

**NATIONAL REGISTRATION AND ACCREDITATION SCHEME FOR THE  
HEALTH PROFESSIONALS**

**AMA (NSW) AND ASMOF (NSW) RESPONSE TO SECOND CONSULTATION  
PAPER-  
PROPOSED ARRANGEMENTS FOR HANDLING COMPLAINTS, AND  
DEALING WITH PERFORMANCE, HEALTH AND CONDUCT MATTERS**



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## INTRODUCTION TO THE RESPONSE- GUIDING PRINCIPLES

AMA (NSW) and ASMOF (NSW) support the continuation of the NSW model of the separation of the investigative and prosecutorial functions from the adjudicative functions.

In 1993, the Health Care Complaints Commission was established in New South Wales following the Royal Commission into Deep Sleep Therapy (or the “Chelmsford inquiry”). Chapter 16 of the Commission Report found that the then Department of Health Internal Complaints Unit should be established as a separately constituted body, responsible to Parliament, with clear statutory powers. Accordingly, the Health Care Complaints Commission (HCCC) was then established by legislation passed in 1993.

It is important to note the historical significance of the HCCC in New South Wales. The Chelmsford Commission, along with other issues of significant public importance in New South Wales in relation to the operation of health systems and the role of health professionals, gained significant public and media attention. The subsequent Special Commission of Inquiry into Campbelltown and Camden Hospitals, and recent issues surrounding Bega doctor Graeme Reeves have involved significant consumer concern about health systems and health professionals in New South Wales. The importance of a separately constituted HCCC to investigate and prosecute complaints cannot be over estimated. In New South Wales, the Medical Board is able to maintain in its independence by the fact that it is not responsible for prosecuting complaints, which adds an extra layer of transparency to complaints against medical practitioners and other health practitioners.

AMA (NSW) and ASMOF (NSW) believe that the preservation of the HCCC is essential in New South Wales, in order that the public of New South Wales retain their trust that health practitioners are objectively and transparently investigated and adjudicated in New South Wales.

We note that the recent Inquiry into Dr Harold Shipman, in the United Kingdom, investigated the function of the General Medical Council and the lack of separation of function in relation to investigation, prosecution and adjudication.

We note at Chapter 25, Report 5, the following comments on the separation of function:

“25.27 By 2000, the GMC had decided that the time had come to separate the two functions more clearly. This decision was, in part, prompted by the coming into force, in October 2000, of the Human Rights Act 1998, which incorporated into UK law the entitlement of a person to ‘**a fair and public hearing ... by an independent and impartial tribunal**’ in the determination of his/her civil rights and obligations. However, the GMC had also become convinced that the existing arrangements gave rise to an appearance of unfairness. Doctors, it was said, perceived that the same organisation was both prosecuting them and sitting in judgement on them, and they considered that to be

unfair. The GMC decided, therefore, that there was a need for the functions to be separated, so that everyone involved in complaints about doctors would be able to see that the organisation and the people making the final decision on a case were different from those who had taken the decision that it should be heard and from those representing any of the interested parties.”

It is noted that Dame Janet Smith in her findings, recommended the separation of functions completely, with separate bodies established to investigate and prosecute.

Further, AMA (NSW) and ASMOF (NSW) believe that a separate body such as the HCCC is best equipped to investigate systemic failures, as it is already appropriately constituted to investigate concurrent claims against many different types of medical practitioners.

## **2. PROPOSED TERMINOLOGY**

Proposal 2.1.1- the terminology of “notification” and “notifier” are accepted. The terms are neutral and better reflect the nature of the many different notifications a board may get (ie not all notifications are complaints).

Proposal 2.1.2- the term “preliminary assessment” to describe the action taken by a board or committee or HCC to determine how the matter is best dealt with (ie performance, health, disciplinary) is accepted.

Proposal 2.1.3- the term “notifications assessment committee” is accepted to describe the committee conducting the “preliminary assessment”.

Proposal 2.1.9- The term “health assessment” proposed is accepted. Such assessment should only be carried out by a medical practitioner, and where appropriate, a registered health practitioner.

Proposal 2.1.10- The term “health panel” is accepted.

Proposal 2.1.11- The term “conduct management committee” is not accepted. The NSW model of independent investigation carried out by a body separate from the Board is preferred.

Proposal 2.1.12- The term “conduct investigation” is not accepted. The NSW model of independent investigation carried out by a body separate from the Board is preferred.

Proposal 2.1.13 The term “conduct panel” is not accepted. The NSW term of “professional standards committee” is preferred.

Proposal 2.1.15- The term “not of good character” is accepted.

Proposal 2.1.16- The term “impairment” is accepted, except for the inclusion of the word “habitual”. Misuse of drugs and alcohol may not be habitual but may still be an impairment issue (for example, an alcoholic may be recovered and have a “one off” incident of abuse of alcohol, which may still constitute impairment).

Proposal 2.1.17- The term “unsatisfactory professional performance” is unnecessary. The New South Wales code of two types of misconduct is preferred. To use the term “performance” confuses the disciplinary stream with the performance stream.

Proposal 2.1.18- The term “unsatisfactory professional conduct” is accepted, with the exception of points a) and b). The standard should not be particularized as being that of the public or a health practitioner, but rather should be expressed generally as conduct falling short of the standard expected of a practitioner of an equivalent level of training.

Non-clinical issues may also be dealt with under the “good character” test. Point b) should be deleted entirely as the term “performance” refers to the performance stream, which should be kept separate and discrete from the disciplinary pathway. Further, whilst the definition of i) is broadly accepted, the definition should contain reference to the fact that there is legislation in relation to some benefits (for example, pathology and diagnostic imaging). Further, the NSW legislation has more comprehensive and helpful definitions which assist to give medical practitioners certainty. This approach should be adopted.

### **3. DEFINITIONS FOR WHAT CONSTITUTES A DEPARTURE FROM PROFESSIONAL STANDARDS**

Proposal 3.3.1 has been addressed above.

## 4. NOTIFICATIONS

Proposal 4.1.1 is accepted. It is strongly recommended that notifications must be made in writing with the notifier identified, in order to allow the health practitioner to respond fully to the notification.

Proposal 4.2.2 is accepted. However, clear criteria surrounding what assistance the Board may give to notifiers should be developed. For example, assistance to put in writing the circumstances and details of the notification is appropriate, but this should be a brief information gathering exercise instead of a comprehensive exercise (which is appropriate at the investigation stage). In other words, enough information needs to be collected to enable the initial assessment of the notification.

Proposal 4.3.1 is accepted.

Proposal 4.3.2 is accepted, however in order to allow procedural fairness to the medical practitioner, if investigation into the notification is to occur, it should occur when the notification is received in order for the medical practitioner to respond immediately whilst the medical practitioner has the best recall of events. Further, there should be clear criteria as to whether the notification will be investigated or not- ie the duty of the Board or the HCCC to preliminarily assess should not be discretionary.

### 4.4- Mandatory Reporting Options

Option 1b is preferred.

We support mandatory reporting of physical and mental impairment only where there is a strong impairment or health program present. Mandatory reporting of such events if there is no such health program will result in practitioners who suffer a health issue “going underground” and not seeking assistance from other practitioners if the only result of such a report is disciplinary or punitive.

It is noted that the words “gross or flagrant” should be adopted throughout all legislation to describe when a departure is mandatorily reportable. For example, in the paragraph below the options for mandatory reporting the comment is made “Registrants would only be expected to report *major* departures from professional standards where it is within their competence to make such a judgment.” Inconsistent wording in relation to mandatory reporting is not helpful.

It is noted that the element of harm is a very important component which should be emphasised. Conduct which risks harm should be reportable, not other lesser forms of behaviour or conduct. Therefore the element of risk should be a separate, dot point in order to properly recognise this element. Further, the element of risk should not be to “the public” (which may unnecessarily restrict the category of harm) but rather any person.

Option 2a and 2b are not appropriate provisions under the Inter Governmental Agreement. Employers are not registered under the proposed legislation and it is therefore inappropriate to use this legislation to enforce requirements in relation to reporting. It is a matter for each government to legislate appropriately as to what requirements public health organisations have in relation to reporting. It would also be a very unworkable situation if any form of misconduct is reportable by an employer and lead to much unnecessary reporting (for example, issues of clinical practice which are properly handled by performance management). It would also lead to over reporting which as stated above could stretch the resources of a national board to such an extent that it is unable to appropriately deal with notifications.

The proposed option 2b is strongly opposed as it requires mandatory reporting of the lesser form of misconduct, unsatisfactory professional conduct, and not “flagrant breaches”. The above concerns about having only the most serious, flagrant breaches as reportable are relevant.

Option 2a is also opposed for the same reasons as explained above. The implementation of Option 2a would result in practitioners failing to advise their employer of health issues for fear of reporting, and reduce the opportunity for practitioners to work co-operatively with their employer to ensure appropriate mechanisms are in place where a health issue may effect the practice of a practitioner. Not all forms of health issues will require monitoring by the national board and may be dealt with satisfactorily at a local level between a practitioner and employer.

The position that registrants should only be mandatorily reported where a registrant has the clinical competence to make a judgment is strongly supported.

AMA (NSW) supports only mandatory reporting of flagrant breaches. It is very important that the legislation does not support a situation where the national board would receive a “flood” of complaints, overwhelming the board and paralyzing its function. A similar situation occurred in NSW in relation to the introduction of mandatory reporting of child abuse. The Department of Community Services, after the introduction of the mandatory reporting requirement received a flood of complaints which severely impaired the Department’s ability to investigate the complaints.

If students are to be registered under the Scheme, mandatory reporting should also apply to those students who arguably if in a placement in a hospital, public health organisation or private practice, could cause harm.

Proposal 4.5.1 is accepted. However, the issue of frivolous reports is not addressed. The legislation should make provision to prosecute notifiers who consistently and frivolously report without basis.

Proposal 4.6.1 is accepted.

Proposal 4.7.1 is accepted in terms of the ability of the Board to suspend where there is a significant risk to public health and safety. Currently in NSW a suspension only occurs after a hearing by the Medical Board on the merits of suspension, and a suspension is only ordered where there is significant risk if the practitioner is allowed to continue to practice. It is not accepted that the Notifications Assessment Committee be empowered to suspend a practitioner without an appropriate hearing. Suspension from practice is an action which greatly affects the practitioner and therefore should not occur without a hearing on the merits.

A more appropriate period of suspension before re-assessment is eight weeks (not six months or twelve months as suggested) which allows for the suspension to cease in a short timeframe if appropriate. For example, if a practitioner has short term psychosis which is treated by medication within a short period of time, a period of eight weeks suspension is more appropriate and will allow a return to practice in an appropriate timeframe. Further, the Board should be empowered to shorten or terminate the suspension.

Proposal 4.7.2 is accepted in part. Whilst a review of suspension is appropriate, the Board should be empowered to review the suspension if a practitioner seeks a review. If a court of tribunal is required to review a decision, this may lengthen the process. If the Board has an ability to review the decision it may do so in a shorter timeframe.

Proposal 4.7.3 is accepted, provided that it is clear from the legislation what effect an undertaking has (for example, disciplinary action if undertaking not complied with). The details of an undertaking should not be entered on the register where related to health, so for example next to the registrant's name would be "undertaking to not practice medicine for eight weeks" with no details as to reason, if that reason is health related, in order to maintain confidentiality of the practitioner's health status.

## **PRELIMINARY ASSESSMENT OF NOTIFICATIONS**

Proposal 5.1.1 is accepted. The HCCC should be similarly empowered if a co-regulatory model is adopted.

Proposal 5.2.1 is accepted. If the model of the HCCC investigating complaints is accepted, the HCCC should be similarly empowered. Further, an additional ground should be added- “where the board determines the notification would be better dealt with as a systemic issue rather than a notification against an individual practitioner.”

Proposal 5.5.1 is accepted in part. Suspension without hearing should not be used except in extraordinary circumstances (for example, where a practitioner is so impaired that a hearing would not be necessary). Further, a matter should not be referred to a tribunal for hearing without investigation, to refer to a tribunal without investigation will mean that the tribunal does not have enough information before it to make a decision.

Proposal 5.5.2 should only occur after investigation. It is not clear that the process of referral should only occur after investigation. Obviously referral should only occur after investigation, otherwise matters might be referred unnecessarily to a tribunal, without basis.

Proposal 5.5.3 is accepted, however the practitioner should also have a right of review, given the notifier has a right of review.

5.6- Option 2 is preferred. We note that a right of review for notifiers often ensures early resolution of issues that a notifier has and which if not addressed are likely to be raised in other areas of review (for example, the ombudsman). It is appropriate that there be no right of review if a matter is referred to the health program as it is not a matter appropriate for review.

## **PERFORMANCE MATTERS**

In relation to the “performance stream”, we note we generally support a performance stream where practitioners are assessed and assisted in improving clinical performance if issues are proven during assessment. However, in New South Wales this is a non punitive stream, which does not give rise to any disciplinary action, in order that practitioners can co-operate fully without fear of disciplinary actions. This has led to the success of the program in New South Wales. It is not clear from the paper that the health stream will be entirely separate from disciplinary streams. We do not support any “blurring” of the streams where a matter may jump from the performance stream to disciplinary without a new investigation occurring. In the New South Wales system, if a matter is of a very serious nature, it cannot be referred to the performance program and instead is dealt with as a complaint. Further, after assessment of the notification, either the matter is treated as a complaint, or it is referred to the performance program (section 86J of the Medical Practice Act). If during a performance review the performance panel forms a view that the matter is capable of being professional misconduct or unsatisfactory professional conduct, it is referred back to the board for investigation. At the end of a performance review the panel cannot give a disciplinary finding, if it believes it is a disciplinary matter, again it must be referred back the board.

We support the establishment of a performance stream, however we do so only on the above basis, and not where a “blurring” of the performance stream and disciplinary stream exists. We note the legislative structure in New South Wales around the performance stream and commend this structure.

Proposal 6.2.1 is accepted, although we believe the term “below standard” is preferable, as “unsatisfactory” refers to matters which are in the disciplinary stream, not the performance stream.

Proposal 6.2.2 is accepted, however if a matter is referred as a conduct matter, it should be investigated and not proceed immediately to hearing (ie be referred back to the conduct management committee).

Proposal 6.3.1 is accepted.

Proposal 6.3.2 is accepted.

Proposal 6.3.3 is accepted, except for the referral to the tribunal. The matter should be investigated before referral to a tribunal for hearing, so that the tribunal has all the available information before it when considering the matter.

Proposal 6.4.1 is accepted, however the restriction on the number on the panel being members of the same profession should be deleted. Performance matters should be peer reviewed, and it is indeed very useful that a panel be mostly members of the same profession. For example, a panel of nurses should assess the clinical performance of a

nurse. Given the emphasis of the panel is on the improvement of clinical performance, peer feedback is most appropriate in this context.

Proposal 6.5.1 is accepted.

Proposal 6.5.2 is accepted, however before hearing of a matter, the notification should be investigated and prepared for hearing in front of the Board or Tribunal, rather than information collected in the performance process being used. (See general comments above).

Proposal 6.5.3 is accepted.

## HEALTH OR IMPAIRMENT MATTERS

We are supportive generally of the presence of a health program, and regard the impairment program for doctors in New South Wales as the leading program in the world for dealing with practitioners with health concerns. Currently in New South Wales it is estimated 8,000 working years of doctors with health issues have been saved by the program in New South Wales.

We note in New South Wales the Board is not actively involved in the treatment of practitioners, and submit this is an appropriate separation of function- eg practitioners should be referred to seek psychiatric treatment, rather than the Board appointing a specific psychiatrist, or the Board employing a psychiatrist for this purpose. This ensures practitioners can seek treatment from an independent practitioner, ensuring they are confident in being open with their treating practitioner. We are not supportive of the Board running programs for treatment, for example, and believe this role should be left to the treating practitioner in terms of what is clinically appropriate.

We support programs and referral services being conducted externally to the Board as they are in the New South Wales system.

Proposal 7.1.1 is accepted, provided that the Board has no part in referring the practitioner to specific support programs that it conducts itself.

Proposal 7.1.2 is not accepted as we do not accept health programs should be conducted by the Board. Currently in New South Wales an independent service, the Doctors' Health Advisory Service, is funded by way of grant from the New South Wales Medical Board. The Service provides anonymous referrals for doctors with health issues, to doctors and other health professionals to assist them with their health issues (for example, GPs, psychiatrists, psychologists, drug and alcohol specialists). This model has meant that doctors are able to seek assistance independently from the Medical Board. Where appropriate, the treating practitioner will encourage self referrals to the Board's impairment program, or may report a practitioner themselves if necessary. We support the continuation of this program in New South Wales, and submit it should be funded by the National Board if established by this legislation. If a health program is to be run by a Board, notwithstanding our opposition to such a model, all registrants' fees should fund the program, not the individual registrants seeking treatment.

Proposals 7.2.1, 7.2.2, 7.3.1, 7.3.2 and 7.3.3 are all accepted, provided that the word "habitual" or "habitually" is deleted, for reasons explained above.

Proposal 7.3.4 is accepted, provided that the alleged refusal is first referred back for investigation before a hearing is conducted. (ie the matter should be referred back to the conduct panel).

Proposal 7.4.1 is accepted, however if a matter is to be referred to the Tribunal it should first be investigated, as stated previously in this paper. Further, the panel should be able

to be entirely made up of medical practitioners or relevantly qualified health practitioners (excluding one member), as it is a panel considering health issues this is appropriate. For example, if the health issue is psychiatric in nature, the panel may be entirely made up of psychiatrists (excluding one member).

Proposal 7.5.1 is accepted, however we note in New South Wales, the emphasis is on the voluntary nature of undertakings, which once agreed to become conditions. We believe this emphasis is more empowering and hence more successful.

Proposal 7.5.2 is accepted, again with the comment that the panel must refer the matter back to investigation before a tribunal hearing.

## **CONDUCT MATTERS**

We accept the flexibility required to deal with matters, however we comment generally that matters should go back to the conduct committee for investigation (even if the investigation is relatively brief and simple) to allow the basic principle of investigation, evidence and a right to reply. Conducting an investigation will not reduce flexibility in the system to move matters around appropriately.

We also comment that generally we support a separate investigation body and have not reiterated this point at every proposal. We rely on our introduction in this regard.

Proposal 8.2.1 is accepted. We prefer external investigation as previously stated.

Proposal 8.2.2 is accepted.

Proposal 8.3.1 is accepted, provided that the investigation body is the HCCC.

Proposal 8.3.2 is accepted, provided that there should be no referral to the tribunal without investigation other than in extraordinary circumstances (for reasons of natural justice and procedural fairness).

Proposal 8.3.3 is accepted, provided that the practitioner is given a copy of the notification.

Proposals 8.3.4 and 8.3.5 are accepted.

Proposals 8.4.1, 8.4.2 and 8.5.1 are accepted.

Proposal 8.6.1 is accepted, provided that undertakings are not “required” but rather are agreed to.

Proposals 8.6.2 and 8.6.3 are accepted.

## **ACCOUNTABILITY, TRANSPARENCY AND PROCEDURAL FAIRNESS**

We submit that the best model to ensure accountability, transparency and procedural fairness is for the investigation and prosecutorial functions to be separated from the registration board.

Proposal 9.1.1 Option 2 is therefore preferred.

Proposal 9.1.2 is accepted, and we recommend reference to the criteria contained in the Health Care Complaints Act 1993 (NSW).

Proposal 9.2.1 is accepted, provided that the HCCC is maintained. The HCCC is best equipped to deal with systemic issues. Having several different bodies interact over matters would be complex and cumbersome. The HCCC model in this regard is also much more cost effective, as it is able to quickly deal with concurrent complaints as it already does in New South Wales, using the information it has already investigated and verified.

Proposal 9.3- option 2 is preferred. Legal representation in several jurisdictions is already allowed, and does not slow down processes (indeed in many cases representation of the registrant facilitates a speedier process, as opposed to registrants self representing who may not have an understanding or capacity to represent themselves).

Proposal 9.4- option 1 is preferred, however if option 2 is adopted, legal representation is necessary, due to the potentially public nature of the hearing.

Proposal 9.4.1 is accepted.

Proposals 9.5.1, 9.6.1, and 9.7.1 are accepted.

In relation to proposal 9.8, neither option is preferred, other than to note an ombudsman is appropriate, either at state or federal level, in order to provide a review of process where appropriate.

## **TRIBUNAL HEARINGS**

We note that if state tribunals are retained, case law from each state will only be strictly followed as precedent in that particular state. Whilst it may become custom to follow decisions from other state tribunals, they will not be considered formally as precedent.

Proposals 10.2.1 and 10.2.2 are accepted.

Proposal 10.3.1- alternative option is preferred, as the co-regulatory model is preferred. The same submission applies to proposal 10.4.1.

Proposal 10.4.2 is accepted.

Proposal 10.5.1 is accepted, provided that the element of performance is deleted- this should be a concept contained to the performance program and not treated punitively, as previously submitted.

Proposal 10.5.2 is accepted, with the exception of the power to cancel registration permanently- this is inappropriate as it does not allow for the fact that circumstances may change such that a practitioner could be re-registered after consideration of the merits of re-registration.

Proposals 10.5.3 and 10.5.4 are accepted.

Proposal 10.6.1 is accepted, and as stated previously should also apply to health and performance panels.

Proposals 10.7.1 and 10.8.1 are accepted.

Proposal 10.9.1 is accepted.

Proposal 10.10.1 is accepted, provided that the review is a review on the merits.

Proposal 10.11.i is accepted, provided that the Tribunal is empowered to allow non-publication where appropriate.

Proposal 10.12.1 is accepted.

## **OFFENCES AND RELATED CONDUCT**

The offences proposed in proposal 11.3.1, 11.4.1, and 11.5.1 are generally supported.

In relation to proposal 11.6, the regulation of advertising, the New South Wales legislation is commended.

Proposal 11.7.1 is accepted, as is proposal 11.8.1 and 11.8.2.

In relation to proposal 11.8.3, a breach of a critical compliance condition should result in suspension only after investigation and hearing has occurred.

Proposal 11.10.1 is accepted.

## **TRANSITIONAL ARRANGEMENTS**

We support clear and easy to understand transitional arrangements.

The clearest option seems to be to complete all complaints and processes in train prior to the 1<sup>st</sup> July 2010, in accordance with the repealed legislation.