



Health Practitioner Regulation National Law

17 July 2009

Response from the Medical Practitioners Board of Victoria to the exposure draft released by the Australian Health Workforce Ministerial Council for public consultation on 12 June 2009

The Medical Practitioners Board of Victoria (MPBV) is a statutory authority established to protect the community and guide the medical profession.

The MPBV registers doctors, investigates complaints about doctors, monitors the health of doctors who are ill and may be unfit to practise medicine, and develops guidelines for the profession.

The Medical Practitioners Board of Victoria is pleased to be offered an invitation to provide comment on matters covered by the Australian Health Workforce Ministerial Council public consultation exposure draft of the *Health Practitioner Regulation National Law*.

The MPBV has chosen to respond in a two part submission. The first part outlines the MPBV's understanding of the purpose of the legislation and the interrelationship between the health, performance and conduct pathways. This is based on extensive experience in regulation of medical practitioners in Victoria under the *Health Professions Registration Act 2005 (Vic)* (HPRA) and before that the *Medical Practice Act 1994 (Vic)*. The second part responds with input and suggestions relating to specific clauses within the draft legislation.

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National registration – General comments on key aspects of the Exposure Draft

Language, tone and general underlying philosophy

The primary aim of the new legislation is to protect the public and this is appropriate. A secondary but important aim is to maintain and enhance professional standards, for the benefit of the community. Accountability to the community and the profession is crucial. The MPBV is concerned that the draft legislation as it currently exists could lead to a significant *reduction* in the effectiveness of the current regulatory system for doctors. It is possible that Bill B represents a step back to the reactive / punitive nature of a complaints-driven system where Boards did not make adverse findings unless a matter reached the level of misconduct. It does not offer an opportunity to deal with more minor breaches in conduct (which are neither wilful nor reckless) which, in many jurisdictions has the effect of a reduction in future recurrence. We are very aware that when this opportunity is available (as it is under the current HPRA), it has the effect of a reduction in future recurrence.

The MPBV has the largest and most extensive experience in the country in relation to the ‘end-to-end’ management and process of notifications regarding medical practitioners’ conduct, performance and health. Based on this experience, the MPBV knows that except for a very small proportion of complaints in which the practitioner is found to have engaged in serious unprofessional conduct, most notifications have the potential to be resolved in a constructive and mutually beneficial manner that enhances professional standards, while acknowledging and addressing the concerns of notifiers and protecting the community. This is borne out by the MPBV experience, in which 67% of notifications investigated over a recent 12 month period were determined to require no further action or no further investigation. Only 6% related to matters of serious misconduct.

One of the most resource intensive activities currently undertaken by Boards is the investigation of notifications and actions arising from the investigation. The consultation paper confirms that investigation by the Boards will continue to be the case. This is one of the main ways in which the Board protects the public. Through this national process, there is an opportunity to reinforce that health regulatory boards are protective jurisdictions. This is confirmed by accepted legal precedent (*refer Ziems v The Prothonotary of the Supreme Court of NSW (1957) 97 CLR 279*. In this case, the High Court dealt with the question of whether a man should remain registered as a lawyer. Dixon CJ noted “*The jurisdiction the court exercises has nothing to do with punishment. The purpose of the power to remove from the role of barristers is simply to maintain a proper standard.*”)

The principal role of health regulation boards is not to punish practitioners. When required, this is the role of the courts. While in serious cases, practitioners may feel that the Board’s actions are punitive, Boards should be clear that their actions are always aimed at protecting the public from the specific doctor and by way of example, giving a signal to the profession about what are acceptable – and unacceptable – professional standards.

The outcomes of all investigations should aim to protect the public. Except in the few serious cases in which a Board might put limits on or alter a practitioner’s registration, the public is better served by Boards focusing on outcomes that are constructive and aimed at enhancing the individual practitioner’s professional standards. This Board believes strongly that remediation, education and defined and relevant counselling are preferred outcomes to reprimands and cautions.

Except in serious cases of unprofessional conduct, Boards should aim to manage most matters referred to them in flexible and constructive ways, with a view to achieving improvements in behaviour or performance whilst ensuring the public is protected.

The language in the legislation will also influence notifier's expectations. Terms such as "enhancing professional standards through the management of notifications" rather than "disciplinary action" are helpful when explaining to notifiers the likely outcomes of a notification to the Board. It also explains the reasons for the Board's actions. It means that notifiers are more likely to have reasonable expectations of the investigation process and less inclined to expect deregistration or suspension for relatively minor issues. Similarly, the MPBV would support the use of the word "notification" instead of "complaint" where this would be appropriate.

The MPBV 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 some 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.

Management of notifications: the relationship between conduct, performance and health

Bill B appears to propose three separate pathways in dealing with notifications about practitioners:

1. Professional Conduct
2. Professional Performance
3. Health

This is quite similar to that under the *Medical Practice Act 1994 (Vic)* (MPA), the legislation under which the MPBV operated until 2007. The *Health Professions Registration Act 2005 (Vic)* (HPRA) under which the Victorian health regulation boards have been operating since 1 July 2007, has enabled more progressive and constructive approaches in the investigation and management of notifications. We believe that this has been to the benefit of both notifiers and practitioners, particularly given that the notifier has no direct role in any performance or health assessment of a medical practitioner and receives no feedback on the outcome of any such assessment. From the MPBV's experience, some of the issues that arose with three separate streams included:

- ***Many notifications received by the MPBV are about the standard of care provided by the practitioner.*** The MPBV's data suggests that some 60% of notifications fall into this category. These are best dealt with in a performance framework. After investigation, the overwhelming majority of these notifications lead to an outcome of "no further investigation".

Expressed in a slightly different way, most of the notifications received by the Board are not particularly serious in a regulatory sense, though we acknowledge the serious impact on the individual patient or notifier. The notifications involve concerns about the

performance of a practitioner, in a single instance. It would be inappropriate to propose that the only option available in such a case would be a performance assessment.

Therefore, it is recommended that if a decision is made to continue with separate streams, the performance stream should include the explicit ability to investigate the concerns, in the same way that “conduct” is investigated. This should include the appointment of an investigator.

As proposed, it is appropriate to have a range of determinations aimed at education, remediation and alteration of the scope of practice. We strongly caution against the development of strategies to deal with “low level complaints” that lie outside the legislation. This approach is not transparent and perpetuates the attitude of “doctors protecting doctors”.

- **Many notifications received by the MPBV do not fit cleanly into one category.** Some notifications are clearly defined. For example, allegations of sexual misconduct or serious breaches of legislation clearly relate to a doctor’s conduct. However, many notifications received by the MPBV do not fit neatly into one category. The boundaries between low level conduct and performance issues can be, and often are, blurred. This is acknowledged in the definition of unprofessional conduct including unsatisfactory professional performance.

By way of example, a notifier may be unhappy with the standard of care they received but may also allege that the doctor was rude. It is preferable to deal with the notification in its entirety rather than splitting it into two separate investigation streams with potentially two investigators – one working on the “conduct issue” and the other working on the “performance” issue. Clearly, a ‘split’ approach is not consistent with protecting the community, and would not meet the notifier’s expectations about resolution of the issues and would not help to raise professional standards.

It would be an even less constructive approach to deal with the “conduct issue” first and then refer the matter for management of the “performance issue” in a serial manner. This would prolong the investigation, increase the possibility of omissions in the investigation and would lead to the potential for multiple or inadequate determinations being made for a single incident.

- **The need for an integrated and holistic approach.** At the MPBV, we have on occasion received notifications in which a conduct investigation, a health assessment and performance assessment were all indicated. Under the HPRA, a single investigator investigates the notification and is assisted by other specialist staff who arrange and coordinate the health and performance assessments. The health and performance assessments inform the conduct component of the investigation, leading to a coordinated outcome that takes into consideration all elements of the notification. It also takes into account concerns about the doctor’s health and has a remedial focus if issues of performance are found. Overall, the public is better served because in addition to dealing with the specific concern, the practitioner’s performance has been managed and appropriate, constructive or supportive action can be taken. Under previous legislation, each of these would have occurred in isolation. We are concerned that the new legislation will not provide for the level of flexibility the public and profession enjoy under Victoria’s current legislation.
- **The need for outcomes in relation to the behaviours of the medical practitioner.** Under the MPA, a performance investigation examined the practitioner’s performance

but did not specifically examine and reach a conclusion about the notification that triggered the investigation. While this is consistent with the Board's primary aim of protecting the public, notifiers tended to feel that they had not been taken seriously and felt aggrieved that their specific issues were not considered important enough to investigate. This feedback was provided even when the notifiers were informed about the performance assessment and its outcome.

The process of consecutive, rather than concurrent investigations was bureaucratic, prolonged the investigation significantly and if there were issues of both conduct and performance, it was usual to abandon the conduct investigation without a finding. This was unsatisfactory for notifiers and practitioners and did not result in improved practice.

It is our belief, in consultation with the public, represented by the MPBV Community Consultative Committee, that a streamlined approach to investigations rather than a split approach minimises the stress and inconvenience experienced by the notifier and more effectively protects the community and we urge that this be considered in the drafting of Bill B.

Preferred alternative: a single (or more flexible) investigative pathway in which health and performance assessments are available tools to inform investigations.

The available outcomes available to a Board, tribunal or a panel should be identical, regardless of pathway.

The benefit of this alternative is that the investigation is dealt with in a more holistic and effective way. This approach particularly has the potential to develop a comprehensive and integrated response to the issues raised by a notification that transcends a narrow and artificial construct of separate pathways.

All relevant elements of a notification are addressed concurrently, giving rise to a more efficient and timely investigation. The notifier also receives feedback about the particular incident that they expressed raised and whether the Board found the practitioner's conduct or performance to be deficient. Rather than "trawling" for material to inform a potential hearing, it should be explicit that the purpose of performance and health assessment during the investigation of a notification is to inform the Board and to assist in the resolution of the issues in a constructive way. Even when an incident might give rise to a hearing, the information obtained during a performance or health assessment can inform the determination, rather than the findings. For example, a catastrophic but isolated lapse in performance might have occurred. If a performance assessment confirms that the practitioner's performance is generally satisfactory, or if remedial action was taken after the performance assessment, a tribunal hearing would reasonably conclude that further education was unnecessary. Therefore, assessments are used in a way that is consistent with the protective jurisdiction of health regulation boards, while also raising professional standards.

To ensure that the processes are not abused, the decision to proceed to an assessment could be made by the relevant statutory committee.

Panels should also be able to request that a practitioner undergoes a health or performance assessment as a part of the proceedings, rather than as an outcome of proceedings. This can inform the determination of the panel, aimed at constructive outcomes. For example, if a panel is hearing that a practitioner has treated a patient in a way that is not evidence based and the doctor admits that this is his usual practice, it is reasonable to request that a performance assessment be undertaken to determine whether there are other aspects of his practice that are

not evidence based. A determination can therefore be made about alteration of practice and education so that the public is protected from any unsafe practice.

The Public Interest Assessor

The proposal in the Bill to introduce a Public Interest Assessor (PIA) to act as an independent voice in the handling of complaints or notifications raises significant questions and concerns for the MPBV. From the outset, it should be clear that the MPBV is fully supportive of the need to ensure transparency, openness and accountability for the actions of regulatory agencies. It has been consistently acknowledged by the MPBV that the need to address community / consumer concerns as to a transparent and unbiased approach to complaints management is paramount.

This notwithstanding, the MPBV feels that this circumstance is entirely achievable without the creation of a PIA role, by using the currently proposed framework of community Board (and Committee / State "Board") members in combination with the ongoing and enhanced interaction with current health complaints bodies in each State and Territory.

There are currently three community members on each State / Territory Board and it is understood that this will also occur with the Medical Board of Australia (and is likely at State level). With such a balance of membership it is possible for there to be a directive that all notifications / complaints assessment committees (as delegated from the Medical Board of Australia) have an equal number of community members as there are medical members to assess notifications. In addition to this, enhanced communication with the health complaints bodies, particularly as to matters which may fall to either jurisdiction, can be formally set up (if they are not already).

The cost of setting up a national PIA is unknown but assumed to be extensive given the requirement for all complaints to be considered by this person or body (clause 165) and an "Office of the PIA" seems part of the likely solution. Alternatively, the cost of implementing standardised, independent, jurisdictional assessors (to fill the role of PIA) is unknown but likely to be extensive given the need for all complaints to be considered twice and the need for an understanding of what constitutes unprofessional conduct. Of note is that the Bill is silent on the skill set required to fulfil the PIA role.

To establish a model where a single office holder could over-rule a decision of a Board of nine experienced authorities selected and appointed by Ministerial Council through a publically advertised process - that includes three people specifically appointed to represent the public interest - is fundamentally flawed. This would appear to be contrary to standard administrative law / review structures where a board, tribunal or court consisting of multiple members would normally have greater powers than a single decision maker. It is also concerning that a scheme could be established a role where one person appears to have absolutely no accountability to anyone, not even a requirement for an annual report (clause 37).

The MPBV would urge the Ministerial Council to delete from Bill B the requirement for the PIA.

In the event that removal of the need for a PIA from the draft Bill does not occur, it is vital that the operation of the PIA does not delay matters, particularly when a notification raises the possibility that the health and safety of the public may be at imminent risk.

The MPBV is of the view that a PIA or any other similar arrangement must:

- not impact negatively on investigation timeframes. This is not in the best interest of either the practitioner or the notifier, and has the capacity to compromise the health and safety of the public;

- be founded on processes and systems that ensure time efficiency;
- have regulatory experience;
- have true independence in that they do not fulfil any other role within the national framework;
- be implemented in a consistent manner across each jurisdiction;
- have moderate financial impact on the public purse, and not be a cost to the practitioners - who are already funding the internal notifications management and investigation process.

It is noted that the Bill as drafted makes no provision for review of decisions of Boards at the conclusion of either the preliminary assessment or the investigation, and the MPBV would suggest that this might be a more appropriate role for the PIA, and somewhat similar to the function undertaken by the Investigation Review Panels provided for in the *Health Professions Registration Act 2005*.

Lastly, a proposal to use the existing health complaints bodies as a jurisdictional PIA raises the possibility of a serious conflict of interest. These bodies are generally independent (of the health professional and the public) and proceed to investigate complaints with a view to conciliation. The Boards are of a prosecutorial nature in respect of disciplinary matters. One body being involved in both roles would be untenable.

Specific Comments on the Exposure Draft

PART1: PRELIMINARY

6. Definitions

MPBV Response

The definitions, especially “unprofessional conduct”, are too descriptive, and therefore possibly too restrictive.

Comments on other definitions are:

- “reportable conduct”: definition should be amended to read “.....means there exists a reasonable belief the health practitioner has:”
- “reportable conduct”: part (d) of the definition should be amended to read “....has practised the profession in a way that constitutes a substantial departure from accepted professional standards”
- “professional misconduct”: the MPBV has a concern over the inclusion of multiple matters and / or findings (where past resolved unprofessional conduct matters are allowed to be revisited) and the interface with the Victorian Charter of Human Rights (refer also to MPBV comments under clause 142 below)
- the use of the term “suitable person” in the definition of “professional misconduct” should be a reference to “fit and proper”.
- “unsatisfactory professional performance” should take into account the *context* in which a practitioner is working or their usual scope of practice.

PART 4: AUSTRALIAN HEALTH PRACTITIONER REGULATION AGENCY

35. Public Interest Assessor

MPBV Response

See comments on pages 5 and 6 of this submission.

PART 6: ACCREDITATION

MPBV Response

The MPBV is generally supportive of the provisions in this part of the Bill, but would note that more information on the governance arrangements between the Boards and the accrediting agencies would be desirable.

PART 7: REGISTRATION OF HEALTH PRACTITIONERS

90. Period of time of limited registration

91. Limited registration not to be renewed or restored

MPBV Response

The period of limited registration should be extended to at least four years, reviewed annually.

97. Power to enquire about qualifications, registration status and practice in health profession

MPBV Response

Clause 97 focuses on eligibility for registration, but does not address questions of suitability (e.g. previous conduct/performance matters). If clause 98(1)(a), which gives a Board power to “investigate the applicant”, is not sufficient to address these concerns, the MPBV would advocate that applicants be required to disclose such details with their application for registration and that there be suitable penalties for the provision of false or misleading information.

105. National Board may ask education provider for list of persons undertaking approved program of study

MPBV Response

Clause 105 implies a very distant relationship between students and the profession, mediated by the education provider, and offering no opportunity for interaction or guidance. The MPBV supports the fostering of a closer professional relationship through, for example, the inclusion of student registrants on distribution lists for quarterly Bulletins or other guidance publications.

133. Restriction on use of specialist titles

MPBV Response

This does not contemplate or make provision for Area of Need specialists.

142. Information about offences, clinical privileges and billing privileges

MPBV Response

The MPBV has serious concerns over the perceived incompatibility of both clause 142(3)(a) and the definition of “criminal history” (especially (c)) with the Victorian Charter of Human Rights.

PART 8: COMPLAINTS, PERFORMANCE, HEALTH AND CONDUCT

MPBV Response

The MPBV is strongly believes that the provisions of Part 8 are regressive and represent a serious backward step from the approach adopted under the *Health Professions Registration Act 2005*, and international best practice, with the apparent reinstatement of the silo approach to managing professional performance. There is also an apparent focus on “disciplining” the practitioner rather than remediation and/or protecting the public.

As outlined in the first section of this submission, the MPBV supports increased flexibility between the conduct/health/performance pathways, improved management of professional standards and an increased focus on remediation rather than discipline.

163. National Board may require further information

MPBV Response

A provision giving Boards the ability to seek information from persons not covered by 163(a), (b) or (c) should be included.

167. Rejection of complaint

MPBV Response

The MPBV strongly advocates for the inclusion of “*notification does not warrant investigation*” as a ground for rejecting a complaint (refer section 45(1)(c) of the *Health Professions Registration Act 2005*).

Additionally, the passage of time alone might not constitute a reasonable ground for rejection of a complaint (clause 167(b)).

168. Immediate suspension or imposition of condition

MPBV Response

Immediate suspension or imposition of a condition might be also be necessary because the practitioner has a health impairment which is impacting upon his or her ability to practise safely. Clause 168(1)(a) should be expanded to include this as a legitimate ground for action on the part of the Board.

With specific reference to clause 168(6), the MPBV is of the view that provision needs to be made to allow Boards to review the suspension after a defined period, and extend that suspension if circumstances so warrant. The period for which the suspension has effect should also be extended from 3 to 6 months, as matters in other jurisdictions (e.g. criminal proceedings) often take longer to finalise.

172. Decision

MPBV Response

Another possible decision needs to be included in this clause – “has a health impairment which is contributing to unsatisfactory professional conduct or performance”.

174. Requirement for performance assessment

MPBV Response

There are some impractical aspects to the proposed notice requirements. These are:

- date/time/place often takes time to arrange;
- ‘place’ implies remoteness from the practitioner’s practice, but performance assessment is best undertaken in a practice/clinical setting;
- more than one assessor is essential;
- clause 174(4) provides for a practitioner to be referred to a Professional Standards Panel if they fail to undergo a performance assessment, but under the proposed arrangements the Panel cannot compel the practitioner to comply. Not only does this defeat the purpose of the referral, it is strongly suggestive of a disciplinary rather than a protective approach.

178. National Board’s decision

MPBV Response

The focus on “behaviour” in the wording of this clause again implies a punitive rather than a protective jurisdiction or philosophy. This is regressive.

Professional performance is not just low-level professional (mis)conduct. Performance assessments have a legitimate role in the investigative process and flexibility of movement

between the conduct, health and performance pathways is often necessary to ensure the protection of the public and achieve the best outcomes for both practitioner and notifier.

179. Action that may be taken by National Board at end of proceeding

MPBV Response

Section 59 of the *Health Professions Registration Act 2005* provides a well-structured and comprehensive set of possible outcomes, related to the information obtained during the investigation process (which may have included a performance assessment).

The MPBV would advocate the inclusion of some of these provisions in the new legislation, and especially the capacity to arrange to have the matter settled by agreement, either between the Board and the practitioner or between the Board, the practitioner and the notifier.

193. Requirement for health assessment

MPBV Response

These are more coercive powers than those made available under the *Health Professions Registration Act 2005*, where a practitioner is requested to undergo a health assessment. The MPBV advocates the retention of this cooperative approach.

Further, there is a need to ensure that all “impairments” dealt with under this clause are impairments which are directly relevant to fitness to practise.

199. Notice to be given to registered health practitioner or student and complainant

MPBV Response

There may be privacy concerns associated with providing health-related information to third parties, including complainants. There is a need to ensure that relevant Privacy legislation is being observed.

210. Notice to be given to registered health practitioner and complainant

MPBV Response

Refer to the comment in relation to clause 199 above.