



Medical Board of Queensland

Submission on Bill B

INTRODUCTION

The Medical Board of Queensland supports the concept of a National Registration and Accreditation Scheme for medical practitioners and is keen to contribute wherever possible to its development.

The Board particularly appreciated time given by members of the NRAIP team to a joint meeting with representatives of the State and Territory Medical Boards to discuss operational concerns with the draft Bill. The Board wishes to acknowledge that as a result of this discussion these staff and the Board gained a greater understanding of the nature and intent of the Bill and issues which may require amendment to ensure the legislation will achieve its purpose.

The Board is concerned, however, that it is not intended there will be any further consultation when the next draft of the Bill is developed. It is extremely important National Boards are not hamstrung as a result of inadequate or inappropriate legislative power to effectively regulate the professions to protect the public into the future.

The Board therefore requests that serious consideration be given to allowing Boards and their staff an opportunity to review a further version of the Bill thereby helping to ensure the National Registration and Accreditation Scheme will achieve the intended goals.

The Bill is particularly unsatisfactory in its approach to the critical matters of Conduct, Performance and Health. The scheme as it is currently proposed is confused, cumbersome and confrontational in this area. Furthermore, it lacks clear focus on improvement in the health and performance of health professionals who need positive intervention to improve patient safety.

In fact it is the Board's view that the issue of public safety should be more prominent and explicitly addressed throughout the entire document.

SUBMISSION

This Board has contributed to the joint submission prepared by the State and Territory Medical Boards and the matters raised in that submission.

Therefore the Board does not intend to revisit the matters raised in that submission other than where it considers additional comment is necessary or in respect of a matter which has not already been addressed.

This submission is therefore comprised of three parts:-

- Joint Submission prepared by the State and Territory Medical Boards (see **Attachment A**)
- particular areas of concern arising from the current Draft Bill (see **below**)
- specific points regarding details of the Bill (see **Attachment B**).

Additional areas of particular of concern to the Board relate to the following:

1. Accreditation

The Board holds significant concerns that the clauses in s10 of the Bill could require a National Board to lower the standards of education and training to solve workforce problems, thus putting the public at risk of sub-standard health care.

In particular, clauses 10(3)(d), 10(4) and 10(6) as currently written, could be interpreted as provision for interference in the accreditation of education and training for health professionals and jeopardise Australia's international standing in relation to the quality of its education and training of health professionals.

In addition, further consideration may need to be given to the facilitation of cross-disciplinary accreditation where aspects of practice may be shared by more than one profession (eg dentists/medical specialists in oral and maxillofacial surgery). Clause 51 should be expanded to include provisions requiring consultation in respect to accreditation matters which are of a cross-disciplinary nature. In the case of oral maxillofacial surgery, the Australian Medical Council and Australian Dental Council were both involved in the accreditation of the relevant training program.

The Board also suggests the definition of the accreditation function may need to be broadened to include:-

- assessment of other authorities which do not necessarily accredit training programs, but have licensing examinations as occurs in the USA and other countries;
- entities which accredit intern training programs (e.g. Postgraduate Medical Education Councils);
- accreditation of other areas as required, such as, but not limited to, supervised practice programs, bridging courses and re-entry programs.

2. Public Interest Assessor

While the Bill is intended to regulate the health professions to ensure the safety of the public through the maintenance of standards, the inclusion of a "Public Interest Assessor" in the current format, appears to focus on consumer interests rather than public interest. Often the outcomes sought by consumers are those of redress or reconciliation or compensation. Matters examined in the public interest focus on the maintenance of professional standards and public safety issues.

The Board is further concerned that it may be the case that the Public Interest Assessor is not subject to the control and direction of any entity. This arrangement risks giving power to a person to unnecessarily increase investigation and prosecution costs for a health profession, particularly if the position is "consumer" driven rather than focussing on "public safety and interest" and the most serious action must prevail. There needs to be some form of accountability and justification provided to require a National Board to take a more serious action as a result of a

decision by the Public Interest Assessor. A requirement for the Public Interest Assessor to make a report to the Ministerial Council of such occurrences might overcome such concerns.

This Bill should permit the current legislative arrangements already established between Boards and Health Care and Complaints Commissions and which provide for the timely exchange of information and review of investigative outcomes regarding consumer complaints to be maintained.

3. Restriction on use of specialist titles

The Board is aware that concern has been raised by other entities regarding the proposal to allow a registrant with limited registration to practise in a recognised speciality and be able to use the title “medical specialist”.

What currently occurs in Queensland is that an applicant for such registration would be required to be assessed by the relevant specialist college to confirm that the applicant has training and experience substantially equivalent to that of an Australian trained specialist which was relevant to the requirements of the area of need position. A person who is not assessed by the college as being substantially equivalent would not be granted limited special purpose/limited registration as a “specialist”.

Therefore it would be expected the National Board will develop a registration standard setting out the requirements for approval of limited registration to practise in an area of need as a specialist which would require assessment and support from the relevant college that the applicant is substantially equivalent to an Australian graduate.

Of more concern to the Board is the fact that members of the public associate terminology such as “consultant”, “anaesthetist”, “obstetrician”, “surgeon” etc as being the same as “medical specialist” therefore all such terminology should be restricted for use only by those persons with appropriate speciality training and post-graduate qualifications registered in such specialities.

4. Conduct, performance and health

The title for Part 8 “Complaints, performance, health and conduct” should be renamed “Conduct, performance and health”. This will assist to emphasise the importance of a remedial and non-punitive approach which leads to an enhancement in the provision of health care for doctors with performance or health issues.

Careful thought should be given to the risks and benefits of the involvement of community members on health assessment panels.

The Board notes the joint Medical Boards submission outlines the difficulties regarding this part. The Board is concerned that without major revision, the gains made over the past decade in respect to development of internationally recognised performance assessment programs and transparent and accountable processes will be compromised.

The Board is also concerned that privacy afforded to health practitioners through the current health assessment process will be undermined by the inclusion of consumer members on these panels.

It is further concerned that the suggested model has the potential to substantially increase investigation and health assessment costs due to the proposal that where agreement can not be reached, the most serious action would prevail.

5. Period of limited registration

Sections 90 and 91 of the Bill appear to indicate that limited registration can only be held for a maximum of two years and can not be renewed. At various forums however, it has been indicated that further applications for limited registration may be made and registration approved.

The Board is concerned there will be no requirement for an international medical graduate holding limited registration to make progress toward obtaining either general or specialist registration. A legislated progress requirement will provide a National Board with the appropriate head of power to refuse a further period of limited registration in circumstances where equivalence to an Australian trained graduate has not been demonstrated.

Such a progress requirement was legislated in Queensland in 2006. Unfortunately, some international medical graduates have not been able to demonstrate, through examination, that they can practise at an equivalent level to that of an Australian graduate and their applications for renewal of registration have been refused. Without such a provision requiring progress to general or specialist registration, protection of the public could be put at risk.

6. Information Exchange

A full mutual exchange of information must be facilitated under the national scheme to ensure that the National Agency, National Boards, Colleges and the HCCs work collaboratively and in the interests of patient safety. Sufficient protection must be provided to facilitate this important flow of information, this is especially in the case of Colleges.

It is also vital that national Boards are able to take action based on information received from overseas regulatory authorities without the necessity to undertake a further investigation.

JMBAC SUBMISSION ON BILL B

1. INTRODUCTION

This submission represents the consensus view of the Joint Medical Boards Advisory Committee of the Australian Medical Council. Individual medical boards will be making their own submissions as well.

JMBAC's general view of Bill B is that while it broadly covers the necessary elements of a professional regulatory scheme, it has failed to present a workable or effective framework for handling complaints/notifications and will, as it stands, lead to a significant reduction in the effectiveness of the current regulatory system for doctors.

The Bill marks a reversal of the trend towards a risk management/proactive approach exemplified by Performance Assessment, health assessment and constructive management of low level lapses in conduct that would not usually cause a practitioner's registration to be affected. It represents a step back to the reactive/punitive nature of a complaints driven system where Boards could not make adverse findings unless a matter reached the level of misconduct. It represents a loss of opportunity to deal with lesser breaches of professional standards (not wilful or reckless) which, in many jurisdictions, has had the effect of a reduction in future incidences. As a result, the Australian Medical Board's ability to meet the first element of its statutory objective, namely to 'provide for the protection of the public' will be less than that currently exercised by the State and Territory Medical Boards ..

This submission addresses in broad terms the shortcomings in the Bill, and more particularly, in the complaints handling mechanisms identified by JMBAC. It also identifies a number of more specific issues of common concern to the Medical Boards, noting that individual Boards will be making their own more detailed submissions.

JMBAC acknowledges the positive and constructive approach to concerns which have previously been raised, as demonstrated in response to comments made at State and National Forums, and in subsequent discussions. In this same spirit JMBAC is hopeful that substantial improvements can be made to the next draft of the Bill.

It is understood that it is unlikely that there will be a further public consultation process before Bill B is presented to the Queensland Parliament. JMBAC strongly recommends that this deadline driven approach is reconsidered. Getting well drafted legislation that will shape the direction of health professional regulation into the future is too important an objective to be lost sight of in the desire to meet timeframes that were developed over two years ago, when the magnitude of the task was perhaps not fully recognised.

2. THE COMPLAINTS/PERFORMANCE/HEALTH PROVISIONS

2.1 Extensive regulatory experience of Medical Boards

Medicine is not the largest profession covered by the Bill, but regulation of the medical profession constitutes about 70-80% of the workload for existing regulatory bodies. This is reflected in the complexity of legislation governing medical practitioners, which has been developed over many years to meet the growing requirements of transparency and accountability, and the primary goal of public protection. Doctors who fail to measure up to proper standards are in a position to do substantial harm to health care consumers in many professional / clinical situations. Additionally, doctors are well resourced to resist attempts at regulatory action, and will often test the limits of a medical board's powers to exercise their functions. The experience of boards in dealing with this legal environment is reflected in the construct of the various state Medical Acts, but much of the important detail which has enabled medical boards to function effectively in the face of these challenges has not been clearly reproduced, or has been omitted from the Bill.

JMBAC recognises that the Bill aims to provide a framework for all the professions covered by AHPRA, from the largest to the smallest, and is well aware of the fact that smaller professions may well not need to have the level of detail that is required for the effective regulation of the larger professions. It may be that the Bill, as drafted, will lead to a raising of standards for the majority of professions by introducing provisions that they do not currently have. However, the desire to not over-complicate matters and processes must not lead to a diminution of the effectiveness of the professions which operate in a more complex and litigious environment. Smaller boards may have no need to invoke some of the provisions which are of paramount importance for larger boards, but if these are left out, both the public and the health professionals will suffer.

2.2 Disciplinary and non-disciplinary provisions

Disciplinary provisions are an essential feature of professional regulation, but of equal importance are the mechanisms for dealing with practitioners who are not deliberately or recklessly engaging in misconduct, but who are impaired, or whose standards have fallen below an acceptable level. The Bill purports to cover Impairment and Performance, but does so in a way that does not recognise nor understand the difference between these pathways and the Disciplinary pathway, and how they relate to each other. The Bill is couched in terms of 'complaints', failing to recognise the non-disciplinary nature of the Impairment and Performance processes which is essential to their successful implementation. Allowance should be made for the use of the word 'notifications' which do not have the disciplinary overtone of complaints.

2.3 The role of Performance Assessment in regulation

A critical definitional and conceptual failure of the Bill is the characterisation of unsatisfactory performance as a subset of unsatisfactory conduct. While there will be individual cases where this is appropriate (the practitioner who recklessly or wilfully undertakes procedures for which he/she is not trained),

in the vast majority it is not. To define performance in this way significantly detracts from its remedial and non-punitive approach, reflecting the worldwide regulatory movement towards assessment and enhancement of professional skills, with punitive measures reserved for ‘bad’ conduct.

Australia is at the forefront in the development of performance assessment programs, and is regarded by the International Performance Assessment Coalition, a group of a dozen or more jurisdictions from all the countries where performance assessment is seen as a vital tool of professional regulation, as a world leader. The performance provisions in the current Bill (which JMBAC believes to be misconceived and seriously inadequate) will undo over ten years work in this area, leading to a corresponding diminution in the Boards’ ability to meet its public protection charter.

2.4 Flexibility of assessment and assignment of matters

All notifications should be initially assessed with a view to establishing whether they are to be treated as conduct, performance or impairment, and regardless of whether they have come to the Board’s notice as a patient notification/complaint, a self referral, a notification by an employer etc. Once initial assessment has been made, and the matter assigned to the relevant pathway, there must be the power to reassess and reassign at any time, or to deal with a practitioner in two pathways simultaneously if appropriate. The Bill appears to require a matter, once assigned to a particular pathway, to go through the entire process of that pathway before reassignment is possible.

2.5 Definition of Complaint

The language of complaint used in the Bill fails to recognise the significant amount of regulatory activity undertaken by Boards which should not be characterised as disciplinary. The term “notification” was originally used during the consultation process, and this should be reinstated. Complaints should be viewed as a subset of notifications, and the source of the information should be viewed as secondary to the characterisation as Conduct, Performance or Health once assessment has been undertaken.

The language of the Bill should not add to the current level of confusion regarding the role played by HCEs in conciliation of consumer complaints.

The title of Part 8 should be amended to reflect this, and the interactions between conduct, performance and health.

2.6 Health Panel Procedures

The Bill indicates that practitioners will have a right of legal representation before Health Panels. While there is no debate that health proceedings and the practitioner will almost invariably benefit from the practitioner being assisted by a sympathetic and understanding adviser, JMBAC considers that providing

for a right of legal representation will promote an adversarial culture. This is clearly not in the best interests of the public or the impaired doctors.

The Bill provides that the notifier / complainant has a right to make a submission to a Health Panel. While this information may be useful in providing evidence to the Panel relating to behaviour, this should be a matter solely for the Panel to determine and on a case-by-case basis.

It is difficult to see the rationale for requiring the publication of the decisions of Health Panels (and Performance Panels) and we suggest that this be reviewed.

The provisions regarding self-referral appear to contemplate that the first step after receiving the referral will be to enter into an agreement with the practitioner. It is difficult to see this being possible in most circumstances, without first obtaining a health assessment.

2.7 Status of Undertakings

Undertakings can provide a useful means of resolving relatively low level matters in a consensual atmosphere, but if they are used, they must be transparent and binding.

2.8 How will it work?

The view of the CEOs/Registrars of the Medical Boards, based on their collective experience across all the jurisdictions, is that aspects of Bill B, especially the Complaints components as currently proposed, will be very difficult to implement or to operate effectively.

Attempts at modelling how a typical complaint would flow through the system have led to a variety of different interpretations, with the common threads being that the system is cumbersome, circular, and inadequate.

3. OTHER ISSUES

3.1 Transitional provisions concerning complaints

Division 13 covers transitional arrangements for complaints and disciplinary proceedings. If the expression “had started but not completed dealing with a complaint” is interpreted broadly, there will be a very substantial backlog of complaints to be dealt with under previous legislation in larger jurisdictions. This tail could extend for many years, and a preferable position may be to make the point of referral to formal proceedings the cut off.

3.2 Reportable conduct

It is suggested that the definition at paragraph (d) should be amended to read

“place the public at risk of harm because the health practitioner has practised the profession in a way that constitutes a substantial departure from accepted professional standards”.

It is considered that by moving the word “substantial” to qualify the departure from standards rather than the risk of harm, the likelihood of significant over-reporting of minor matters will be reduced.

There is support for extending the mandatory reporting requirements to students, to provide educators with protection against any action by a student as a result of reporting matters to the Board.

3.3 Location of jurisdiction

The Bill indicates that jurisdiction to handle a matter with multi-jurisdictional elements will be based on the practitioner’s registered address. This has the potential to lead to jurisdiction-shopping and anomalous requirements for action to be taken outside the jurisdiction with the closest connection to the case. Jurisdiction would be more appropriately founded on the place where an incident occurred or the practitioner’s usual place of practice.

3.4 Two year limit on limited registration

Reassurance has been given that Sections 90 and 91 which appear to restrict limited registration to a single two year period will be amended to make it clear that this may be reviewed.

A number of other interpretation issues have been raised where the intended meaning appears contrary to the language of the provision concerned. Rules of interpretation should reflect ordinary usage wherever possible.

3.5 Area of need specialists

The decision of COAG to support a Specialist register with barrier requirements of holding Australian qualifications and experience was a significant improvement in increasing public understanding and confidence in the identification of specialist doctors. S133(1)(b)(ii) is inconsistent with this principle. The section allows doctors with limited registration to ‘take or use’ the title of Specialist to ‘enable the person to practise in a recognised speciality in the medical profession’

This has the potential for doctors who do not hold specialist qualifications (as assessed by the professional specialist colleges) to hold themselves out to the public as ‘Specialists’ and to claim substantial equivalence with practitioners who have Australian specialist colleges qualifications.

The inclusion of the above removes any benefit of the COAG agreed intent and further broadens the public confusion as to which medical specialists hold Australian qualifications (and are suitably assessed to a standard), and those who have not yet attained the qualifications and either undergoing specialist

training or further assessment. JMBAC strongly recommends the use of the title ‘Specialist’ must be restricted to those who meet the requirements for specialist registration on the specialist register.

3.6 Public Interest Assessor

The creation of this role is unnecessary and the potential cost a deterrent. There are concerns that the role constitutes an intrusion into the regulatory independence of the National Board, creating an expensive and unnecessary bureaucracy; and an imbalance of power between the NB and the PIA. The proposed framework of Boards/Committees with significant community membership, can readily satisfy the need for transparency and an unbiased decision making base for complaints. To manage the proposed role through the existing HCEs would result in conflict, delays and variability of outcome between states. Further, the role may generate a substantial amount of unnecessary work and expense if the PIA has unrealistic views about what warrants further action, with no responsibility for carrying through investigations. The “most serious action proposed” call ignores the professional nature of the bases upon which complaints investigation is conducted under the legislation. The model was proposed to satisfy NSW demands, but with that state likely to opt out, there is no ongoing need for the PIA.

3.7 The international context

The State and Territory Medical Boards have for many years been actively involved in international organisations of medical regulatory bodies established to promote discussion regarding regulatory developments, particularly the international interchange of disciplinary information. Australian Boards are founding members of the International Association of Medical Regulatory Authorities, and Australia’s involvement with the International Performance Assessment Coalition has been referred to elsewhere. Medical migration is a significant and sensitive issue, and Australian Boards must be able have confidence in the bona fides, registration status, etc, of international medical graduates. International exchange of data with overseas jurisdiction is a key element of this, and Bill B does not appear to provide adequately for this. The sections regarding provision of information to overseas regulatory authorities must facilitate this in the public interest.

3.8 Spent convictions

There is a concern that the provisions relating to spent convictions will infringe human rights requirements in some jurisdictions.

3.9 Jurisdictional representation

JMBAC is concerned that the smaller jurisdictions will be disenfranchised by the proposed constitution of the National Board. Regulatory issues differ

significantly between small and large jurisdictions, and also between the smaller jurisdictions themselves. The environment in NT is very different from that in the ACT and Tasmania, and yet as proposed, one Board member will be required to be familiar with and represent all three. This would be addressed by the small step of adding 3 additional members (two professional and one community), so that each jurisdiction has a place on the board, and the professional/community balance is maintained. The additional cost would be minimal, and substantially outweighed by the benefit of having a comprehensive coverage of all national perspectives.

Exposure Draft to Bill B –		
Part 1	Preliminary	
Section	Issue	Proposed Alternative Solution
Preliminary	<p>3 Objective of Law - The objects will become critical to successful prosecutions.</p> <p>4 Objectives and guiding principles of national registration and accreditation scheme – on balance the objectives appear to focus heavily on workforce, training and service provision with only a passing reference to protection of the public. S1(A) Deals with initial registration only and does not make reference to monitoring the practice of registrants where conditions have been imposed either at time of registration or as a result of performance, conduct or impairment.</p> <p>6 Definition</p> <p>Impairment – the critical issue is not whether a practitioner has an impairment, but whether that impairment affects their capacity to practice safely.</p>	<p>S3(a) insert the words “safe” to the phrase “suitably qualified, safe and competent to practise the profession”</p> <p>S4 Suggest - add an additional objectives:- . “to maintaining public confidence in the health professions” . insert an additional sub-paragraph after 1(a) which recognises the need to monitoring adherence to practice restrictions placed on the registration of a health practitioner.</p> <p>6 impairment: after “capacity to” add the words “safely and competently” reportable conduct: para (d) “substantial harm” should be changed to “harm” and add the word “significant” inserted before the word “departure” registration authority: (b) be replaced with “an entity or jurisdiction outside Australia that has responsibility for registration, investigation or disciplinary action in relation to health practitioners in that jurisdiction.” review period: the definition should include a maximum period which can be decided (eg not more than 3 years) Unprofessional conduct: Remove unsatisfactory professional performance (i) from the defn of this section. Performance and conduct should not be confused. That said, ‘improper and unethical conduct’ should be added to defn rather than the current reference to conduct of a lesser standard expected by the public. The standards test should be judged by professionals peers.</p>

Exposure Draft to Bill B –		
Part 2	Ministerial Council	
Section	Issue	Proposed Alternative Solution
Ministerial Council	<p>10 Policy directions – 10(4) and (6) There is significant concern that these clauses, as currently written, the Min Council could require a National Board to lower the standards of education and training to solve workforce problems, thus putting the public at risk of sub-standard health care. Furthermore a direction relating to an accreditation standard could be interpreted as government interference and jeopardise Australia’s international standing in relation to the quality of its education and training of health professionals.</p> <p>15 Notification and publication of directions and approvals</p>	<p>10 - add to 10(4) “and the direction does not dilute a currently approved accreditation standard or lower the standard generally of education and training of health practitioners.”</p> <p>15 – typo graphical error - delete “and” at 15(2)(b)</p>

Exposure Draft to Bill B –		
Part 4	Australian Health Practitioner Regulation Agency	
Section	Issue	Proposed Alternative Solution
Division 4 Public interest assessor	35 Public Interest Assessor –There is the potential for this position to substantially increase the workload by requiring unrealistic assessments and thereby increase costs to a National Board, with no requirement to justify the position taken nor to report to the National Board or the Ministerial Council.	35 – insert a provision requiring the Public Interest Assessor to make a report to the Ministerial Council and the National Board regarding those matters it considered a higher level of action was required and the reasons for the position taken.

Exposure Draft to Bill B		
Part 5	National Boards	
Section	Issue	Proposed Alternative Solution
Division 1 National Boards	45 Membership of National Boards – There is concern that for the medical profession, all states and territories are not represented.	45 - for the medical profession, all states and territories should be represented
Division 2 Functions and powers of National Boards	49 Functions of National Boards - fails to mention monitoring conduct conditions/undertakings or conditions imposed at time of registration or as a result of Board action. 50 Powers of National Boards – National Board is not a legal entity. Question whether board can exercise all of its powers 51 Requirement to consult other National Boards – in addition to the requirement to consult other Boards regarding a proposed recommendation to the Ministerial Council, a National Board should also be required to consult with any other National Board in respect to an accreditation matter where aspects of practice may be shared by more than one profession (eg Dental/Medical in respect to maxillo-facial surgery, Podiatry/Medical in respect to podiatric surgery, physiotherapy/musculoskeletal medicine)	49 – para (j) should be amended to read “to oversee the monitoring of the compliance with conditions or undertakings applying to the registration of health practitioners and students” 50 – National Board may need to be a legal entity to become a party to legal proceedings. 51 –after the words “(the other Board)” add the words “or is considering an accreditation matter”

Exposure Draft to Bill B		
Part 6	Accreditation	
Section	Issue	Proposed Alternative Solution
Division 1 Preliminary	<p>59 Definition – the definition should include assessment of other authorities which do not necessarily accredit training programs but have licensing examinations such as occurs in the USA</p> <p>59(d) too limiting on the authorities – the definition should also be broadened to include other entities eg Postgraduate Medical Education Councils and other functions e.g. accreditation of intern training.</p>	<p>59 – add “assessing authorities in other countries which conduct examinations for the purposes of determining suitability for practise in the health profession to determine whether the examination adequately assesses a person who passes the examinations as having the necessary knowledge and clinical skills to practise the profession in Australia”</p> <p>– the definition should also be broadened to include agencies which accredit intern training programs and to include accreditation of other areas as required, such as, but not limited to, supervised practice programs, bridging courses, re-entry programs.</p>
Division 2 Accreditation authorities	<p>60 Ministerial Council may appoint external accreditation entity – to maintain confidence in the profession, the Ministerial Council must only appoint an external accreditation entity on the recommendation of a National Board</p>	<p>60 – add at the end of (1) “if recommended by the National Board”</p>
Division 3 Accreditation functions	<p>65 Approval of accreditation standards – clarification is required as to who is able to review a decision to refuse eg who would be the internal reviewer? If it is a committee that makes the initial decision, an internal review could be undertaken by another committee not involved with the initial decision.</p> <p>67 Approval of accredited programs of study – there does not appear to be an ability to approve accreditation with conditions.</p> <p>-there does not appear to be any provision for review or appeal of a decision to refuse or revoke accreditation</p> <p>68 Accreditation authority to monitor approved courses of study – this clause is too inflexible and does not recognise minor and major breaches. There is a difference between being able to do something via policy as opposed to having a legislative power to do so.</p>	<p>65 – amendment may be required</p> <p>67 – insert provisions to enable conditions to be imposed on accreditation of approved programs</p> <p>– insert a provision to enable a decision to refuse accreditation to be reviewed/appealed by the education provider</p> <p>68 – add an ability to be able to issue notices to remedy;</p> <p>- add an ability to impose conditions to require compliance with accreditation of an approved course</p> <p>- add requirement to notify National Board of any breach.</p>

Exposure Draft to Bill B		
Part 7	Registration of health practitioners	
Section	Issue	Proposed Alternative Solution
Division 1 General registration	<p>69 Eligibility for general registration – subclause (d) would be difficult to monitor and to what extent it is a regulatory function is uncertain. Clarification is required as to how this would protect the public, especially if cancellation of professional indemnity insurance is listed as a “relevant event” in clause 142.</p> <p>70 Qualifications for general registration – (b) is quite broad and could lead to IMGs seeking general registration inappropriately. It may also limit IMGs to obtain registration upon successful completion of an examination or assessment.</p> <p>72 Suitable person for general registration “fit and proper person for registration” is subjective</p> <p>73 Professional indemnity insurance arrangements – interaction between period of registration and PII coverage is not clear. There is also concern relating to what “appropriate arrangements” means and whether a National Board could be at risk of litigation if it accepts too low a level of professional indemnity insurance.</p>	<p>69 remove subclause (1)(d) and elsewhere where reference is made to the requirement to hold professional indemnity insurance.</p> <p>70 – insert “if so assessed by an accreditation authority” at the end of (b) - Insert a clause similar to “holds another qualification and have successfully undertaken an accredited examination or period of satisfactory supervised practice.</p> <p>72 need to indicate how it will be determined if someone is “fit and proper” eg the fitness to practise provision in the <i>Medical Practitioners Registration Act 2001</i></p> <p>73 – preference would be to delete</p>
Division 2 Specialist registration	<p>75 Eligibility for specialist registration – clarification required as to whether registrants can hold both general and specialist registration and if they can have both, do they pay 2 sets of fees?</p> <p>76 Qualifications for specialist registration – (b) is quite broad and could lead to IMGs seeking specialist registration inappropriately. Application of this clause should be limited to IMGs and approval/comments sought from relevant college.</p>	<p>75 – further clarification required.</p> <p>76 – add the words “if so assessed by an accreditation authority” at the end of (b) -Alternatively will Colleges have to be declared accreditation authorities?</p>
Division 3 Provisional registration	<p>There is currently no head of power to approve or accredit supervised practice programs.</p> <p>S80 Consideration could be given to imposing probationary conditions on registration rather than having a separate division to deal with the matter.</p>	

Exposure Draft to Bill B		
Part 7	Registration of health practitioners	
Section	Issue	Proposed Alternative Solution
Division 4 Limited registration	<p>Reference in this Division to “relevant” qualification is considered to be too broad.</p> <p>87 Limited registration for teaching or research 90 Period of limited registration – There needs to be a head of power to require progress to general or specialist registration. Without this, any decision to impose as a condition of registration will result in appeals being successful. 91 Limited registration not to be renewed or restored– need clear statement whether a further application for limited registration can be made and whether there is a limit on the number of times this can occur.</p> <p>There is no provision to protect public by imposing standard conditions relating to supervision or progression to general or specialist registration. Such standard conditions should also not require submissions to be made regarding proposal to impose standard conditions, notice or decision, or be appealable.</p>	<p>Should be changed to “suitable” qualification.</p> <p>87 clarify that it includes clinical practice relating to the teaching or research 90 insert head of power to require practitioners with limited registration to progress to general or specialist registration</p> <p>91 – insert a provision indicating that general or specialist registration must be obtained within XYZ years.</p> <p>Add appropriate clauses.</p>
Division 5 Non-practising registration	<p>Delete if possible – otherwise requires amendment 92 Eligibility for non-practising registration – if this division must remain, eligibility should be extended to a person registered under another law providing for the registration of a health practitioner 93 Period of non-practising registration– should not need to renew but continue to be registered until they wished to change to another category which would then require a new application for registration. As it is non-practising registration, registration fees should not be required.</p>	<p>92</p> <p>93 – delete (2)(B)</p>
Division 6 Application for registration	<p>95 Power to check applicant’s proof of identity 96 Power to check applicant’s criminal history 97 Power to enquire about qualifications, registration status and practice in health profession – a Board should be able to make enquiries regarding qualifications at any time it becomes aware of a need to do so. 98 Boards’ other powers before deciding application for registration - There should be a statement indicating who</p>	<p>95(2) – “(1)” should be added after “subsection” 96(2) – omit “may” insert “must” 97</p> <p>98 (e) add “or another health professional reasonably required”.</p>

Exposure Draft to Bill B		
Part 7	Registration of health practitioners	
Section	Issue	Proposed Alternative Solution
	<p>pays for the health assessment.</p> <p>99 Applicant may make submissions about proposed refusal of application or imposition of condition– there are concerns this process could cause workforce delays, especially in circumstances where standard conditions have been imposed.</p> <p>100 Decision about application</p> <p>101 Conditions of registration – there do not appear to be any provisions to enable conditions to be imposed during a registration period (mostly applies to limited registration when performance issues are raised through assessment reports received at 3, 6 and 12 months but do not warrant action under the HP(PS)A. Information can also be received from specialist colleges and the AMC regarding examination results)</p> <p>103 Failure to decide application – need to clarify that it is 90 days from the latter of section 98 requirements having been received</p> <p>– there is no mechanism to extend the time to receive information by agreement</p>	<p>99</p> <p>100</p> <p>101 – in the Note, after the words “comply with a condition of the practitioner’s registration” add “or undertaking given by the health practitioner”</p> <p>101(1)(b) “must not practice the health profession” is not sufficiently clear – suggest including “Note: For the medical profession, practice of the profession means the cessation of all medical practice including, but not limited to, the writing of remunerated or unremunerated prescriptions or specialist referrals.”</p> <p>- standard conditions should not enliven an appeal right nor require a notice to be issued</p> <p>103</p>
Division 7 Student registration	<p>To ensure accurate data, students should be required to make application for registration.</p> <p>– require a criminal history disclosure to ensure eligibility for general registration with an ongoing responsibility to notify National Board of any convictions</p> <p>- there should be an obligation on the student to notify the National Board regarding any impairment</p> <p>- there should be an obligation for universities to report to the National Board regarding criminal convictions or impairment</p> <p>105 National Board may ask education provider for list of persons undertaking approved program of study</p> <p>108 Notice to be given if student registration suspended or condition imposed – who is responsible for advising the student?</p>	<p>105 - “may” be amended to “must”</p> <p>108 – amend the clause to require the notice to also be sent to the student</p>
Division 8 Endorsement of registration		
Subdivision 1	110 Endorsement for scheduled medicines – this should be	110 – amend the Note to reflect that this subdivision does not apply to medical

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Part 7	Registration of health practitioners	
Section	Issue	Proposed Alternative Solution
Endorsement in relation to scheduled medicines	automatic for medical practitioners	practitioners.
Division 9 Renewal of registration or endorsement	<p>124 Annual Statement</p> <p>125 Decision about renewal – clarification is required as to whether sub-section (4) only applies in circumstances where there were no conditions in place immediately prior to renewal of registration. If so, insert a subparagraph stating “If a National Board decides to renew an applicant’s registration or endorsement of the applicant’s registration, the renewed registration is subject to the conditions attaching to the registration or endorsement immediately before the decision takes effect” (<i>s.77(3) of the MPRA</i>)</p>	<p>124 – include a requirement for a health declaration to be made in the annual statement</p> <p>125 (4) – should it be (1)(c) or (3)(c)?</p> <p>125(5)(a) be amended to “the decision and reasons for the decision made by the Board, and”</p>
Division 11 Title and practice protections		
Subdivision 1 Title protections	<p>There needs to be consistency of terminology - either “intentionally or recklessly” or “knowingly” but not both as currently occurs. “Intentionally or recklessly” may be too high a standard to successfully prosecute, therefore “knowingly” is preferred.</p> <p>128 Claims by persons as to registration – as currently written, this significantly lowers protection of the public - there are no provisions to prosecute a third party</p> <p>129 Restriction on use of titles – need to come up with different terminology to “registered practitioner” because the public don’t necessarily know that health practitioners have to be registered</p> <p>133 Restriction on use of specialist titles – this needs to be clarified to ensure that any permutations are also covered, eg “consultant”, “anaesthetist”, “obstetrician”, “surgeon” etc as being the same as “medical specialist” therefore all such terminology should be restricted for use only by those persons registered in such specialties.</p> <p>134 Claims by persons as to registration in recognised specialty – this heading is identical to that at clause 132</p>	<p>128</p> <p>129 – perhaps replace “registered under this Law” with “eligible to practice under this Law”</p> <p>133</p> <p>134 - change “persons” in title to “registered health practitioners”</p>

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Part 7	Registration of health practitioners	
Section	Issue	Proposed Alternative Solution
Subdivision 2 Practice protections	136 Restrictions on prescription of optical appliances	136(1) – add “or supply” after the word “prescribe”
Division 12 Miscellaneous	There needs to be provision for voluntary undertakings which do not enliven appeal rights in addition to imposing conditions which do have an appeal right.	
Subdivision 1 Certificates of registration	138 Issue of certificate of registration	138 (e) – insert “or undertaking” after “any condition”
Subdivision 2 Review of conditions and undertakings	The Board should have flexibility to review conditions at any time if it receives information warranting such action (eg an unsatisfactory assessment report for an IMG received at 3 or 6 months after registration, report from treating practitioner indicating the health of a registrant has deteriorated, or report from Board nominated psychiatrist that health has improved) 140 Changing conditions or undertakings on Board’s initiative 141 Removal of condition or revocation of undertaking – The Board should have flexibility to remove a condition or undertaking during a review period on receipt of new information	140 (3) – indicate the Board can change a condition or undertaking during a review period. 141(3) - indicate the Board can remove a condition or revoke an undertaking during a review period.
Subdivision 3 Obligation of registered health practitioner to provide information	142 Information about offences, clinical privileges and billing privileges – 142(3)(a) and 155(2)(a) should be consistent	142 – relevant events should also include:- <ul style="list-style-type: none"> • notification of judgements and settlements • action taken by another registration authority • cancellation of professional indemnity insurance
Subdivision 4 Advertising	145 Advertising – consider it important to restrict the advertising of treatments which may be harmful (eg the Tait matter)	145 – add “(f) in a way which minimizes the risk of harm the service may cause
Subdivision 5 Board’s powers to check identity and criminal history	147 Criminal history check	147 – change “may” to “must”

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Part 7	Registration of health practitioners	
Section	Issue	Proposed Alternative Solution
Subdivision 6 General	<p>148 Directing or inciting unprofessional conduct or professional misconduct – clarification is needed in regard to (2) that action can be taken against an owner or operator under another law. If this is not possible how will health practitioners in public health facilities, other licensed health facilities or general practices not owned by registrants be protected from being directed to do something which amounts to unprofessional conduct or professional misconduct?</p> <p>149 Surrender of registration</p>	<p>148</p> <p>149 – add “the Board may refuse to accept a surrender of registration if a complaint has been received against the registrant and the matter has not been finalized”</p>
Part 7 Other comments	<ol style="list-style-type: none"> 1. There needs to be an ability to cancel registration if the registrant ceases to have, or does not have, qualifications necessary for registration (eg fraud, College withdraws fellowship). 2. There needs to be a clear provision for National Board to be able to exchange information with overseas registration authorities. 3. There needs to be authority for a National Board to take action against a registrant (similar to s.311 of the <i>Health Practitioners (Professional Standards) Act 1999</i>) 	<p>Add appropriate provisions.</p>

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Part 8	Complaints, performance, health and conduct	
Section	Issue	Proposed Alternative Solution
Division 1 Preliminary	<p>150 Part also applicable to former registered health practitioners – this part should also apply to Division 3 (Mandatory Reporting) as it would be important to investigate and notify other registration authorities if necessary and to have something on file should the person seek to be registered again.</p>	<p>150 reference to “Divisions 3, 5 and 8” be changed to “Divisions 5 and 8”</p>

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Part 8	Complaints, performance, health and conduct	
Section	Issue	Proposed Alternative Solution
Division 2 Making a complaint	152 Who may make complaint – the word “complaint” is adversarial and should be changed to “notification”. A notification regarding an impairment should not be referred to as a complaint	152
	153 How complaint is made – a verbal complaint should be required to be confirmed in writing with failure to do so resulting in the complaint being withdrawn (unless it was in the public interest not to do so)	153
	154 National Agency to provide reasonable assistance to complainant – need to clarify what would be considered to be reasonable assistance (eg can we just direct to HQCC)	154
	155 Grounds for complaint – it is considered the grounds for complaint are not consistent with the definitions for <i>unsatisfactory professional performance, unprofessional conduct</i> and <i>professional misconduct</i> . Health and performance matters should not be referred to as “complaints” but as notifications.	155
Division 3 Other matters taken to be complaints	156 Mandatory reporting by health practitioners 156(2) why is the report for reportable conduct made to the National Agency rather than the National Board? 156(4) need clarification as to whether this also applies to medical experts providing an opinion to an insurer` 157 Mandatory reporting by employers – clarification is needed as to how a health complaints entity or licensing authority can deal with the issue to protect public safety and the sanctions available – a direct power to prosecute would be preferable. 158 National Board may take action on own initiative	156(2) – change “National Agency” to “National Board” 157 – heading be amended to “employers who are not registrants” (3)/(4) rather than Minister, it should be the national board (7) – needs an offence provision for when there is no relevant licensing authority (eg owner of a general practice who is not a registrant) 158

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Part 8	Complaints, performance, health and conduct	
Section	Issue	Proposed Alternative Solution
Division 4 Dealing with complaints	<p>Reference to the ISO Standard for complaints management would be preferable to legislating timeframes.</p> <p>163 National Board may require further information – There does not appear to be any power to compel information to be provided if requested. Without such a power, an appropriate assessment may not be able to be undertaken.</p> <p>164 Preliminary assessment - what activities is it envisaged the 60 days would include (eg date of receipt of complaint, preliminary assessment and the Board deciding the action to be taken or does it also include agreement with the PIA?)</p> <p>165 Agreement with independent assessor about complaint – doesn't appear to enable referral to other appropriate entities, or to be closed as the matter has been appropriately dealt with.</p> <p>166 Relationship with health complaints entity – clarification is required as to which entity would be responsible for dealing with complaints which currently would be the responsibility of the HQCC. If the Board is to assess all complaints, this would be quite onerous for the Board. It is important to ensure there is no duplication of investigation.</p> <p>167 Rejection of complaint – another reason for rejection is the subject matter of the complaint has already been dealt with adequately by the National Board or another appropriate entity. The term "rejection" may be conceived as dismissive.</p> <p>Note: the link to formal action appears to relate to whether the person is actually registered – formal action should be able to be taken regardless of whether the person was registered. This would then also allow useful information to be provided to regulatory authorities overseas where the practitioner may have commenced practice.</p>	<p>163 – add (d) any person who may have knowledge of information relevant to the matter of complaint. - add a provision similar to s.78 of the HP(PS)A to require a person to give further information to enable an assessment of a complaint to be undertaken. 164</p> <p>165 - add "refer the complaint to another entity that has the function or power under an Act of the State, the Commonwealth or another State to deal with the matter" and "no further action on the basis it has been adequately dealt with."</p> <p>166 – add a provision similar to s.51 of the HP(PS)A requiring the National Board to refer certain complaints to a health complaints entity.</p> <p>167 - add "the subject matter of the complaint has already been dealt with adequately by the National Board or another appropriate entity". Change the term "rejection" to a less derogatory word eg "dismissal"</p>

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Part 8	Complaints, performance, health and conduct	
Section	Issue	Proposed Alternative Solution
Division 5 Immediate action	<p>168 Immediate suspension or imposition of condition– with respect to “serious risk”, does this raise the bar from the current serious potential risk? It is also important to make it clear that “serious risk to persons” includes the registrant as needing protection.</p> <p>Clarification is sought as to under what circumstances would this action be taken against a student and what would be the outcome of such action in respect to ability to continue the course of study.</p> <p>If the matter relates to a student, the Board should be able to refer the matter to a responsible Tribunal</p>	<p>168 (2)(b) - confirm the National Board can decide not to accept the surrender of registration</p> <p>- add that the National Board may decide “to accept an undertaking from a health practitioner or student” (<i>subject to confirmation that undertakings are binding</i>)</p> <p>168(6)(c) - 3 months is too short a period to complete an investigation – either six months with ability to re-impose or no specified period should be included.</p> <p>Add provision to refer student to a responsible Tribunal.</p>
Division 6 Referring complaints to tribunals	<p>170 Complaint to be referred to responsible tribunal The matter should be referred to the jurisdiction where the most serious matter and/or prevalent action occurred. Using mailing address is not appropriate in any circumstance and the relevant jurisdiction at minimum should be where the majority of the registrant’s practice occurs. Some registrants use an overseas mailing address!</p> <p>171 Parties to the proceedings – clarification is required as to whether a National Board can be a party to a proceeding if a National Board is not a legal entity</p> <p>172 Decision</p> <p>173 Action that may be taken by tribunal – clarification is required as to whether the tribunal can take more than 1 action referred to in this section.</p> <p>173(1)(d)(iv) and (vi) – examples of what these conditions might be would be useful.</p>	<p>170</p> <p>171</p> <p>172 add that the Tribunal may decide “the health practitioner may be impaired and refer the practitioner for assessment under Division 8”.</p> <p>173 - add words to indicate the Tribunal can take one or more of the actions referred to in the subsection</p> <p>- add a “catchall” that the Tribunal can do any other thing it sees fit</p>
Division 7 Professional standards matters		

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Part 8	Complaints, performance, health and conduct	
Section	Issue	Proposed Alternative Solution
<p>Subdivision 1 Performance assessment</p>	<p>174 Requirement for performance assessment– what can the Board do if the matter is of a lesser conduct matter but it is not a performance assessment matter? Performance assessment definition is too narrow and focuses on hospital practice - conduct also needs to be dealt with at this level. Options proposed are only of a formal nature. There does not appear to be a process to deal with “unprofessional conduct” matters other than by way of a performance assessment or a professional standards panel which are formal processes.</p> <p>175 Appointment of assessor to carry out assessment - has a very singular view of performance assessment – it may be necessary to appoint more than one assessor</p> <p>177 Copy of report to be given to health practitioner – discussing a report with a registrant will have significant cost implications, will slow down the process and may not be appropriate in some circumstances. Allowing the registrant to make submissions regarding the report would be appropriate.</p> <p>178 National Board’s decision– need to be able to make a decision that the health practitioner may be impaired and refer to a health assessment panel</p> <p>179 Action that may be taken by National Board at end of proceeding</p>	<p>174 – should be able to undertake the performance assessment at the place of practice - more than one health practitioner may be required to carry out the assessment – the matter should be referred to the jurisdiction where the most serious matter and/or prevalent action occurred. Using mailing address is not appropriate in any circumstance and the relevant jurisdiction at minimum should be where the majority of the registrants’ practice occurs. - add a process similar to the current Board level hearing, the decision of which is not appellable.</p> <p>175 replace “appoint an assessor” with “appoint one or more assessors”</p> <p>177 (2) change the word “must” to “may”</p> <p>178 add that the National Board may decide “the health practitioner may be impaired and refer the practitioner for assessment under Division 8”.</p> <p>179 - add words to indicate the National Board can take one or more of the actions referred to in the subsection 179(1)(b)(ii) – the matter should be referred to the jurisdiction where the most serious matter and/or prevalent action occurred. Using mailing address is not appropriate in any circumstance and the relevant jurisdiction at minimum should be where the majority of the registrant’s practice occurs.</p>

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Part 8	Complaints, performance, health and conduct	
Section	Issue	Proposed Alternative Solution
<p>Subdivision 2 Professional standards panels</p>	<p>180 Establishment of professional standards panel – clarification is required as to under what circumstances the Board could be <u>required</u> to refer a complaint to a professional standards panel.</p> <ul style="list-style-type: none"> - The National Board needs to be able to refer unprofessional conduct direct to a professional standards panel for hearing without the requirement for a performance assessment to have been conducted. - clarification is required as to how the national agency will assist the panel and whether the panel can be assisted by a legal representative. <p>183 Procedure of professional standards panel -There needs to be processes in place to ensure consistency regarding panel procedures.</p> <ul style="list-style-type: none"> - an ability to give instructions (similar to a directions hearing) as to the order of the proceedings should also be included. <p>184 Legal representation</p> <p>188 Referral to responsible tribunal – it is considered the registrant should only be able to request the matter be referred to a tribunal before a panel commences to hear the matter.</p> <p>190 Action by professional standards panel at end of proceeding</p> <p>191 Notice to be given to registered health practitioner - clarification is sought as to why the panel doesn't give the notice to the registrant itself as the National Board could misinterpret the reasons for decision etc which must be included in the notice and would be quoted in any review or appeal.</p>	<p>180 – add “at least one member must be a legal practitioner” (to ensure legal conventions are complied with)</p> <p>183 – add provision outlining arrangements for directions relating to the order of proceedings for the panel hearing.</p> <p>184 – insert provisions to enable the National Board to also be accompanied by a legal practitioner and to allow the legal practitioner to address the panel on behalf of the National Board.</p> <p>188 (1) – replace the words “the Board” with “the Panel”</p> <ul style="list-style-type: none"> – amend the provision to enable the registrant to only being able to request the matter be referred to the Tribunal prior to the panel commencing to hear the matter. <p>188(2)(b) - add words to indicate the National Board can take one or more of the actions referred to in the subsection</p> <p>190 - add words to indicate the panel can take one or more of the actions referred to in the subsection</p> <p>191(2) – remove the word “making”</p>

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Part 8	Complaints, performance, health and conduct	
Section	Issue	Proposed Alternative Solution
ISSUES	<ol style="list-style-type: none"> 1. Clarification is required as to the difference between Subdivision 1 and Subdivision 2 as the roles/functions/powers appear to have the same outcomes. 2. There are no inspection powers to enable investigation of matters that are not a complaint (eg advertising, restriction on use of titles, monitoring of conditions) 	Insert appropriate powers.
Division 8 Health matters		
Subdivision 1 Self-referral	<p>192 Procedure if registered health practitioner or student informs National Board of impairment – this section contains no process by which the National Board could make an informed decision as to the terms of an agreement it should enter into with a registrant.</p> <ul style="list-style-type: none"> - clarification is required as to what action the National Board can take if an agreement can not be reached with the health practitioner or student. - consequences for breach of any such agreement have not been outlined. <p>192(2) – there is no mechanism to separate receiving information from treating practitioners as well as reports from independent practitioners. It is important to protect the relationship between a patient and their treating health practitioners. It is not appropriate to require treating practitioners to act as agents of the Board and provide reports to it for monitoring purposes. Such reports should be provided by an independent practitioner.</p>	<p>192 –add a process for a health assessment to be undertaken to determine the terms of any agreement to be entered into.</p> <ul style="list-style-type: none"> - add a Note indicating “A failure by a registered health practitioner or student to comply with an agreement entered into does not constitute an offence but may constitute behaviour for which disciplinary action may be taken.” <p>192(2) – end the clause after the words “compliance with the agreement” and remove the example provided. If an example must be given, perhaps “by requiring the practitioner or student to attend for review by a health practitioner or health practitioners nominated by the National Board, as requested by the National Board”</p>
Subdivision 2 Health assessments	<p>194 Appointment of assessor – this clause does not appear to allow for more than one health practitioner to be used to carry out the health assessment – this may be required depending on the nature of the suspected impairment and in circumstances where an assessment report may be inconclusive and a second assessment is required.</p> <p>194(2)(b) needs refinement as it does not preclude a person that has a personal or professional connection with the registrant (eg friend, work colleague).</p> <p>194(2)(a) – states “is not a member of the National Board” - this should also state or “Committee appointed by the National</p>	<p>194(1) – add the words “suitably qualified” before “assessor”</p> <p>194(2) – add “(c) does not have a personal or professional connection with the health practitioner or student the subject of the health assessment”</p>

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Part 8	Complaints, performance, health and conduct	
Section	Issue	Proposed Alternative Solution
	<p>Board”</p> <p>195 Report from assessor</p> <p>196 Copy of report to be given to health practitioner – the practicality of discussing the report with the health practitioner would be difficult in terms of time, cost and the availability of persons with appropriate knowledge and skills. Giving the health practitioner the opportunity to make a submission regarding the contents of the report whether they are prepared to alter the way in which they practise the profession.</p> <ul style="list-style-type: none"> - timeframes for completion of the process would increase and would likely result in doubling the cost of the current health assessment process. - assessment of students will be an additional cost burden. <p>198 Action by National Board at end of proceeding</p> <p>199 Notice to be given to registered health practitioner or student and complainant</p>	<p>195 – need a specific timeframe eg 14 days “as soon as practicable” is too open-ended</p> <p>196(3) replace “must” with “may” . Add a provision enabling a submission to be made by a health practitioner or student regarding a health assessment report.</p> <p>198 - add words to indicate the National Board can take one or more of the actions referred to in the subsection</p> <p>198(1)(a)(i) this subclause does not relate to impairment and should be removed.</p> <p>199 – notice to entity making complaint should not include information the National Board has decided under s.272(1) not to include in the register.</p>
Subdivision 3 Health panels	<p>200 Establishment of health panel - 200(2)(c) -clarification is required as to what role such a person would have on a health panel and the value they would add to a health panel. The Board considers this would breach the privacy of an impaired health practitioner. Training of panel members regarding the intent of the legislation regarding rehabilitation of registrants is critical.</p> <p>203 Procedure of health panel – the health panel may consider that further assessments are required, however there is no provision for an external assessor to be appointed. This may be necessary, especially in circumstances where the health panel was appointed as a result of failure of the health practitioner or student to attend for a health assessment.</p> <ul style="list-style-type: none"> - there does not appear to be any power to compel a person to provide information to a health panel, nor indicate that it would be an offence to provide false or misleading information to the health panel. 	<p>200 – delete 200(2)(c)</p> <p>203 - add clauses to enable the health panel to:-</p> <ul style="list-style-type: none"> - require a health practitioner or student to undergo a health assessment to be conducted by an external assessor; - require a person to give stated information and that it is an offence to provide false or misleading information. <p>203(3) – add “(c) written or oral submissions received from the health practitioner or student”</p>

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Part 8	Complaints, performance, health and conduct	
Section	Issue	Proposed Alternative Solution
	<p>204 Legal representation – what is the purpose of this clause? While it may be appropriate for a health practitioner or student to be accompanied for support, representation is a different issue. If this is to remain, the health panel should also be able to have legal representation which will increase costs to the National Board. Legal representation also implies the process is of a punitive nature when its purpose is intended to be supportive to rehabilitate the health practitioner or student.</p> <p>209 Action by health panel at end of proceeding</p> <p>210 Notice to be given to registered health practitioner and complainant</p>	<p>204 -change the words “may be represented” to “may be accompanied, but not represented”</p> <p>209 - add words to indicate the health panel can take one or more of the actions referred to in the subsection 209(1)(a)(i) this subclause does not relate to impairment and should be removed. 209(1)(c)(ii) – the matter should be referred to the jurisdiction where the most serious behaviour and/or prevalent behaviour occurred. Using mailing address is not appropriate in any circumstance and the relevant jurisdiction at minimum should be where the majority of the registrant’s practice occurs.</p> <p>210– notice to entity making complaint should not include information the National Board has decided under s.272(1) not to include on the register.</p>
Division 9 Investigations		
Subdivision 1 Preliminary	<p>211 When investigation may be conducted – is it necessary for investigation to be a legislative process or could it be an administrative process?</p> <p>212 Registered health practitioner to be given notice of investigation – is it necessary for the requirement to give notice of progress each 3mths to be a legislative process rather than as part of a policy particularly as there is no consequence for failing to do so?</p>	<p>211</p> <p>212 delete subparagraph (3)</p>
Subdivision 2 Investigators	<p>214 Appointment of investigators – need to be able to appoint an external investigator, especially if there is any perceived conflict of interest with a staff member doing the investigation eg complaint against a National Board or committee member</p>	<p>214 – add provision to enable National Board to appoint external investigators.</p>
Subdivision 3 Power to obtain	<p>217 Powers of investigators – there needs to be an ability to obtain information for the purposes of monitoring compliance with the Law.</p>	<p>217 - amend to “For the purposes of conducting an investigation, or monitoring compliance with the Law ...” - change “documents” to “stated thing”</p>

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Part 8	Complaints, performance, health and conduct	
Section	Issue	Proposed Alternative Solution
information	219 Inspection of documents	219 – heading be amended to “Inspection of produced things” - replace the word “document” with “thing” - add “photograph” the thing 219(b) – change to “for a document – make a copy of, or take an extract from, it”
Subdivision 4 Power to enter places	220 Entering places 221 Application for warrant 222 Issue of warrant	220 – add a provision to enable an investigator to enter a place for the purpose of asking the occupier of a place for consent to enter (<i>s.82(2) of the HP(PS)A</i>) 221 – should this refer to a warrant “to enter” a place? 222 – after the words “about a matter being investigated” add “or monitoring compliance with the Law”
Subdivision 6 Procedure after investigation	241 Agreement with independent assessor about action to be taken	241(3)(c)- add a Note indicating “A failure by a registered health practitioner or student to comply with an agreement entered into does not constitute an offence but may constitute behaviour for which disciplinary action may be taken.”
Division 10 Review	245 Review of reviewable decision – clarification is required as to how (by whom) a review is conducted if the National Board made the decision rather than a delegate. - clarification is also required to confirm whether the review is merits based and therefore the review decision is not limited to the information before the original decision maker and new evidence/information can be received.	245
Division 11 Appeals	246 Appellable decisions 249 Decision	246 a provision be added requiring the registrant to exhaust review provisions before being able to lodge an appeal 249(2) add the word “panel” after “health”

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Part 9	Finance	
Section	Issue	Proposed Alternative Solution
Finance	256 Payments out of Agency Fund - 256(1)(b) needs clarification that the National Agency can not recommend payments from the fund of a National Board without approval	256

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Part 9	Finance	
Section	Issue	Proposed Alternative Solution
	<p>of that National Board. The intent of this subclause is not clear the way it is currently written and could be read to mean the National Agency, with approval from the Ministerial Council, could make a payment from a National Board fund for a purpose not approved by the National Board.</p> <p>256(2) – MBQ currently does not contribute toward the cost of the responsible tribunal, and therefore has cost implications.</p>	

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Part 10	Information and privacy	
Section	Issue	Proposed Alternative Solution
Division 2 Disclosure of information and confidentiality	266 National Board to publish certain decisions	266 – should be a provision requiring publication of Tribunal decisions 266(1)(c) – after the word “health” add “panel”
Division 3 Registers in relation to registered health practitioner	It would be preferable there be only 1 register. If there must be two, there needs to be a provision indicating that restrictions on one form of registration applies to the other. 269 National Registers 270 Specialists Registers 271 Information to be recorded in registers – will have high cost implications if data fields are required to be populated for current registrants as this data may not be in current systems. 272 Board may decide not to include certain information in register	269 after the words “cancelled” add “or suspended” 270 after the words “cancelled” add “or suspended” 271 272
Division 5 Records	276 Records to be kept by National Boards 276(g) – clarification is required as to whether details of the nature of information received in a criminal history check can be retained by the National Agency	276

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Part 11	Miscellaneous	
Section	Issue	Proposed Alternative Solution
Part 11	280 Protection from personal liability for persons exercising functions	280 add as protected persons specialist colleges, members of accreditation survey teams and supervisors of health practitioners that have a restriction on their registration requiring them to practice under supervision.
Division 2 Ministerial Council	290 Accreditation functions exercised by existing accreditation entities - clarification is sought as to whether this includes an entity which currently undertakes the accreditation of intern training programs	290

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Part 12	Transitional provisions	
Section	Issue	Proposed Alternative Solution
Division 11 Registration	310 Specialist registration 312 Limited registration	310(3) delete definition for corresponding purpose 312 – add a timeframe in which general or specialist registration must have been obtained.
Division 13 Complaints and disciplinary proceedings	327 Complaints being dealt with on participation day – given the number of complaints which the Board would have started looking into, but not completed prior to the participation day, it could be up to 3 years before such matters would be completed under the repealed Act. Closed matters should not be able to be re-opened under the new Law	327 – amend section to reflect that where a Board had “made a decision to take disciplinary action, but not completed dealing with the matter in relation to a complaint”, that the matter would continue to be dealt with under that Act had it not been repealed. Add a new clause indicating matters which had been closed under a prior Act can not be re-opened (? unless the previous Act provided for this to occur).
Division 14 Local registration authority	332 Records relating to registration and accreditation – fails to refer to health records of an individual	332 – add “(d) health records of individuals who are or were registered”
Division 15 Staged commencement for certain health professions	340 Qualifications for general registration in relevant profession – consider that reference to 2015 should be 2012	340
Division 16 Savings and transitional regulations	343 Savings and transitional regulations - consider that reference to 2015 should be 2012	343
Part 12 Other comments	Throughout the Bill, penalty amounts have been stated in respect to offences against the legislation – would it not be better for these amounts to be listed in a schedule as it would be easier to change the amounts if required.	

Exposure Draft to Bill B – Operational Forum 7 July 2009		
Schedule 3	Constitution and procedure of National Boards	
Section	Issue	Proposed Alternative Solution
Part 2 Constitution	6 Disclosure of conflict of interest – terminology in (2) appears archaic.	6(2) – remove the words “in a book kept for the purpose”

Exposure Draft to Bill B – Operational Forum 7 July 2009		
Schedule 4	Miscellaneous provisions relating to interpretation	
Section	Issue	Proposed Alternative Solution
Schedule 4 Other comments	Part 8 – Application to coastal sea – clarification is required as to whether this means a National Board has jurisdiction in respect to health practitioners working on cruise ships in Australian waters and such practitioners will be required to hold registration with the appropriate National Board.	