NEW SOUTH WALES MEDICAL BOARD

Submission on Bill B

17 July 2009

INTRODUCTION

The New South Wales Medical Board (NSWMB) has supported the introduction of a system of National Registration of medical practitioners and has actively contributed to the debate.

The NSWMB considers that Bill B as it currently stands has touched on most of the major elements required of a system of professional regulation, but it has significant shortcomings in some areas, and without major amendment it will be inadequate for the purposes for which it is intended, and possibly unworkable. The Bill is overly prescriptive in some areas, while others where a degree of detail is necessary are very short on detail.

The Bill is particularly unsatisfactory in its approach to the critical matters of Conduct, Performance and Health, apparently misunderstanding the relationship between these major aspects of a NSWMB's work, and proposing a system that is at the same time both cumbersome and inadequate.

The NSWMB notes that the NSW Government has indicated that it is likely to opt out of the Complaints provisions, and to the extent that this occurs, the NSWMB's concerns regarding these provisions may not be relevant. However the NSWMB believes that insofar as it is possible, the legislation should represent best practice, and if it is amended to reflect this, there is a greater chance of NSW reversing the decision to opt out. Also, with movement of practitioners, the NSWMB will have to deal with the consequences of poor decisions made under inadequate provisions if Bill B is not rectified.

The NSWMB has made its views clear at the various forums at which an opportunity has been given to comment on Bill B, and it also notes in this regard that its concerns regarding the complaints handling system have been echoed by all other Medical Boards and apparently by a substantial number of other professional Boards as well.

Finally, the NSWMB is pleased to note that its concerns about Bill B have been listened to carefully by the NRAIP staff responsible for developing the next version, and it is hopeful that many of the issues raised by it and other bodies during the consultation process will be understood and taken into account in the next version.

NRAIP has indicated that there will be no further public consultation when the next draft of the legislation is developed. The NSWMB believes that in a matter as critical as this where legislation is being developed that will set the course for the regulation of health professions in Australia into the future, it is vital that more time is taken to

get it right, rather than adhering to deadlines set several years ago which are becoming increasingly unrealistic. Serious consideration must be given to allowing a further round of consultation so that the new system gets off to a sound start, with the commitment of those who will be participating in it strengthened by the knowledge that it is a good system, rather than one that has been finalised in haste to meet artificially imposed deadlines.

This submission consists of:

- general comments extracted from the Joint Medical Boards Advisory Committee Submission on Bill B concerning issues arising from the complaints/ performance/health provisions of Bill B (in italics below), which the NSWMB supports, and

- specific points regarding details of the Bill.

EXTRACTS FROM JMBAC SUBMISSION

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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.

SPECIFIC COMMENTS REGARDING BILL B

Definitions

Criminal History - Does this mean including charges that are dismissed or not proceeded with?

Disciplinary body includes a Professional Standards Panel, and a Health Panel. As argued elsewhere, performance and health matters should not be included in the 'disciplinary' construct. A more appropriate term may be *'Regulatory body'*

Impairment – this should not be defined so as to exclude unregistered persons, eg applicants, suspended or deregistered practitioners, as the Board may need to have an applicant for registration examined for possible impairment, or a suspended practitioner may need to be examined with a view to lifting of suspension.

Registration status - does the inclusion of undertakings, conditions, findings, etc, include those which have expired?
Why is registration status limited to applicants – it is a term in common usage for registrants, and should remain so.

Reportable conduct – para (d) should be amended to refer to at a minimum, a '**significant** departure from accepted professional standards'. The NSW legislation sets the bar at a 'flagrant' departure, in order to pre-empt unnecessary reporting of minor matters. As Bill B stands, it could encompass many situations where a doctor is undertaking an inherently risky procedure, and is required to do something that may not be in precise conformity with usual standards, but quite reasonable in the circumstances.

Unprofessional conduct - The concept of unprofessional conduct being judged by a standard expected 'by the public' is very problematic. While the notion of non medical input into decision making has been embraced in medical regulation for many years, and it has an important role to play in the development and application of appropriate standards, professional conduct must ultimately be judged by professional peers, with appropriate public input.

While the definition is stated to 'include' the listed range of forms of conduct, it is submitted that a general expression such as 'and any other improper or unethical conduct' should be added to ensure that its scope is not limited.

S.10 – Ministerial Council may give directions to the National Agency or National Board about policies, including a direction relating to an accreditation standard if it has a substantive and negative impact on recruitment or supply of health practitioners. The NSWMB is of the strong view that the accreditation process must be independent of political interference, and is aware that the AMC has addressed this question in its submission. The NSWMB understands that the powers of the Ministerial Council to give directions would not apply to individual accreditation decisions.

S.13 – MC may approve "areas of practice" for endorsement. The concept of 'areas of practice' is problematic, in that it may be seen as creating a form of second class specialist, and the distinction between endorsed practitioners and specialists is not likely to be clearly understood by the public, especially as it can be anticipated that endorsed practitioners may seek to exploit this confusion.

S.35 – Public Interest Assessor – the NSWMB notes that the PIA concept has generated much disquiet in jurisdictions unfamiliar with the NSW HCCC model. While the NSWMB does not consider that the PIA would add a major additional burden to the complaints process, it does note the concern that if the PIA is not responsible for investigation of complaints as in the NSW model, it could lead to unrealistic assessments, requiring significant resources to deal with relatively minor matters.

S.44 –the National Board - the NSWMB notes concern amongst smaller jurisdictions at lack of representation on the MBA

S.66 – Programs of study may be accredited. The accreditation system appears to encompass accreditation of educational bodies, ie medical schools, but it does not seem to include accreditation of intern training, and intern training positions as is currently undertaken by Postgraduate Medical Councils or similar, or accreditation of specialist colleges as undertaken by the AMC.

S.69 –it is unclear how s69(2) interacts with s101 which seems to say that all registrants are subject to conditions that they must do CPD and hold PII.

S.73 – PII insurance must cover the whole period of registration and be of a type and level considered sufficient by the MBA. The interaction between periods of registration and PII coverage is not clear, as the Bill seems to suggest that they must coincide, which may require major change to current practices of medical defence organisations providing PII.
The MBA should have authority to obtain information directly from PII providers if necessary to verify declarations.

S.74 – the period of general registration is 12 months and the Bill seems to say that if someone is registered during the registration period, registration only lasts until the end, ie. there will be a fixed registration year. The NSWMB has commented

elsewhere on its concerns about having all registrations falling due on a single day from a risk management and business process perspective. While this may work if registration is a simple on-line process, experience has shown that demands for accountability have led in NSW to the need for complex annual returns, many of which require individual consideration.
Is pro-rata payment envisaged for registration periods of less than one year?

S.75 – the Bill does not indicate how the process of recognition of specialties will occur, presumably leaving it open to the MBA to develop its own processes, or rely on existing processes such as the existing AMC specialist recognition system.

S.77 – examination for specialist registration must be conducted by an accreditation authority unless Board decides otherwise – does this mean the Colleges will have to be declared as accreditation authorities?

S.80 – Provisional registration to complete a period of supervised practice. There is no clear mechanism for accreditation of the required period of supervised practice, and assessment of the provisional registrants to ensure that they have satisfactorily completed the period.

S.90 – Limited registration may not be for more than two years and may not be renewed or restored. It is understood that this will be clarified to ensure that limited registration may be renewed annually for more than two years.

S.94 - There should be an explicit power to require personal attendance to verify identity.

S.97(1)(b) – this should not rely upon the applicant's declaration but should be open to the Board if it 'becomes aware'

S.98 – before deciding an application, the Board may investigate, require further information, require to undergo an examination or assessment, or health assessment into physical, mental or psychological capacity. Here, as elsewhere, it should be clear who is responsible for the cost of any such assessment.

S.101 – Registration is subject to conditions that the practitioner must complete CPD and must not practise without PII and if Non-practising, must not practise the health profession – this would seem to suggest that all practitioners will be classified as conditional, which would seem nonsensical. These requirements should be prerequisites for ongoing registration, in the same way that continued competence is.

S.104 – Student registration – the NSWMB considers that there is a case for mandatory reporting of students by their educational and training institutions, or as an alternative, clearly expressed and comprehensive protections for notifications made in good faith.

Division 8 Endorsement

S. 110 – Endorsement for scheduled medicines – MBA may endorse a practitioner who is qualified to administer, obtain, possess, prescribe, etc, scheduled medicines

– this suggests that every medical practitioner will require endorsement , which is unnecessary and would be a very heavy administrative burden, both because of the numbers involved and also because the Bill seems to indicate that endorsement and renewal of registration are separate processes.

S.113 – Endorsement for approved areas of practice – under s.13, MC may on recommendation of MBA approve areas of practice for endorsement, and under s.113, may endorse registration – as stated previously, the NSWMB is concerned at the public confusion that may arise from having two levels of 'specialisation'.

Division 9 – Renewal of registration or endorsement

These provisions seem to envisage that renewal of registration and endorsement are separate processes, and depending on how endorsement is interpreted, this could be an additional administrative burden.

S.123 – If a practitioner does not apply to renew registration or endorsement before end of period, it remains in place for three months. The three month period of grace that applies in NSW is designed to prevent patients being out of pocket because Medicare benefits are not payable for services rendered by an unregistered doctor. The three month period is a period during which their name can be returned to the register as at the day it was removed, to avoid this patient disadvantage. Their name is actually removed from the Register and Medicare advised within 2 weeks of the due date, which provides a strong incentive to get back on quickly.

Division 10 – **Restoration of General or Specialist Registration**

These provisions appear to relate to practitioners whose registration has lapsed eg through non payment of registration fees. It is not clear whether they are intended to apply to applications for restoration following removal from the Register for disciplinary or other reasons. If so, there need to be provisions governing how and to whom such an application is made. In NSW, unless ordered otherwise, the de-registered doctor seeking restoration must apply to the Medical Tribunal.

Division 11 – Title and Practice protections

S.128 - Unregistered persons must not intentionally or recklessly use titles, etc, suggesting they are registered. NSW includes the sanction of imprisonment, which has been ordered for repeat offenders.

S.139 – Practitioner or student may apply to MBA to change or remove conditions or undertakings unless during a specified review period. Does this indicate that the MBA is the default reviewer of conditions, even if they were imposed by the Tribunal?.
This also touches on the nature of undertakings, suggesting that once given, they cannot be unilaterally revoked by the practitioner. While perhaps being an unusual use of the term, the NSWMB believes that this interpretation, combined with the fact that undertakings are to be shown on the register would go some way to allay its reservations about undertakings. They must be transparent, and binding to have any real benefit

S.140 – The MBA may after giving notice, etc, change conditions or undertakings – does this suggest they can be changed to make them more onerous?

S.142 – Practitioner or student must notify within 30 days of charge or conviction or finding of guilt for offence punishable by 12 months imprisonment, withdrawal or restriction of clinical privileges because of conduct, performance or health, or withdrawal or restriction of billing privileges by Commonwealth or private health insurer because of conduct, performance or health.
The thirty day period may be too long in serious cases where urgent action under s168 may be required. A seven day period is not unreasonable.

S.144 – the MBA should have a general power to obtain information from practitioners, subject to meaningful sanctions for non cooperation, and to a reasonableness requirement. See s127C of the NSW Medical Practice Act.

Part 8 – Complaints, Performance, Health and Conduct

As per the NSWMB's introductory remarks, it sees these provisions as fundamentally flawed, and in making some specific comments, it is not suggesting that they can be fixed by dealing with these comments in isolation. Rather, the comments below represent some particular issues which need to be addressed within the much more fundamental changes outlined in the introduction

S.151 – see earlier comments regarding the independent assessor

Division 2 – **Making a Complaint**

Any entity (includes person) may make a complaint verbally, in writing, etc, including particulars. NA must assist if required. Complaints have to be reduced to writing at some point, and this should be early in the process, to minimise time spent on matters that end up being abandoned.

S.155 – While complaints can and will be made in relation to all the categories listed in this section, the inclusion of health and performance matters as grounds for complaint highlights the problem of treating the three pathways as complaints. Many health and performance matters come to the NSWMB as notifications from concerned colleagues as well as self-notifications. To characterise these as complaints goes against developments in regulatory best practice going back twenty years.
It is suggested that the term 'notification' be resurrected, and that it should include complaints as a subset.

S.156 – Mandatory reporting – amendments to the definition of *reportable conduct* have been suggested elsewhere.

S.158 – MBA may make complaint on own initiative. This should be broadened to encompass 'taking action in relation to a registrant', so as not to limit its options.

S.163 – this should be covered with the general provisions for requiring practitioners to provide information, including sanctions for non-cooperation

S.164 – Preliminary assessment within 60 days to decide whether it relates to a health practitioner, whether it fits within ground of complaint and whether it could also be made to a health complaints entity, and envisages several complaints constituting a pattern of conduct – the criteria for passing a matter on to the health complaints entity are not stated, though 166 suggests that this is based on the local powers of the HCE, leading to inconsistent handling of matters in different states.

S.165 – MBA must notify independent assessor of complaint and consult as to whether to reject the complaint or to handle under Division 5 - urgent action.
The NSWMB supports the idea of joint preliminary assessment. It is not clear how a decision could be made at this stage (ie prior to any significant investigation) to refer a matter to the relevant Tribunal, and nor are there any criteria indicating which matters could be dealt with in this way. A serious matter may well warrant action under s168, as a form of injunctive relief pending rapid investigation and a full hearing before the Tribunal in due course.

S.166 – MBA and HCE must notify each other of relevant complaints – it is not clear what the criteria for referral to the HCE are, or what happens after this – does this mean somebody could be investigated by both bodies at the same time?

S.168 – the power to suspend or impose conditions in an emergency can not be exercised if the practitioner is impaired. This is a common basis for exercising this power, and must be included.
It seems that suspension is limited to three months – there must be a roll-over power, as well as a power for the MBA to modify conditions as appropriate.

Recent amendments in NSW have added the concept of taking urgent action under similar provisions “in the public interest”.

S.170 – MBA must refer a complaint to a Tribunal if it reasonably believes, based on preliminary assessment or investigation, that there is professional misconduct, registration has been improperly obtained, or a Professional Standards Panel or Health Panel requires it to refer to the Tribunal.
The NSWMB considers that it is premature to refer a matter to the Tribunal until such time that there is a well founded view based on evidence obtained in investigation or other proceedings that such a referral is warranted. There is rarely evidence of sufficient persuasive value at the time of preliminary assessment to make this judgement, and the Tribunal should not be burdened with matters that on closer examination are not going to proceed in that forum

Regardless of when the referral occurs, there do not appear to be any criteria upon which a decision can be made as to whether a matter is to be referred to a tribunal or elsewhere.

Division 7, **Professional Standards matters**

Subdivision 1 **– Performance Assessment**

This division seems to envisage that lower level conduct matters and performance matters will be handled by the same body. While this is technically possible, and there may be arguments based on administrative simplicity supporting it, these two streams should be emphatically separated. Unsatisfactory performance is not a lesser form of unsatisfactory conduct, and the Bill should not make it appear so. The body which has the power to impose conditions on a poorly performing doctor may function in essentially the same way as a body dealing with misconduct, but the two should be, and should be seen to be quite distinct.

To function effectively a performance assessment system must have detailed provisions explicitly stating the powers of assessors to carry out the assessment in the doctor's workplace, ask questions, review records etc.

All adjudicatory bodies need appropriate powers to summons witnesses, manage proceedings etc.

NSWMB would welcome the opportunity to discuss the details of the required provisions, and assist in ensuring that the legislation is adequate.

The following comments on specific provisions should not be taken as indicating that the problems with the legislation can be remedied by addressing these particular points, without major overall revision

S.175 – MBA appoints an assessor who must be a member of the relevant profession and is paid by the MBA.
To avoid uncertainty, there should be a reference to one or more assessors with powers to carry out the assessment in the practitioner's workplace. Clear procedures and powers regarding the assessors and the assessment need to be specified. Performance assessment is a powerful and effective tool for establishing deficiencies in practice, and as a consequence, there can be a strong incentive for a practitioner to seek to avoid it. The NSWMB experience is that lack of explicit powers provides an opportunity for these practitioners to seek to avoid the scrutiny which the public interest requires.

S.177 – Report given within 14 days to practitioner and a person nominated by the MBA must discuss the report with the practitioner and if adverse, ways of dealing with the finding, including whether the practitioner is prepared to alter the way in which he/she practises.
While this kind of informal process may be effective in some cases, it must be backed up by non-optional provisions. This step in the process could be satisfied by more general provisions regarding agreement to have conditions placed on registration, rather than adding another step at this point which may only be of occasional value.

S.178 – MBA, after considering report and discussions, may decide practitioner has "behaved" in a way that constitutes unsatisfactory professional performance, unprofessional conduct or professional misconduct, that their registration was improperly obtained or that the complaint is to be dismissed – this provision seems to be taken straight from the general disciplinary provisions and is quite misplaced. It suggests some kind of adjudicatory process, whereas what it should be doing is deciding how to take the matter further in the light of the assessors' report, and the practitioner's response to it.

S.179 – Provides powers including requiring education or supervision, counselling, accepting undertakings, imposing conditions or referring for health, referring to a PSP, investigation or referral to the Health Complaints entity. If professional misconduct, must be referred to the Tribunal.
This reinforces the previous comments. If the Report suggests performance issues, then the matter should be referred to the body with the power to impose conditions etc in a formal manner after a proper hearing, unless agreement can be reached as per comments re s 177.

***Subdivision D* – Professional Standards Panels**

PSPs seem to be intended to cover both performance and less serious conduct matters. For the reasons outlined above, there should be clearly distinct bodies for the different types of matters

S.186 – The complainant may make a written submission with the leave of the PSP. Particularly in performance matters, the role of the complainant/notifier will be limited to providing the trigger for taking action. In a conduct matter, the complainant will often be a witness

S.188 – PSP must require MBA to refer complaint to Tribunal if the practitioner asks for this, or it believes there is professional misconduct.
It is most unlikely that with proper processes preceding the PSP, a matter of 'misconduct' is going to emerge at this stage, unless misconduct is defined to include significantly substandard performance, which for reasons already outlined, it should not. There must be a pathway to enable suspension or deregistration of a practitioner whose performance is so substandard (or whose impairment is so severe) as to be dangerous and beyond redemption, but this should not be by way of calling it 'misconduct' and referring it into the conduct stream. The body forming this conclusion should have the power to refer its decision and a recommendation to the Tribunal, for rapid action, with the normal appeal rights.

S.189,**S.190 –** A standard list of decisions and actions that can be taken has been developed which is applied regardless of the nature of the matter before the body. For example, each of these provisions includes a finding that registration was improperly obtained and then consequences of what must occur, ie. referring to the MBA for investigation, referring to the Tribunal, etc, although it is hard to imagine why a PSP would be looking at a fraudulent application. False applications should be handled quickly and simply in the registration provisions by a power to withdraw registration, with a right of appeal.

Division 8 – Health Matters

A number of the general comments made in relation to the performance provisions apply here too. Health proceedings will usually be triggered by a notification rather than a complaint. There should be a general power to enter into agreed conditions, regardless of whether there has been self referral, and the requirement for the practitioner to discuss the health assessor's report with a nominated person would be an unnecessary step in most cases. The MBA seems to undertake some sort of adjudication but then refers the matter on to a Health Panel (or elsewhere) for further adjudication. The outcomes of a Health Panel are inappropriately generic.

The Bill does not quarantine 'protected reports' which are an important feature in encouraging frank and open reporting of impairment, secure in the knowledge that the reports can not be used for other purposes

One very important difference from the PSP provisions is that the practitioner before a Panel may be represented by a legal practitioner or other person. While impaired practitioners should always be encouraged to bring a support person, an explicit right to legal representation at this level could undermine the effectiveness of Health Panels, which could become adversarial and legalistic, rather than collegial and supportive. Lack of insight often underlies impairment matters, and this provision would make these already difficult cases more so. It is vital that a Panel is able to hear directly from the practitioner so as to assist in the assessment of the level of impairment of insight.

It is difficult to see the logic of a complainant/notifier having a right to make submissions. Impairment is an objective medical issue, and while there may be some merit in having this person attend to assist the Panel in some circumstances, a right to make a submission seems misconceived.

S.266 provides for publication of Panel decisions, while s.272 indicates that information regarding impairment need not be recorded in the Register. This inconsistency should be resolved by removing the requirement to publish decisions (other than to the parties affected)

Division 9 – Investigations

As the NSWMB does not have experience of conducting investigations, it will not comment on these provisions, other than in general terms.

While recognising the importance of keeping complainants informed of progress, the three monthly reporting requirements may be onerous, particularly in complex matters.

Division 11 – Appeals

Appeals lie to the Tribunal against various decisions. The Bill does not specify whether these will be heard *de novo* or otherwise.

There are no provisions for appeal from the Tribunal – are these to be covered by local law?

Division 12 - Miscellaneous

S.266 – MBA must publish decisions of PSP and Health Panels - see comments elsewhere regarding publication of health related material

S.268 – Protected information may be disclosed to a registration authority. Presumably this relates to overseas authorities – it may be argued that this provision is limited by the requirement that disclosure is 'necessary for the authority to exercise its functions'. The NB should have the fullest power to release all regulatory information to other regulatory bodies, so that they can effectively carry out their functions, as per the JMBAC comments regarding the international context.

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