

## **Attention: Practitioner Regulation Subcommittee**

### **Submission to National Registration and Accreditation Scheme in regard to the Consultation Paper entitled “Proposed arrangements for handling complaints, and dealing with performance, health and conduct matters”.**

This submission focuses narrowly on a small number of issues only and in the order in which they appear in the Consultation Paper.

**General comments:** It is very reassuring to note the intention of those responsible for the introduction of the National Registration and Accreditation Scheme to look to identify and carry forward the best elements of the existing state based schemes. Although you will have observed considerable variations between the jurisdictions, you may not have become aware that this has been seen by at least one very well informed international observer of the Australian and Canadian medical registration systems (both of which are state/province based) as a strength of the systems when compared to the unitary UK model. This observer felt that the Australian and Canadian systems encouraged initiatives and a degree of “competition” between the jurisdictions such that important improvements were made more quickly in Canada and Australia as compared to the UK and that other states/provinces tended to adopt these good ideas (albeit not always promptly, because of political and other obstacles).

Not all of the more recent initiatives of existing medical boards are based in legislation and I hope that other submissions touch on these. Below, I will refer to two that are Victorian initiatives (viz the Victorian Doctors Health Program and the SupportService offered by the Medical Practitioners Board).

I am more familiar with medical boards than with other health registration boards and thus I will refer only to medical professionals in this submission.

#### **Proposal 2.1.1**

I am opposed to the use of the term “notification” for a number of reasons including:

- It is alienating language to most healthcare consumers and is not part of the lexicon of the Health Complaints Commissions. I suspect that it might even create a sense of disempowerment of those who lodge complaints.
- Although you state that in everyday practice, the registration boards will be free to use the alternative word “complaint”, this was not the response of the Medical Practitioners Board of Victoria when the new legislation was introduced a year or so ago.
- The recently issued Australian Charter of Healthcare Rights speaks of the right to comment or complain, not to notify.

I am surprised that the consultation paper states (page 20) that “complaints from consumers represent only a proportion of all notifications”. The last three annual reports of the Medical Practitioners Board of Victoria show that around 70% of complaints about professional

conduct are lodged by patients or their relatives (see page 20 of the Annual Report for 2007).

I recognise that there is a need to identify accurately that important matters around professional conduct, health and competence are indeed “notified” to registration boards by other agencies and that these do not fit the usual understanding of what constitutes a “complaint”. However, I would urge you to consider other approaches which might include (a) using “complaint” and defining a complaint to encompass “notification” or (b) using both terms.

### **Key features of proposed system (pages 11-13)**

#### **Complaints sharing**

Having worked in the Victorian system where there was considerable uncertainty as to whether the medical registration board or the health complaints authority had the final “say” when deciding which agency would handle a matter and having learned by working with four different Health Services Commissioners that personalities often played a large part in the process, I applaud the approach you are recommending as it puts the protection of the public ahead of conciliation for an individual.

#### **Prosecution of cases at a tribunal**

I wish here to draw to your attention an initiative of the Medical Practitioners Board to establish a “support service” for complainants giving evidence and for doctors facing disciplinary hearings about serious allegations of misconduct. The Victorian service was modelled on the Court Network, a service which supports victims of crime and other persons giving evidence in the Victorian courts. Its establishment was driven primarily by our observations of how stressful it was for persons alleging sexual misconduct against doctors and that “prosecutions” were at times abandoned when distressed complainants were reluctant to follow through. We recognised that doctors were often equally stressed and the service was made available to them also, although in practice not many avail themselves of this as most appear to obtain adequate support from other sources such as their medical indemnifier. The service is funded by the medical board.

I realise that the service does not need legislative backing but I would ask you to note its existence and support the potential for its retention. It has the strong backing of Victoria’s services for rape and sexual assault victims.

#### **Options for mandatory reporting**

In my experience this is a very difficult area for doctors and regulators. My suggestions are that you seek to (a) maintain the mandatory reporting by treating doctors of ill and possibly impaired health professionals – but find words which clearly indicate that an ill and impaired health professional who stops work voluntarily does not need to be so reported (see final para on page 4 of this submission also), (b) introduce mandatory reporting of allegations of sexual misconduct alone as this has been the most problematic area for boards to adequately protect the public from serial predators\* and (c) find words that make it an ethical but not a mandatory duty to report other issues as listed in Option 1b.

\*If you are not familiar with the history of the benefits of mandatory reporting of sexual misconduct allegations in most Canadian jurisdictions, I will be pleased to provide you with more information.

#### **Proposal 5.2.1**

I strongly support the additional words “misconceived or lacking in substance” as grounds for not proceeding with investigations. This will allow common sense to be applied.

#### **Proposal 5.5.1**

Later in the consultation document there is more detailed reference to legal representation but I will touch on it here in regard to this proposal. One of the most marked differences between the then NSW and Victorian medical acts were the powers of lower level hearings/inquiries/ assessment panels. In Victoria, the legislation basically provided that the board could not interfere with a doctors’ registration in a manner that would prevent him/her making a livelihood unless the doctor had legal representation – other of course than when urgent temporary action was needed because of imminent risks to the public. At this level of investigation, without legal representation, the board was confined to caution, counsel and reprimand or referral to a higher level of inquiry – it could not for example place conditions on registration. I commend this principle to you as you resolve the situations where legal representation is needed.

#### **5.6 Notifier’s rights of review**

The most recent health professions registration act in Victoria has incorrectly in my view provided complainants with a right of review. The persons who drafted that legislation misunderstood the fundamental purpose of the legislation which is to protect the community and not to right other wrongs. Civil action or health complaints conciliation are the correct pathways for the latter. In hearings before a registration board or tribunal the only person in jeopardy is the health professional under investigation and he/she should be the only person with a right to review. The risk of injustice to the health professional by invoking a second hearing in this manner far outweighs the supposed increased community confidence in the system which such a right of review might bring. The conscientious people (health professionals, lay persons and lawyers) who undertake this difficult and usually not well paid work (especially if one includes reading time and unpaid writing of reasons time) deserve to be trusted.

These comments also apply to **proposal 9.1.1** where I support Option 1. I am deeply opposed to Option 3 as it would basically tell all panel/committee members that they could not be trusted and that their work was under continuous scrutiny . Who would want such a task?

#### **Proposal 7.1.2 Health programs**

I am very supportive of this proposal, **preferring Option 1** to apply to programs whether run directly by the board or run by agreement with the board but at arms length from the board. It seems that this proposal (especially Option 2) has been written with the Victorian Doctors Health Program (VDHP) in mind. If this is so, then it has misunderstood one fundamental element of the VDHP. The VDHP does NOT provide medical care. Instead, its staff are charged with triaging ill doctors and medical students to the best available and most

appropriate care, and all costs of treatment are borne by the doctor (ie with access to Medicare rebates, and private health cover if possessed).

I here repeat a previous offer to explain the history, purpose, cost and governance arrangements of the VDHP. The VDHP is established as a “public company limited by guarantee and not having a share capital” and has two shareholders: the Medical Practitioners Board of Victoria and the Victorian Branch of the Australian Medical Association. It is not yet clear to me how this model will be able to be funded and maintained with a national agency. The VDHP is presently seeking advice about possible future governance models and if we arrive at what might be workable suggestions will pass them on to you.

#### **Proposal 10.10.1**

In Victoria over the last 30 years the grounds for appeal of medical board decisions to the Supreme Court have swung between on points of law only to a complete rehearing on the other. I hope informed lawyers or civil rights activists make submissions on this topic as I think it is difficult to get the right balance. My preference is to allow appeals only on points of law.

#### **Finally re attachment 2, page 49**

This is a relatively minor point but is related to my comment above about mandatory reporting of possibly impaired doctors. Your summary of Section 36 of the Vic Health Professions Registration Act 2005 has omitted mention of the last clause about “and may result in the public being put at risk”. This is a vital element of the reporting requirements to which I have already alluded and should not be overlooked. This is the clause that allows lots of ill doctors who have insight, and who agree to stop work temporarily or permanently, not being reported to the medical board.

#### **Dr Kerry J Breen AM, MB BS, MD, FRACP**

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President of the Medical Practitioners Board of Victoria, 1994 -2000

President of the Australian Medical Council 1997 -2000

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Chair of the Board of Directors of the Victorian Doctors Health Program 2006-