

Victorian Doctors Health Program

Submission re mandatory reporting of possibly impaired doctors

Scope of this submission

This submission focuses narrowly on Sections 155 and 156 of the exposure draft legislation and on the associated definition of 'reportable conduct'. We recognise that there are other issues around mandatory reporting provisions of alleged unprofessional conduct and alleged sexual misconduct, but these are not canvassed here. We recognise that the draft legislation covers most health professionals but this submission focuses solely on doctors and medical students.

About the VDHP

VDHP was established jointly by the Medical Practitioners Board of Victoria (MPBV) and AMA Victoria (AMAV) in 2000 in response primarily to the observations of MPBV that doctors coming to the attention of the MPBV with health problems including drug or alcohol dependence were often referred late in the evolution of those problems and that MPBV had no means of ensuring that these doctors accessed the best available care, rehabilitation, and support to re-enter the workforce. Changes brought about by the new Victorian Medical Practice Act in 1994, intended to make it less threatening for possibly impaired doctors to approach the MPBV, had not improved this situation.

The constitution of VDHP lays down five objectives directed towards the wellbeing of medical practitioners and students. They are to (a) encourage the development of, and facilitate access to, optimal services for education and prevention, early intervention, treatment and rehabilitation, (b) encourage and support research into the prevention and management of illness, (c) facilitate early identification and intervention for those who are ill and at risk of becoming impaired, (d) act as a referral and co-ordination service to enable access to appropriate support for participants and their families and (e) ensure access to high quality rehabilitation and encourage re-training and re-entry to the workforce. The model chosen for VDHP was partly based on similar organisations already established in most US states and Canadian provinces. Although still unique in Australia, services similar to VDHP have long been established in those two countries.

There is in place a memorandum of understanding (MoU) between MPBV and VDHP which details the obligations of VDHP to MPBV. The MoU specifically addresses the obligations of treating doctors to comply with Section 36 of the *Health Professions Registration Act (Vic) 2005*; ie the reporting to MPBV of any doctor whose illness has seriously impaired the doctor's capacity to practise and is putting the public at risk. The VDHP Board supports and monitors the work of its clinical staff via two Board subcommittees, one for financial matters and the other for clinical audit. Board members have no access to the clinical records or identifying information of any participants in the Program but problematic cases are discussed anonymously at meetings of the clinical audit subcommittee.

The program is staffed by two part time senior clinicians (one a psychiatrist, who is also the Director of the Program, and the other an addiction medicine specialist), a psychologist and a full time office manager. The work of the clinical staff includes the assessment of new participants and referral to appropriate care, monitoring the progress of those who enter into voluntary agreements, education of medical students and doctors, and research. The work also includes giving advice and/or

preliminary counselling by telephone. Some contacts result in the caller being able to access appropriate assistance directly without the potential participant attending VDHP for assessment. Telephone advice is also given to concerned colleagues, employers, or clients' families. After hours telephone cover is provided.

VDHP clinical staff do not provide direct treatment of participants but instead provide triage to ensure that health needs are met promptly and with the best available and appropriate resources. Participants who do not have their own general practitioner are expected and assisted to find one. Over time, the VDHP has built up a network of general practitioners and relevant medical specialists and clinical psychologists to whom participants can be referred. In addition, an agreement has been signed with a large private psychiatric hospital to facilitate referral and where necessary admission of participants whose needs are urgent. It has also built up a strong referral base in that the advice and services of VDHP are increasingly relied upon by medical administrators in public and private hospitals and by medical school staff who have concerns about the wellbeing of students.

VDHP concerns re the exposure draft legislation

Given one of the original stated intentions of the National Registration Implementation process was to seek to maintain what is best in the existing state and territory health professionals legislation, VDHP is deeply alarmed at the approach taken to reporting concerns about the health of doctors and medical students. The proposed legislation goes far beyond the existing legislation in Victoria in at least three ways. It extends the reporting obligation to all doctors and not just a treating doctor. It fails to identify that any possibly impaired doctor who agrees voluntarily to cease practice or alter the scope of practice is no longer a risk to the public and should not be reported to a medical board. Lastly it broadens the type of risk that any ill doctor might pose to the public in a manner that will create considerable dilemmas for other doctors in deciding if or when a report should be made. No attempt has been made in any of the accompanying papers to explain, give an evidence base for, or justify such ill-conceived and counterproductive provisions.

If a template has been used for this aspect of new legislation, then the obvious source is the 2008 amendment to the NSW Medical Practice Act. We wish to highlight here that those NSW amendments do not refer to doctors who may be practising while impaired and you will readily find advice on the NSW Medical Board website that makes it clear that such reporting remains an ethical and professional obligation. Furthermore, the NSW provisions (in regard to conduct and NOT impairment) specify "flagrant" breaches of professional standards and do not expect reporting doctors to make judgements about the risk of "substantial harm".

The VDHP Board of Directors believes that this draft legislation, if enacted, will set back the enormous improvements seen in Victoria in terms of earlier presentation and accessing of the best available help for sick doctors and medical students. It will return us to the 1990s when doctors were fearful of being referred for "help" to the Medical Board and as a result, late presentations were the norm. The draft legislation in relation to impairment is inconsistent with all the existing medical and health professionals acts in the States and Territories. Even the UK Medical Act does not contain such draconian provisions, preferring to leave reporting as an ethical responsibility.

We urge you most strongly to remove the present provisions and adopt Section 36 of the Victorian Health Professionals Act 2005, a section which is serving the Victorian community and the medical profession very effectively.



VDHP Board of Directors

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