections (1) and (2) apply whether or not the title is taken or used with or without any other words and whether in English or any other language.

Section 115: Restriction on use of specialist titles

(1) A person must not knowingly or recklessly take or use—

(a) the title ‘dental specialist’ unless the person is registered under this Law in a recognised specialty in the dentists division of the dental profession; or

(b) the title ‘medical specialist’ unless the person is registered in a recognised specialty in the medical profession; or

(c) a specialist title for a recognised specialty unless the person is registered under this Law in the specialty.

Maximum penalty—

(a) in the case of an individual—$30,000; or

(b) in the case of a body corporate—$60,000.
(2) A person must not knowingly or recklessly take or use—

(a) the title ‘dental specialist’ in relation to another person unless the other person is registered under this Law in a recognised specialty in the dentists division of the dental profession; or

(b) the title ‘medical specialist’ in relation to another person unless the person is registered in a recognised specialty in the medical profession; or

(c) a specialist title for a recognised specialty in relation to another person unless the person is registered under this Law in the specialty.

Maximum penalty—
(a) in the case of an individual—$30,000; or
(b) in the case of a body corporate—$60,000.

(3) Subsection (1) applies whether or not the title is taken or used with or without any other words and whether in English or any other language.

Section 116: Claims by persons as to registration as health practitioner

(1) A person who is not a registered health practitioner must not knowingly or recklessly—

(a) take or use the title of ‘registered health practitioner’, whether with or without any other words; or

(b) take or use a title, name, initial, symbol, word or description that, having regard to the circumstances in which it is taken or used, indicates or could be reasonably understood to indicate—

(i) the person is a health practitioner; or
(ii) the person is authorised or qualified to practise in a health profession; or

(c) claim to be registered under this Law or hold himself or herself out as being registered under this Law; or

(d) claim to be qualified to practise as a health practitioner.

Maximum penalty—
(a) in the case of an individual—$30,000; or
(b) in the case of a body corporate—$60,000.

(2) A person must not knowingly or recklessly—

(a) take or use the title of ‘registered health practitioner’, whether with or without any other words, in relation to another person who is not a registered health practitioner; or

(b) take or use a title, name, initial, symbol, word or description that, having regard to the circumstances in which it is taken or used, indicates or could be reasonably understood to indicate—

(i) another person is a health practitioner if the other person is not a health practitioner; or

(ii) another person is authorised or qualified to practise in a health profession if the other person is not a registered health practitioner in that health profession; or

(c) claim another person is registered under this Law, or hold the other person out as being registered under this Law, if the other person is not registered under this Law; or
(d) claim another person is qualified to practise as a health practitioner if the other person is not a registered health practitioner.

Maximum penalty—

(a) in the case of an individual—$30,000; or

(b) in the case of a body corporate—$60,000.

Section 117: Claims by persons as to registration in particular profession or division

(1) A registered health practitioner must not knowingly or recklessly—

(a) claim to be registered under this Law in a health profession or a division of a health profession in which the practitioner is not registered, or hold himself or herself out as being registered in a health profession or a division of a health profession if the person is not registered in that health profession or division; or

(b) claim to be qualified to practise as a practitioner in a health profession or a division of a health profession in which the practitioner is not registered; or

(c) take or use any title that could be reasonably understood to induce a belief the practitioner is registered under this Law in a health profession or a division of a health profession in which the practitioner is not registered.

(2) A contravention of subsection (1) by a registered health practitioner does not constitute an offence but may constitute behaviour for which health, conduct or performance action may be taken.

(3) A person must not knowingly or recklessly—

(a) claim another person is registered under this Law in a health profession or a division of a health profession in which the other person is not registered, or hold the other person out as being registered in a health profession or a division of a health profession if the other person is not registered in that health profession or division; or

(b) claim another person is qualified to practise as a health practitioner in a health profession or division of a health profession in which the other person is not registered; or

(c) take or use any title in relation to another person that could be reasonably understood to induce a belief the other person is registered under this Law in a health profession or a division of a health profession in which the person is not registered.

Maximum penalty—

(a) in the case of an individual—$30,000; or

(b) in the case of a body corporate—$60,000.

Note. A contravention of this subsection by a registered health practitioner may also constitute unprofessional conduct for which health, conduct or performance action may be taken.

Section 118: Claims by persons as to specialist registration

(1) A person who is not a specialist health practitioner must not knowingly or recklessly—

(a) take or use the title of ‘specialist health practitioner’, whether with or without any other words; or
(b) take or use a title, name, initial, symbol, word or description that, having regard to the circumstances in which it is taken or used, indicates or could be reasonably understood to indicate—

(i) the person is a specialist health practitioner; or

(ii) the person is authorised or qualified to practise in a recognised specialty; or

(c) claim to be registered under this Law in a recognised specialty or hold himself or herself out as being registered under this Law in a recognised specialty; or

(d) claim to be qualified to practise as a specialist health practitioner.

Maximum penalty—

(a) in the case of an individual—$30,000; or

(b) in the case of a body corporate—$60,000.

(2) A person must not knowingly or recklessly—

(a) take or use the title of ‘specialist health practitioner’, whether with or without any other words, in relation to another person who is not a specialist health practitioner; or

(b) take or use a title, name, initial, symbol, word or description in relation to another person who is not a specialist health practitioner that, having regard to the circumstances in which it is taken or used, indicates or could be reasonably understood to indicate—

(i) the other person is a specialist health practitioner; or

(ii) the other person is authorised or qualified to practise in a recognised specialty; or

(c) claim another person is registered under this Law in a recognised specialty or hold the other person out as being registered under this Law in a recognised specialty if the other person is not registered in that recognised specialty; or

(d) claim another person is qualified to practise as a specialist health practitioner if the person is not a specialist health practitioner.

Maximum penalty—

(a) in the case of an individual—$30,000; or

(b) in the case of a body corporate—$60,000.

Note. A contravention of this section by a registered health practitioner may also constitute unprofessional conduct for which health, conduct or performance action may be taken.

Section 119: Claims about type of registration or registration in recognised specialty

(1) A registered health practitioner must not knowingly or recklessly—

(a) claim to hold a type of registration or endorsement under this Law that the practitioner does not hold or hold himself or herself out as holding a type of registration or endorsement if the practitioner does not hold that type of registration; or

(b) claim to be qualified to hold a type of registration or endorsement the practitioner does not hold; or

(c) claim to hold specialist registration under this Law in a recognised specialty in which the practitioner does not hold specialist registration or hold himself or herself out as holding
specialist registration in a recognised specialty if the person does not hold specialist registration in that specialty; or

(d) claim to be qualified to practise as a specialist health practitioner in a recognised specialty in which the practitioner is not registered.

(2) A contravention of subsection (1) by a registered health practitioner does not constitute an offence but may constitute behaviour for which health, conduct or performance action may be taken.

(3) A person must not knowingly or recklessly—

(a) claim another person holds a type of registration or endorsement under this Law that the other person does not hold or hold the other person out as holding a type of registration or endorsement if the practitioner does not hold that type of registration or endorsement; or

(b) claim another person is qualified to hold a type of registration or endorsement that the other person does not hold; or

(c) claim another person holds specialist registration under this Law in a recognised specialty which the other person does not hold or hold the other person out as holding specialist registration in a recognised specialty if the other person does not hold specialist registration in that specialty; or

(d) claim another person is qualified to practise in a recognised specialty in which the other person is not registered.

Maximum penalty—

(a) in the case of an individual—$30,000; or

(b) in the case of a body corporate—$60,000.

Note. A contravention of this subsection by a registered health practitioner may also constitute unprofessional conduct for which health, conduct or performance action may be taken.
Appendix 7: ‘Direct or incite’ provisions that applied in New South Wales for medical practitioners and in Victoria for all registered health practitioners prior to 2010

Medical Practice Act 1992 (NSW) –

Section 116A: Prohibition against directing or inciting overservicing or misconduct

(1) A person (‘the employer’) who employs a registered medical practitioner must not direct or incite the practitioner to do either of the following in the course of professional practice:

(a) engage in overservicing,

(b) engage in conduct that would constitute unsatisfactory professional conduct or professional misconduct.

Maximum penalty:

(a) in the case of a corporation, 400 penalty units for a first offence or 800 penalty units for a second or subsequent offence, or

(b) in any other case, 200 penalty units for a first offence or 400 penalty units for a second or subsequent offence.

(2) For the purposes of this section, any actions of an agent or employee of the employer are taken to be actions of the employer unless the employer establishes:

(a) that the employer had no knowledge of those actions, and

(b) that the employer could not, by the exercise of due diligence, have prevented those actions.

(3) If a person is convicted of or made the subject of a criminal finding for an offence against this section in respect of the actions of an agent or employee of the person, the agent or employee is for the purposes of this Part taken to have been convicted of or made the subject of a criminal finding for the offence also.

(4) When a court convicts or makes a criminal finding against a person for an offence against this section, the Clerk or other proper officer of the court must notify the Director-General in writing of the conviction or criminal finding.

(5) This section does not apply in respect of the employment of a medical practitioner by any of the following:

(a) a public health organisation within the meaning of the Health Services Act 1997,

(b) a private health facility,

(c) a nursing home within the meaning of the Public Health Act 1991.

(6) In this section:

‘engage in overservicing’ means:

(a) provide a service in circumstances in which provision of the service is unnecessary, not reasonably required or excessive, or

(b) engage in conduct prescribed by the regulations as constituting overservicing.

Health Professions Registration Act 2005 (Vic)

Section 85: Offence of directing or inciting unprofessional conduct
Offence of directing or inciting unprofessional conduct

(1) A person must not direct or incite a registered health practitioner to do anything, in the course of providing regulated health services, that would constitute unprofessional conduct or professional misconduct.

Penalty: 240 penalty units in the case of a natural person and 1200 penalty units in the case of a body corporate.

(2) If a body corporate commits an offence against sub-section (1), any officer, within the meaning of section 9 of the Corporations Act, of the body corporate who was in any way, by act or omission, directly or indirectly, knowingly concerned in or party to the commission of the offence is also guilty of that offence and liable to the penalty for it, irrespective of whether the body corporate has been prosecuted for, or convicted or found guilty of, the offence.

(3) If a court convicts or finds a person guilty of an offence against this section, the Clerk or other proper officer of the court must notify the responsible board and the Secretary in writing of the conviction or finding.

(4) This section does not apply to the employer of a registered health practitioner providing regulated health services if the employer is a registered funded agency, private hospital or privately-operated hospital within the meaning of the Health Services Act 1988.
Appendix 8: Information on the public register – Australia

Section 225 of the National Law sets out that public national register must include the following information:

(a) the practitioner’s sex;
(b) the suburb and postcode of the practitioner’s principal place of practice;
(c) the registration number or code given to the practitioner by the National Board;
(d) the date on which the practitioner was first registered in the health profession in Australia, whether under this Law or a corresponding prior Act;
(e) the date on which the practitioner’s registration expires;
(f) the type of registration held by the practitioner;
(g) if the register includes divisions, the division in which the practitioner is registered;
(h) if the practitioner holds specialist registration, the recognised specialty in which the practitioner is registered;
(i) if the practitioner holds limited registration, the purpose for which the practitioner is registered;
(j) if the practitioner has been reprimanded, the fact that the practitioner has been reprimanded;
(k) if a condition has been imposed on the practitioner’s registration or the National Board has entered into an undertaking with the practitioner—
   (i) if section 226(1) applies, the fact that a condition has been imposed or an undertaking accepted; or
   (ii) otherwise, details of the condition or undertaking;
(l) if the practitioner’s registration is suspended, the fact that the practitioner’s registration has been suspended and, if the suspension is for a specified period, the period during which the suspension applies;
(m) if the practitioner’s registration has been endorsed, details of the endorsement;
(n) details of any qualifications relied on by the practitioner to obtain registration or to have the practitioner’s registration endorsed;
(o) if the practitioner has advised the National Board that the practitioner fluently speaks a language other than English, details of the other language spoken;
(p) any other information the National Board considers appropriate.
Appendix 9: Analysis of information on the public register – Australia and international comparisons

A review of the information available on online registers across Australian and international jurisdictions was conducted in November 2017, focusing on the how each register was used (its purpose), levels of transparency regarding the information made available to the public, and the ways in which the functionality of the registers enabled increased transparency or variation of purpose.

Online registers from the following regulators/jurisdictions were considered:

- **Australian Health Practitioner Regulation Agency (AHPRA), AU**
- **General Medical Council (GMC), UK**
  <www.gmc-uk.org/doctors/register/LRMP.asp>
- **Health and Care Professions Council (HCPC), UK**
  <www.hcpc-uk.org/check/>
- **New York State (NYS), US**
  [New York State Physician Profile](www.nydoctorprofile.com)
  [Office of Professional Medical Conduct](https://apps.health.ny.gov/pubdoh/professionals/doctors/conduct/factions/Home.action)
  [Office of the Professions](www.op.nysed.gov/opsearches.htm)
- **Ontario, CAN**
  [Ontario Health Regulators (OHR)](https://ontariohealthregulators.ca/) including:
  - [College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario (CTCMPAO)](https://www.ctcmpao.on.ca/)
  - [Ontario College of Pharmacists (OCP)](www.ocpinfo.com/protecting-the-public/about-register/)
  - [The College of Physicians and Surgeons of Ontario (CPSO)](www.cpso.on.ca/public-register/all-doctors-search)
  - [College of Audiologists and Speech-Language Pathologists of Ontario (CASLPO)](http://www.caslpo.com/)
  - [College of Chiropodists of Ontario (COCOO)](http://cocco.on.ca/)
  - [Royal College of Dental Surgeons of Ontario (RCDSO)](http://www.rcdso.org/)
- **The College of Physicians and Surgeons of British Columbia (CPSBC), CAN**
  <www.cpsbc.ca/physician_search>
- **The Medical Board of California (MBC), US**
  <www.mbc.ca.gov/>
- **The Medical Council of New Zealand (MCNZ), NZ**
  <www.mcnz.org.nz/>
- **The Nursing and Midwifery Council (NMC), UK**
  <www.nmc.org.uk/registration/search-the-register/>

In health practitioner regulation, a register’s primary purpose is to provide a safeguard for the public through allowing the public and employers of health practitioners to check that a health practitioner is qualified and fit to practise in a competent and professional manner. All registers examined met this objective. Online registers have made it easier for the public to access this information and allow for increased functionality that, if applied, can vary the purpose for which the register is used and in ways not originally envisaged when the register was established (McDonagh 2009, p. 23).

The AHPRA Register of practitioners is accessible from the AHPRA homepage, where a search based on surname or registration number and health profession can be conducted. A more advanced search,
available on a separate ‘Register of practitioners’ page, includes categories for given name or principle place of practice (suburb, postcode or state) to help refine a practitioner search. Correct spelling is required. The initial result displayed will provide a written indication if the practitioner has any conditions, undertakings or reprimands imposed on their registration. If ‘view details’ is selected, further information can be accessed, which includes details about any endorsements, notations or conditions, undertakings and reprimands. Practitioner sex (male/female/intersex or indeterminate), languages in addition to English and qualifications are also displayed in a practitioner’s full register entry.

The public register lists if a condition has been imposed on a practitioner’s registration or if the National Board has entered into an undertaking with the practitioner. Conditions and undertakings are removed from the register when they no longer have effect. Reprimands may be removed from the register after a minimum period of five years subject to the practitioner’s application and no other relevant events having occurred in the five-year period.

User tips are available to support the use of the register, as well as guidance on terms used in the register, professions and divisions, and specialties and specialty fields. It is noted clearly that if a health practitioner’s entry cannot be found, AHPRA can be contacted for further advice.

The register has limited functionality (searches cannot be conducted on language spoken or sex, for example). The AHPRA website also hosts a Cancelled health practitioners register and a List of practitioners who have given an undertaking not to practise. These registers are not linked, so the public may need to consult all three registers.

For the US and Canadian registers, the emphasis is on the consumer using the register to find a health practitioner, rather than to check an individual practitioner’s registration status; this is a variation on the primary purpose of a register. Search categories for Ontario health regulator websites vary, but they allow searches to be conducted based on a wide variety of categories such as gender (CPSO); location of practice and languages in which practitioners can provide care (OCP); clinic name (CTCMPAO); age of the patient treated (CASLPO); registration status; if they make house calls and disciplinary history (COCOO); and specialty and sedation type (RCDSO).

The functionality enabled on these online registers allow searches on a wide variety of categories and in combination (for example, adjusting search parameters to find a female physician who speaks Danish in Burlington, ON). The MCNZ register offers slightly less functionality, in that it allows searches based on district and vocational scope only.

To contrast, registers for AHPRA, the GMC, the NMC and the HCPC provide limited search categories to establish registration status only, with a name or registration number (and for the HCPC, a profession) required to conduct the search. The GMC register does allow a gender (male or female) to be selected, but only after entering a name or reference number.

Increasing the information available on a health practitioner register or changing the ways in which information on an online register can be accessed, through increased functionality, risks departing from the register’s primary regulatory purpose and may be considered outside the remit of the regulator. In 2016, the GMC ran a formal public consultation on developing their online medical register to make it more ‘open, relevant and useful’ (GMC 2017b, p. 2). The majority of respondents did not support the options set out for developing the register and were also resistant to any variation to the register’s primary purpose (GMC 2017b, pp. 1–3). As a result, the GMC has agreed to, at the present time, limit further development of the register to ‘enhancing its functionality in relation to the information it already contained’ (GMC 2017c, p. 4). It is worth noting, however, that the majority of respondents to the public consultation were medical professionals (GMC 2017b, p. A5), and that a separate survey of 2,000 members of the public conducted later in the consultation process showed more support for additional information on the register as a way of facilitating patient choice (GMC 2017b, pp. A3 & A22).
The CPSO, striking a different balance, has started to publish more extensive information about medical practitioners on its register and with more functionality on offer. The CPSO frames this approach in terms of meeting its obligations for public protection: ‘In fulfilling our mandate to protect the public, we believe it’s important that the public have information to help them to decide who they wish to see for care’ (CPSO 2017c). More information is needed regarding the implications of these change for consumers and practitioners in Ontario.

The level of detail about disciplinary histories or legal actions differs across jurisdictions. The CPSO, guided by a set of transparency principles, has made more practitioner information available on its register to ‘help patients make informed choices and enhance our accountability to the public’ (CPSO 2017b). The CPSO register now includes information such as:

- cautions and orders to complete a Specified Continuing Education or Remediation Program (SCERP) (which remain on the register unless overturned)
- disciplinary findings by another medical regulatory or licensing authority made on or after 1 September 2015, including the facts and dates (where known), the jurisdiction and the status of any appeals
- current bail conditions, if any, that affect a physician’s right to practise
- Criminal Code and Health Insurance Act charges placed against a doctor (with information removed when the charge is no longer outstanding)
- the location of medical records, if available, when a physician is no longer practising in Ontario (CPSO 2017b).

Consumers can also conduct a search to show physician records with past decisions relating to discipline or fitness to practise matters or records with current referrals, where a disciplinary hearing is pending.

In Ontario, the Protecting Patients Act 2017 has strengthened provisions relating to transparency of information on the public register for health practitioner regulators in Ontario, including the CPSO. This Act has resulted in amendments to Ontario’s Regulated Health Professions Act 1991 in relation to what information health regulatory colleges in Ontario publish on public registers, including:

- where a member is deceased, the name of the deceased member and the date upon which the member died, if known to the registrar
- a notation of every caution that a member has received
- a copy of the specified allegations against a member for every matter that has been referred by the Inquiries, Complaints and Reports Committee to the Discipline Committee and that has not been finally resolved
- every result of a disciplinary or incapacity proceeding
- a notation of every revocation or suspension of a certificate of registration
- a notation of every finding of professional negligence or malpractice, which may or may not relate to the member’s suitability to practise, made against the member, unless the finding is reversed on appeal.

Other legal actions against practitioners listed on registers include:

- findings of malpractice/professional negligence (made on or after 4 June 2009) (CPSO)
- hospital privilege restrictions and criminal convictions (NYS, listed in the New York State Physician Profile)
- felony convictions and misdemeanour convictions that resulted in an accusation or disciplinary action being filed by the board that are not subsequently withdrawn or dismissed (MBC)
- settlement payments, if the total number exceeds three in a ten-year period (NYS, listed in the New York State Physician Profile; MBC)
• medical malpractice judgements and arbitration awards of any amount reported to the board since 1993 (MBC).

The length of time details about disciplinary history are published on registers also varies. In some jurisdictions, regulatory actions are recorded but removed when expired. AHPRA will remove, for example, information about tribunal decisions regarding suspensions, reprimands or registration conditions from the register, although court and tribunal decisions are still listed on a separate webpage where there is educational or clinical value (AHPRA 2017b). Other regulators publish details about disciplinary history indefinitely. The NMC publishes regulatory actions imposed since 1 January 2008, and the GMC publishes publicly available fitness to practise history since 20 October 2005. This is changing, however, with the GMC bringing in time limits for publishing doctors’ sanctions, in effect by early 2018 (GMC 2017d), in an effort to achieve a better balance between the transparency expected from the public and a fairer, more proportionate approach for doctors (GMC 2016).

Limited information was available on registers about when information may be suppressed. AHPRA was the most progressive on this point, as it is also guided by clear legislative direction. Explanatory information published by AHPRA both on the register and in guidance about the register was clear that information was sometimes suppressed because of personal safety issues and that AHPRA could be contacted if a practitioner’s name did not appear on the register. The HCPC, MCNZ and NYS (on the New York State Physician Profile website) also provide specific advice for consumers to contact them if they could not find a particular health professional on their registers.

Accessibility of the registers to the public may need some improvement. Consumers visiting the AHPRA website, for example, need to check multiple registers to locate a practitioner if they do not know whether they have a current or cancelled registration or have given an undertaking not to practise. In New York State, consumers need to visit multiple websites to get a full picture of a practitioner’s history and registration status. That is, the OPMC New York State Physician Records Search website is a source of disciplinary actions from 1990 onwards, while the New York State Physician Profile website reflects education, practice information and legal actions. The registration status of a physician and their licence to practise is listed on the Office of the Professions website published by the New York State Department of Education. In both these examples, the onus is on the consumer to negotiate all the registers or websites.

The NMC provides a more comprehensive and easily understood view of practitioners’ registration statuses, available through a single search form and with a ‘traffic light’ approach used to provide a visual cue for people searching the register. The NMC online register search results clearly indicate whether a person has been suspended or removed from the register since 1 January 2008 (indicated by a red ‘X’, with documents relating to sanctions attached) or whether a person is on the register but has restrictions on their practice or a caution order (indicated with an amber ‘?’, with related documents attached). If a search is conducted where details are returned for multiple practitioners, the practitioners where actions have been imposed are displayed first, in order of severity of outcome and sanction.

When they were consulting on the development of the UK medical register, GMC research revealed that of 2,000 members of the UK public ‘only a quarter of respondents had ever searched online for information about a doctor and only a third of respondents were aware of the GMC’s register’ (GMC 2017b, p. 2) To provide greater value to public safety, an online health practitioner register needs to be known and used, and its usefulness to the public may be improved if its purpose is recast and functionality expanded. The Australian Commission on Safety and Quality in Health Care (2011, p. 21) has noted previously that increasing consumer participation in their own care leads to better, safer health outcomes. Through such enhancements, the primary regulatory function of a register might be supported, rather than supplanted.
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**Legislation**

**Australia**

*Competition and Consumer Act 2010* (Cwlth) Schedule 2 (‘Australian Consumer Law’)

*Explanatory Notes, Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2017* (Qld)

*Health Care Complaints Act 1993* (NSW)

*Health Practitioner Regulation Amendment Act 2017*, as in force in each state and territory

*Health Practitioner Regulation National Law Act 2009*

*Health Practitioner Regulation National Law and Other Legislation Amendment Act 2017* (Qld)

*Health Practitioner Regulation National Law (SA) Act 2010*

*Health Practitioner Regulation National Law (WA) Amendment Bill 2017*

*Health Practitioners (Disciplinary Proceedings) Act 1999* (Qld) s. 385B

*Health Professions Registration Act 2005* (Vic) s. 34
Medical Practice Act 1994 (Vic)
Medical Practitioners Act 1983 (SA) s. 72
Medical Practitioners Act 2008 (WA) s. 61
Medical Practitioners Registration Act 1996 (Tas) s. 68
Nurses Act 1991 (NSW)
Therapeutic Goods Act 1989 (Cwlth)

United States of America
45 CFR § 60.7
CA Bus & Prof Code § 2285