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Making a submission

Once you have completed your response, please email it to NRAS Review Implementation Project Secretariat < NRAS.consultation@dhhs.vic.gov.au>

or post your response to:

NRAS Review Implementation Project Secretariat
Health and Human Services Regulation and Reform
Department of Health and Human Services
GPO Box 4057
MELBOURNE VIC 3001

Submissions are due by midnight, Wednesday 31 October 2018.

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About you / your organisation

What is your name / your organisation's name?

Avant Mutual

Are you a:

- ☐ Consumer of health services
- ☐ Registered health practitioner
- ☐ Employer of health practitioners
- ☐ Representative of a professional association
- ☐ Representative from a health regulator
- ☒ Other – please state: Medical indemnity provider/medical defence organisation

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- ☒ **Yes**, you may publish my submission, including my name/my organisation's name.
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Would you like to be informed about the outcome of the consultation?

- ☒ **Yes**
- ☐ **No**

If you answered 'yes', please provide your contact details below.

Name:	Ms Georgie Haysom
Position/title (if applicable):	Head of Research, Education and Advocacy
Email:	Georgie.haysom@avant.org.au

Thank you for taking the time to make a submission.

Avant's General Comments

Avant welcomes the opportunity to provide input into the COAG Health Council's consultation paper *Regulation of Australia's health professions: keeping the National Law up to date and fit for purpose*.

Avant is Australia's largest medical defence organisation, providing professional indemnity insurance and legal advice and assistance to more than 78,000 healthcare practitioners and students around Australia. Avant provides assistance and advice to members involved with complaints and notifications to AHPRA and the Medical Board of Australia, as well as to regulators in the co-regulatory jurisdictions, and to Health Complaints Entities (HCEs).

Overall, we agree that the National Scheme needs to be efficient, fair and responsive for both health consumers and practitioners. We support the risk-based regulatory approach taken by AHPRA and the National Boards in their work to protect the public. However, it is important to get the balance right between the need to protect the public and ensuring that legislation and regulatory processes are proportionate and fair to practitioners.

We support changes to the National Law and to policy that improve regulatory processes and that make those processes more flexible, efficient, timely and cost effective, and comply with the rules of natural justice and procedural fairness. We support changes that reduce the significant impact regulatory processes can have on practitioners' personal and professional lives and their reputation.

We support the following proposals to amend the National Law to:

- Empower a National Board to accept an undertaking from a practitioner at first registration or renewal.
- Provide National Boards with the discretion to deal with a practitioner who has inadvertently practised while unregistered for a short period by applying the disciplinary powers under Part 8 s. 178 rather than prosecuting the practitioner for an offence under Part 7.
- Empower practitioners and employers to provide patient and practitioner records during preliminary assessment when requested to do so by a National Board.
- Clarify the powers of a National Board following preliminary assessment, including a specific power to enable the National Board to refer a matter to be dealt with by another entity.
- Empower a National Board to decide not to refer a matter to the responsible tribunal for hearing when the Board reasonably forms the view that there are no serious ongoing risks to the public.
- Enable a right of appeal against a decision by a National Board to issue a caution.

We are concerned about proposing more regulation on the assumption that it will protect the public but where there is little evidence that it will do so. This approach is contrary to the move towards less but more efficient regulation. From our perspective as a medical defence organisation it appears that increased regulation is often a knee-jerk reaction to a perceived crisis, which in our experience usually involves an extreme case. The response is to impose regulation based on the extreme case or outlier that can be disproportionate and unfair when applied to the majority. Recent examples include:

- The Medical Board's adoption of all of the recommendations of the Independent Review of Chaperones to Protect Patients, taking a one-size-fits-all approach which in our view is contrary to the risk-based regulatory principles under which the Board purports to operate and contrary to fundamental common law principles such as the entitlement to the presumption of innocence until proven guilty.

- The Medical Board's initial decision to include on the public register links to all outcomes of disciplinary proceedings, including those with no adverse findings (now reversed where there is no adverse finding).

It is important to ensure that extreme cases do not lead to unfair and disproportionate regulation for the majority who are practising well.

As a matter of general principle, where possible and appropriate we prefer for changes to be dealt with via policy rather than legislation. We have seen how long it can take to achieve legislative changes to the National Scheme, which is made more complex because of the need to obtain the agreement of all Health Ministers. Policy can be more flexible and responsive to change.

Our positions on other key issues raised in the consultation are:

1. The Chairperson of a National Board

   The position of Chairperson of a National Board should be reserved for practitioner members only, to ensure that the Chairpersons can make authoritative statements about clinical matters, and to maintain the confidence of the profession.

2. Reporting professional judgments and settlements to the regulator

   We support maintaining the status quo. Any change to the status quo should be the subject of a separate consultation.

   Settlements and judgments do not necessarily indicate poor performance and reporting settlements and judgments will not facilitate early detection of poorly performing practitioners. The purported benefits do not outweigh the costs, and there are several potential unintended consequences.

   We oppose notification of professional negligence settlements and judgments or claims histories by insurers. It would be a breach of confidentiality and/or legal professional privilege and a conflict of interest for insurers to report, and would undermine the trust that our members place in us as their medical indemnity insurer.

3. Extent of information on the public register

   There is sufficient information on the public register and no additional information is needed.

   Any disciplinary information published on the register should be removed once it is no longer required (eg expired conditions and undertakings), and after five years as long as there have been no other relevant events. Practitioners subject to disciplinary action should be allowed get on with their lives without stigma when there is no longer any risk to the public.

   Details about impairment and health-related conditions and undertakings should never be published on the register.

4. Advertising

   Amending the legislation to confirm that the prohibition on testimonials applies only to websites and social media over which the practitioner has direct control would provide some reassurance to practitioners. However, the drafting of any proposed legislation will need to be carefully considered to ensure that it clarifies the situation rather than further confuses it. By contrast, the status quo, where the legislative provisions are supplemented by guidelines and policy may be more flexible and responsive to the constantly changing social media environment.

If changes are to be made to the legislation, we would welcome the opportunity to comment on the draft legislation as unintended consequences may only become apparent when the relevant provision is drafted.

Consolidated list of questions

Governance of the National Scheme

Section 3.1: Objectives and guiding principles – inclusion of reference to cultural safety for Aboriginal and Torres Strait Islander Peoples

1. Should the guiding principles of the National Law be amended to require the consideration of cultural safety for Aboriginal and Torres Strait Islander Peoples in the regulatory work of National Boards, AHPRA, Accreditation Authorities and all entities operating under the National Law? What are your reasons?	No comment
2. Should the objectives of the National Law be amended to require that an objective of the National Scheme is to address health disparities between Indigenous and non-Indigenous Australians? What are your reasons?	No comment
3. Do you have other suggestions for how the National Scheme could assist in improving cultural safety and addressing health disparities for Aboriginal and Torres Strait Islander Peoples?	No comment

Section 3.2: Chairing of National Boards

4. Which would be your preferred option regarding the appointment of chairpersons to National Boards? What are your reasons?	Our preferred option is option 1. The Chairperson of the National Board, particularly the Medical Board of Australia, should be reserved for practitioner members only. The Chairperson of a National Board is often called upon to make public statements about clinical and professional issues. Where the Chairperson is a registered practitioner from the relevant board, he or she brings advantages including their clinical background and knowledge of standard practices in the relevant profession. We agree with the comments in the consultation paper that a Chairperson who is a practitioner member is generally in a position to make authoritative statements about clinical matters. It is important that the relevant profession has confidence in the regulatory framework. In our view, in the medical context, the profession is more likely to have confidence in a National Board if the Chairperson is a member of the medical profession. A Chairperson from outside the profession would undermine the

	authority of the Board.
5. If your view is that the role of chairperson should be reserved for practitioner members only, then how should circumstances be managed where there is no practitioner member willing or able to carry out the role, or where there is a need to appoint a non-practitioner for the good governance of the board?	We believe that this situation is unlikely to occur in the medical profession. Nevertheless, the legislation could be amended to provide the discretion to appoint a non-practitioner member in the limited circumstances outlined in the question. In these circumstances, the appointee would need to have significant experience in the industry, and have credibility with the profession.
6. If your view is that the role of chairperson should be open to both community and practitioner members, then how should the need for clinical leadership be managed when a chairperson is required to speak authoritatively on behalf of the National Board?	Not applicable

Section 3.3: System linkages

7. Are the current powers of National Boards and AHPRA to share and receive information with other agencies adequate to protect the public and enable timely action?	Yes. In our experience, information is shared between the Medical Board/AHPRA and other agencies, and information sharing between regulators and agencies is increasing. However, if improvements are needed, it is sufficient to deal with this issue through administrative mechanisms rather than amending the legislation.
8. Are the current linkages between National Boards, AHPRA and other regulators working effectively?	Generally yes, although sometimes there can be significant delays in regulators dealing with matters arising out of the same incident. For example there may be a coronial inquiry and a finding that a practitioner be referred to AHPRA, then delay in AHPRA completing the investigation. We are also concerned to ensure that information passing between AHPRA and other agencies (including local law enforcement and health complaints agencies) is provided to practitioners – especially those proceeding through the disciplinary or compliance process – in a timely and comprehensive manner. Again, we see this issue as an administrative rather than legislative one.
9. Should there be a statutory basis to support the conduct of joint investigations with other regulators, such as drugs and poisons regulators and public health consumer protection regulators, and if so, what changes would be required to the National Law?	While the conduct of joint investigations may seem attractive as a way of reducing duplication and improving the timeliness of dealing with investigations, there are practical problems with joint investigations, including different legislative tests under which the incident is being considered and investigated (eg the tests applicable under the National Law compared with local drugs and poisons legislation) and it can be

	difficult to align operationally. Regulators should have the ability to carry out concurrent investigations where appropriate for the particular matter and where it is fair to the practitioner to do so. We support joint consideration (but not joint investigation) of matters such as currently occurs for example between HCEs and AHPRA, and in NSW between the Health Care Complaints Commission and the NSW Medical Council.

Section 3.4: Name of the Agency Management Committee

10. Should AHPRA's Agency Management Committee be renamed as the Australian Health Practitioner Regulation Agency (AHPRA) Board or the AHPRA Management Board? What are your reasons?	No comment

Registration functions

Section 4.1: Registration improperly obtained – falsified or misleading registration documents

11. Should the National Law be amended to enable a National Board to withdraw a practitioner's registration where it has been improperly obtained, without having to commence disciplinary proceedings against them under Part 8?	

Section 4.2: Endorsement of registration for midwife practitioners

12. Should the provision in the National Law that empowers the Nursing and Midwifery Board to grant an endorsement to a registered midwife to practise as a midwife practitioner be repealed?	No comment.

Section 4.3: Undertakings on registration

13. Should ss. 83 and 112 of the National Law be amended to empower a National Board to accept an undertaking from a practitioner at first registration or at renewal of registration?	Yes. Voluntary undertakings are preferable to imposed conditions and practitioners should be provided with the opportunity to give an undertaking on registration and have it accepted by the Board, rather than having a condition imposed upon them.
14. Should the National Law be amended to	It is generally reasonable to amend the National Law so

empower a National Board to refuse to renew the registration of a practitioner on the grounds that the practitioner has failed to comply with an undertaking given to the board?	that undertakings and conditions are treated in the same way in terms of their practical effect. However, refusing to renew a practitioner's registration for failure to comply with an undertaking or a condition may be tantamount to de-registration. Only a Tribunal has the power to deregister a practitioner and giving this power to a National Board under Part 7 would appear to subvert the disciplinary process under Part 8. If a National Board were to be given this power, the practitioner would need to be given notice of the proposal, an opportunity to make submissions and a right of appeal.

Section 4.4: Reporting of professional negligence settlements and judgements

15. Should the National Law be amended to require reporting of professional negligence settlements and judgements to the National Boards?	No. If there is to be a change to the status quo, this should be subject to a more detailed consideration in a separate consultation and a regulation impact statement.
16. What do you see as the advantages and disadvantages of the various options?	See below under answer to question 17.
17. Which would be your preferred option?	Our preferred option is Option 1 – maintain the status quo. We oppose option 4 that would impose an obligation on indemnity insurance providers to report details of professional negligence settlements and judgments in relation to a registered practitioner.

General comments

If there is to be a change to the status quo, this should be subject to a more detailed consideration in a separate consultation and a regulation impact statement.

The reasons for our position are outlined below.

Reporting professional negligence settlements and judgments will not facilitate early detection of poorly performing practitioners

Arguments in favour of the change assume that reporting of professional negligence settlements and judgments will facilitate early detection of impaired or poorly performing practitioner and minimise the risk of regulatory failure. We do not agree with this for the following reasons.

- Reporting professional negligence settlements and judgments will not provide early information. The relevant harm that gives rise to the claim for compensation has usually occurred several years before the claim is made.
- Under limitation acts, patients generally have three years from the date they discover they have a potential cause of action against a practitioner to commence litigation.
- The time taken to resolve a professional negligence matter, from the date it is first initiated in court and served on a practitioner, can range from 12 to 18 months.
- If a matter proceeds to a judgment, the time taken from service of litigation on the defendant ranges from 18 months to two years or more for a complicated case.
- In our experience, patients who make notifications to AHPRA often have lawyers instructed who advise them to make a notification. In our experience, the complaints process is often used by patients and their lawyers as a vehicle to obtain records, information and expert opinion in preparation for a civil claim.
- Our data shows that since tort law reforms in 2000/2001, civil claims have decreased and disciplinary matters have increased. Over the past years, disciplinary matters have increased approximately 7% per annum and we now receive approximately 3 times as many disciplinary complaints as civil claims.
- Professional negligence claims are often made either concurrently with or after a notification has been dealt with by the regulator, and often as a consequence of media attention.

Settlement or judgment does not indicate poor performance

There is an assumption that the settlement or a judgment against a practitioner in a professional negligence matter is an indicator of poor performance and/or that the practitioner is a risk to the public. This is not the case.

- Matters are settled for many reasons that do not necessarily relate to poor performance including an evaluation of the strength of expert evidence, the quality and credibility of witnesses, the quality of the documentary evidence and the costs of running the matter to trial.
- A practitioner may be named in a professional negligence matter on the basis that they are vicariously liable for the acts and omissions of a practitioner who is staff member. It is unfair that those practitioners are reported to the regulator.
- Patient lawyers and advocates are increasingly adopting a 'scatter gun' approach to medical negligence claims whereby they name a large cohort of practitioners as defendants to the one litigation for strategic legal reasons. Practitioners on the periphery of the matter are sometimes caught up in the claim and ultimately are parties to any settlement.
- Generally the rights of the insured practitioner are subrogated to the insurer so that the decision to settle a

professional negligence matter is out of the practitioner's control.

- Most doctors who would be required to report will only ever have one civil claim against them, and this is not a predictor of future risk. This is supported by research using the US National Practitioner Databank. In an analysis of 66,426 claims paid against 54,099 doctors over the period 2005 to 2014, 84% incurred only one claim during the study (accounting for 68% of paid claims) (see Studdert et al "Prevalence and Characteristics of Physicians Prone to Malpractice Claims" NEJM 2016; 374:354-62) It is disproportionate and unfair, and contrary to AHPRA's risk-based regulatory principles to require reporting all professional negligence settlement or judgments to AHPRA in light of this evidence.
- There is little if any correlation between the size of the settlement and the seriousness of the error that led to the claim or the competence of the practitioner involved, as suggested in the consultation paper. The amount of compensation awarded by a court or the amount of the settlement is referable entirely to the condition of the injured patient, the evidence on quantum and (in the case of settlement) negotiations that take into account liability risk, among other things.

There are better ways to obtain early information

There are existing and better ways the regulator can obtain early information about impaired or poorly performing practitioners:

- Mandatory and voluntary reporting under the National Law.
- Employers' obligations to report under the National Law.
- Strengthened powers as a result of tranche 1 reforms to share information with Commonwealth, state and territory governments where a risk to health or safety is identified.

We understand that AHPRA can and does on occasion request information from practitioners about their claims history if they need further information about a practitioner in order to carry out a risk assessment.

There are unintended consequences

There are several unintended consequences of this proposal:

- Doctors are particularly concerned about the impact that a claim or complaint will have on their registration. If doctors have to report judgments and settlements against them, it will make it more difficult for insurers to settle matters and this will have flow-on effects. While a doctor's rights are subrogated to the insurer under the policy, as a mutual organisation is it our practice to obtain the consent of the doctors we act for before resolving a matter with a settlement.
- The proposal notes that practitioners will not need to report judgments in their favour or settlements where there has been a discontinuance. Based on our experience we anticipate that the proposed change will act as a disincentive for doctors to agree to settle matters. Instead they will want to run them to trial in the hope that they will successfully defend the matter and not need to report it to AHPRA. There is evidence that this has occurred in the United States following the introduction of the National Practitioner Databank (see Teninbaum, Gabriel H: "Reforming the National Practitioner data bank to promote fair med-mal outcomes" *William and Mary Policy Review* [2013] Vol 5:1, and see also Morreim H "Malpractice, Mediation and Moral Hazard: The virtues of Dodging the Data Bank" Ohio State Journal on Dispute Resolution Vol 27:1:2012)
- This will increase the costs associated with claims and this will impact doctors' premiums, and ultimately health care costs.
- This will also increase costs of the civil justice system. In last two decades there has been a move towards to the just, quick and cheap disposition of matters in the civil courts. This includes referral of most matters to mediation with a view to resolving them rather than proceeding to a contested hearing. There is a risk with this proposal that matters will be less likely to resolve at mediation, thus denying plaintiffs the opportunity to obtain an early settlement, as well as adding costs to the parties and administrative costs to

the court.

- If the insurer is required to report them or provide their claims history or the doctor themselves has to provide their claims history to AHPRA, this would act as a disincentive to doctors reporting incidents to their insurers, in breach of their duty of disclosure under the *Insurance Contracts Act*. This would potentially leave doctors uninsured for incidents that are not notified to the insurer, with flow-on effects to patients/plaintiffs.
- Providing this information may waive legal professional privilege which is a fundamental legal right.

We opposed notification by insurers

We oppose any requirement that insurers report professional negligence judgments or settlements or be required to provide claims history to AHPRA or a National Board.

- As noted above this would act as a disincentive to practitioners reporting incidents to their insurers, in breach of their duty of disclosure under the *Insurance Contracts Act.* This could result in practitioners not seeking early advice or providing early reports of incidents which in turn will create missed opportunities for harm reduction and mitigation in the interests of public safety (see further mp Consulting *First Principles Review of the Medical Indemnity Insurance Fund* April 2018 at p 32).
- It would be a breach of confidentiality and/or legal professional privilege and a conflict of interest for insurers to report.
- This would undermine the trust that our members place in us as their medical indemnity insurer.

Any proposal that insurers report needs to be considered in light of the proposed changes to the medical indemnity schemes requirements will have on this, following the First Principles Review referred to above.

The costs outweigh any potential benefits

The potential costs to insurers, the medical profession, the health care system and the civil justice system are outlined above.

There would also be costs associated with training AHPRA staff to develop the expertise to evaluate a professional negligence matter so that it could be properly considered as part of the risk assessment process. It is not clear that the benefits of obtaining information about professional negligence settlements and judgments will outweigh the costs of training staff to do this, or the costs associated with staff evaluating the information provided. This will have an impact on practitioners' registration fees.

Section 4.5: Reporting of charges and convictions for scheduled medicines offences

18. Should the National Law be amended to require a practitioner to notify their National Board if they have been charged with or convicted of an offence under drugs and poisons legislation in any jurisdiction?	No. In our view this places the reporting threshold too low. As noted in the consultation paper, it would require practitioners to report relatively minor offences. The current requirements in section 130 to notify charges with an offence punishable by 12 months and convictions punishable by imprisonment sets the threshold for reporting at the appropriate level. Current reporting requirements (mandatory and

	voluntary reporting, employer obligations to report and information sharing between agencies) are sufficient to ensure the AHPRA has relevant information to assess a practitioner's suitability to practise and risks to public safety. In our experience drugs and poisons regulators routinely share information with AHPRA about practitioners who may present a risk to public safety.

Section 4.6: Practitioners who practise while their registration has lapsed

19. Should the National Law be amended to provide National Boards with the discretion to deal with a practitioner who has inadvertently practised while unregistered for a short period (and in doing so has breached the title protection or practice restriction provisions) by applying the disciplinary powers under Part 8 s. 178 rather than prosecuting the practitioner for an offence under Part 7?	Yes. It is not appropriate to prosecute a practitioner for an offence under Part 7 where they inadvertently practised while unregistered for a short period of time.

Section 4.7: Power to require a practitioner to renew their registration if their suspension spans a registration renewal date

20. Should the National Law be amended to require a practitioner whose registration was suspended at one or more registration renewal dates, to apply to renew their registration when returning to practice?	Yes.
21. Noting the current timeframes for registered practitioners applying to renew their registration (within one month of the registration period ending) and for providing written notice to a National Board of a 'notifiable event' (within seven days), what would be a reasonable timeframe for requiring a practitioner to apply to renew their registration after returning to practice following a suspension?	One month is a reasonable time. Seven days is too short.

Health, performance and conduct

Section 5.1: Mandatory notifications by employers

22. Should the National Law be amended to clarify the mandatory reporting obligations of employers to notify AHPRA when a practitioner's right to practise is withdrawn or restricted due to patient safety concerns associated with their conduct, professional performance or health? What are your	No. The National Law does not need to be amended. Employers currently have an obligation under section 142 to report practitioners to AHPRA where they believe a practitioner has engaged in "notifiable conduct" under the National Law. This is the appropriate threshold for mandatory reporting.

reasons?	Employers can also make a voluntary report under section 145 of the National Law. If employers do not understand their reporting obligations, then more education needs to be done. In any event, as noted in the consultation paper, practitioners are required to notify AHPRA if their right to practice is withdrawn or restricted because of their conduct, performance or health within 7 days of the event and on renewal.

Section 5.2.1: Access to clinical records during preliminary assessment

23. Should Part 8 Division 5 of the National Law (preliminary assessment) be amended to empower practitioners and employers to provide patient and practitioner records when requested to do so by a National Board?	Yes. Our members are often hampered in their ability to provide a response to a notification during the assessment phase because of they are unable to access the records held by a third party. This amendment would allow a Board to obtain the records and provide to the practitioner so the practitioner can provide a response by reference to the records, without having the matter referred to investigation. This amendment would also assist where a notification is made by someone other than a patient. Currently a practitioner cannot provide the records to AHPRA without patient consent. If the legislation empowered practitioners to provide records at the request of AHPRA this would protect practitioners from a claim of a breach of confidentiality or privacy by the patient. In our experience the provision works well in NSW. This amendment has the potential to improve the timeliness and efficiency in handling notifications. It would allow a Board to obtain information (records and a response), clarify issues and decide on next steps at an early stage.

Section 5.2.2: Referral to another entity at or following preliminary assessment

24. Should Part 8 Division 5 of the National Law be amended to clarify the powers of a National Board following preliminary assessment, including a specific power to enable the National Board to refer a matter to be dealt with by another entity?	Yes. We agree there is some lack of clarity of outcomes of the preliminary assessment process. Including a specific power to enable a Board to refer a matter to be dealt with by another entity following preliminary assessment would assist the Board to deal with notifications at an early stage, rather than having to refer the matter for investigation. We also recommend that the legislation be amended to allow an additional ground for not accepting a complaint or for taking no further action, namely that the notifier

	has not first raised the matter with respondent to the notification. We note that the Office of the Health Ombudsman (OHO) in Queensland is considering amending its legislation to provide the OHO with the ability not to accept low-risk complaints where they have not first raised their complaint with the practitioner or health service (see Health Communities, Disability Services and Domestic and Family Violence Prevention Committee Transcript of Proceedings *Public Hearing – Oversight of the Health Ombudsman and the Health Service Complaints Management System* 24 August 2018 p.7).

Section 5.3.1: Production of documents and the privilege against self-incrimination

25. Should the provisions of the National Law about producing documents or answering questions be amended to require a person to produce self-incriminating material or give them the option to do so? If so: • **Should this only apply to the production of documents but not answering questions or providing information not already in existence?** • **What protections should apply to the subsequent use of that material?** • **Should the material be prevented from being used in criminal proceedings, civil penalty proceedings or civil proceedings?** • **Should this protection only extend to the material directly obtained or also to anything derived from the original material?**	The privilege against self-incrimination is a fundamental legal right that should be maintained. Practitioners should not be *required* to produce self-incriminating material. However it may be appropriate to provide practitioners with *the option* of providing self-incriminating material in appropriate cases, as long as the material is protected from use in subsequent criminal, civil penalty and /or civil proceedings, and no adverse inference is drawn against the practitioner if they exercise their right to claim the privilege against self-incrimination. This may encourage practitioners to engage with the process and provide full and frank information. This can lead to reduced delays in investigations and improved timeliness and efficiency of the complaints process. The proposal should apply to producing documents and answering questions, and to material directly obtained and also to anything derived from the original material. This last point is important because we have seen situations where otherwise privileged material (root cause analysis reports for example) is used to form the basis of a further request for information or of expert opinion. This subverts the reason for the existence of the privilege. Another concern arises from the fact that the material provided can be used for the purposes of an investigation, subsequent health, conduct or performance action of for prosecution of offences under the National Law. If there is a subsequent hearing and the practitioner gives evidence about the content privileged/protected material, that evidence can then be

	used in subsequent criminal, civil penalty or civil proceedings. This subverts the protections. A mechanism to overcome this is to allow the tribunal to provide a certificate to the practitioner as currently occurs in the coronial jurisdiction (see for example section 57 *Coroners Act* 2008 (Vic) and other state and territory equivalents) The protection should apply to all phases of the notifications process: immediate action, assessment and investigation.
26. Should the provisions be retained in their current form? What are your reasons?	See answer 25 above.

Section 5.4.1: Show cause process for practitioners and students

27. Should the National Law be amended to enable a National Board to take action under another division following a show cause process under s. 179?	While we can see some benefits in this proposal (such as ensuring that a Board's decisions are based on all relevant information), we are concerned that this amendment would allow a Board to "have a second bite of the cherry" at the end of an investigation, and bring up new issues at a late stage, which should have been considered as part of the investigation. This would further prolong investigation timeframes.
28. Should the National Law be amended to provide a statutory requirement for a National Board to offer a show cause process under s. 179 in any circumstance where it proposes to take relevant action under s. 178?	Yes. Allowing a practitioner to make submissions on proposed actions is a key requirement of procedural fairness. We agree that the National Law should be amended to incorporate AHPRA and the Boards' current policy to afford a show cause opportunity for all proposed relevant action under s.178.

Section 5.4.2: Discretion not to refer a matter to a tribunal

29. Should the National Law be amended to empower a National Board to decide not to refer a matter to the responsible tribunal for hearing when the board reasonably forms the view that there are no serious ongoing risks to the public? If not, why? If so, then why and what constraints should be placed on the exercise of such discretion?	Yes. Tribunal matters can be long and costly to all parties. In accordance with the risk-based regulatory principles under which AHPRA and the Boards operate, and given that one of its primary functions is protection of the public, it follows that if there are no ongoing serious risks to the public, a Board should be empowered to decide not to refer a matter to the tribunal.

Section 5.4.3: Settlement by agreement between the parties

30. Should the National Law be amended to provide flexibility for National Boards to settle a matter by agreement between the practitioner,	We agree with the proposal to amend the National Law to provide flexibility for a National Board to settle a matter by agreement between a Board and the

the notifier and the board where any public risks identified in the notification are adequately addressed and the parties are agreeable? What are your reasons?	practitioner, who are the parties to the matter. As a matter of principle we generally support using alternative dispute resolution where possible to avoid litigation, and we agree that the notifier should be engaged and involved in the processes for dealing with notifications. However we do not agree with the proposal to include notifiers as part of a settlement between a Board and a practitioner: • The notifier is not a party to the matter. • AHPRA is a regulator, not a complaints resolution service. • As noted in the consultation paper, all state and territory health complaints entities have statutory powers to conciliate health service complaints, and there is a joint consideration process. This proposal would lead to duplication, confusion and a blurring of responsibilities between HCEs and the Boards. • We agree that this may compromise the independence of the Boards, raises issues of potential conflict of interest and may create unreasonable expectations for notifiers. It could create practical difficulties if the notifier disagrees with the outcome of the consideration by the Board and agreement between the Board and the practitioner to resolve the matter.

Section 5.4.4: Public statements and warnings

31. **Should the National Law be amended to empower a National Board/AHPRA to issue a public statement or warning with respect to risks to the public identified in the course of exercising its regulatory powers under the National Law? What are your reasons?**	No comment
32. **If public statement and warning powers were to be introduced, should these powers be subject to a 'show cause' process before a public statement or warning is issued? What are your reasons?**	No comment

Section 5.5.1: Power to disclose details of chaperone conditions

33. **Should the National Law be amended to empower a National Board to require a practitioner to disclose to their patients/clients the reasons for a chaperone requirement imposed on their registration? What are your**	No. This can be dealt with as a matter of policy rather than under legislation. It is a requirement of AHPRA's current Chaperone

reasons?	Protocol and the NSW Medical Council's Chaperone Compliance Policy that a practitioner disclose to patients in advance the need for a chaperone to be present. See further below under answer to question 34.
34. Should the National Law be amended to provide powers for a National Board to brief chaperones as to the reasons for the chaperone? What are your reasons?	No. This can be dealt with as a matter of policy rather than under legislation.
Chaperones or practice monitors are generally used (pursuant to an undertaking by the practitioner or a condition imposed by a National Board) as an interim measure, pending the outcome of an investigation of sexual misconduct. We disagree with the recommendation in Professor Paterson's report that unless there is a statutory requirement for disclosure, there is a "gaping hole" in the level of protection afforded to patients by chaperone conditions. These issues can be dealt with as a matter of policy. The AHPRA and NSW Medical Council chaperone protocols and policies currently in place deal adequately with disclosure to patients and chaperones.	

Section 5.5.2: Power to give notice to a practitioner's former employer

35. Should the National Law be amended to enable a National Board to obtain details of previous employers and to disclose to a practitioner's previous employer(s) changes to the practitioner's registration status where there is reasonable belief that the practitioner's practice may have exposed people to risk of harm? If not, why? If yes, then why and what timeframe should apply for the exercise of these notice powers?	The consultation paper is not clear on precisely what circumstances this proposed amendment is intending to cover. It is stated that the power would only be exercised where there is a reasonable belief that the health practitioner's health, conduct or performance *may* have exposed patients to harm. This is a broad test with a low threshold. We were informed at one of the stakeholder forums that this was intended to cover situations where a lookback was required for example for an infectious disease or where there are concerns that a practitioner may have misread pathology or radiology. Issues relating to infectious diseases are currently dealt with under public health legislation. This is sufficient and should continue. While the proposed amendment may be appropriate in the limited circumstances noted above, we would be concerned about a general power to provide information to former employers. If the practitioner no longer works at a practice and there is no longer a risk to patients of that practice, then informing a previous employer of a change in registration process can only be punitive and/or a means of encourage patients to make notifications or bring civil claims.

Section 5.6.1: Right of appeal of a caution

36. Should the National Law be amended to enable	Yes. The National Law should be amended to give

a right of appeal against a decision by a National Board to issue a caution?	practitioners the right to appeal against a caution. As noted in the consultation paper, a practitioner's employer is informed that a caution has been issued but currently the practitioner has no right of review or appeal from the decision to issue a caution. Although a caution is the least serious of sanction available to a Board, practitioner regard a caution as punitive, and a caution can have a significant and lasting impact on the practitioner's personal and professional lives and reputation.
37. Which would be your preferred option?	An appeal to a tribunal can be costly and time consuming. A practitioner should have a right of review via an internal review process in the first instance, as well as a the right to appeal to the tribunal.

Section 5.6.2: The rights of review of notifiers

38. Should the National Law be amended to provide a right for a notifier (complainant) to seek a merits review of certain disciplinary decisions of a National Board? What are your reasons?	We are concerned about this proposal, particularly the additional costs that it might be incurred (based on the Victorian experience outlined in the consultation paper),. Costs would be incurred by AHPRA and the Boards in dealing with the review and if the decision of the Board were changed as a result, further costs would be incurred by both the Board and AHPRA in continuing to deal with the matter. The notification process is concerned with ensuring that practitioners are competent to practise and that the public is protected from the risk of harm. Notifiers are key to the process and we agree that they should be engaged and involved, but they are not a party to the action. In our experience, and as recognised in the consultation paper, notifiers often expect an outcome that they cannot get from the process and this may be the reason they complain to the NHOPC. Nevertheless the process appears to work well in NSW in our experience. There may be benefits to the notifier and to AHPRA and the Board if a right of review can be provided in a cost effective way, such as an internal review. It may be appropriate to limit the review to situations where the notifier can point to a clear factual error or relevant information has not been taken into account, rather than disagreement with the outcome.
39. Which would be your preferred option?	See answer to question 38 above.
40. If yes, which decisions should be reviewable and who should hear such appeals, for example, an internal panel convened by AHPRA or the National Health Practitioner Ombudsman and Privacy Commissioner, or some other	See answer to question 38 above.

entity?	

Offences and penalties

Section 6.1: Title protection: surgeons and cosmetic surgeons

41. Should the National Law be amended to restrict the use of the title 'cosmetic surgeon'? If not, why? If so, why and which practitioners should be able to use this title?	No comment.
42. Should the National Law be amended to restrict the use of the title 'surgeon'? if not, why? If so, why and which practitioners should be able to use such titles?	No comment.

Section 6.2: Direct or incite offences

43. Are the current provisions of the National Law sufficient to equip regulators to deal with corporate directors or managers to direct or incite their registered health practitioner employees to practise in ways that would constitute unprofessional conduct or professional misconduct?	No comment
44. Are the penalties sufficient for this type of conduct? Should the penalties be increased to $60,000 for an individual and $120,000 for a body corporate, in line with the increased penalties for other offences?	No comment.
45. Should there be provision in the National Law for a register of people convicted of a 'direct or incite' offence, which would include publishing the names of those convicted of such offences?	No comment.
46. Should the National Law be amended to provide powers to prohibit a person who has been convicted of a 'direct or incite' offence from running a business that provides a specified health service or any health service?	No comment.

Section 6.3.1: Prohibiting testimonials in advertising

47. Is the prohibition on testimonials still needed in the context of the internet and social media? Should it be modified in some way, and if so, in what way? If not, why?	See below under answer to question 48.
48. Which would be your preferred option?	See below under answer to question 48.

General comments

- The increasing use of social media and the internet has fundamentally changed the environment in which the prohibition on testimonials in advertising operates.
- Much of the concern about the prohibition results from the lack of definition of "testimonials" in the National Law. This means that the current prohibition on testimonials is open to interpretation and this causes confusion. It can be difficult to enforce.
- Although AHPRA has provided detailed guidance on the prohibition, it remains a source of confusion and concern. For example, "testimonial" has been interpreted by AHPRA to mean positive comment about clinical issues. However, applying this in practice can be difficult, and it leads to the odd situation where a practitioner can include a positive comment about non-clinical matters such as waiting times, the manner of staff etc but not about the clinical care they provide.
- In our experience, many practitioners continue to be concerned about how the prohibition on testimonials applies in the context of websites over which they have no control, and in the context of responding to negative online comment particularly where the comment raises clinical issues.
- Amending the legislation to confirm that the prohibition on testimonials applies only to websites and social media over which the practitioner has direct control would provide some reassurance to practitioners.
- Option 2 notes that "the prohibition would not apply to testimonials … that are not linked to the practitioner and for which a practitioner has no control of the content". This is confusing. One problem with this is that a practitioner may work for a company that has content on its website that links to the practitioner but over which the practitioner has no control. The wording of option 2 in the consultation paper would suggest that if it is linked to the practitioner in any way (whether or not they have control) then the practitioner is responsible for it.
- Option 2 would appear to codify the status quo as it happens in practice but the drafting of any proposed legislation will need to be carefully considered to ensure that it clarifies the situation rather than further confuses it.
- By contrast, the status quo, where the legislative provisions are supplemented by guidelines and policy may be more flexible and responsive to the constantly changing social media environment.

Section 6.3.2: Penalties for advertising offences

49. Is the monetary penalty for advertising offences set at an appropriate level given other offences under the National Law and community expectations about the seriousness of the offending behaviour?	No comment

Information and privacy

Section 7.1: Information on the public register

50. Is the range of practitioner information and the presentation of this information sufficient for the various user groups?	Yes. The current range of information is sufficient. The register currently records details of reprimands, conditions, undertakings, and suspensions (as required by section 225 of the National Law) that apply to a practitioner. The Medical Board has also decided to include on a practitioner's entry into the register a link to

	relevant tribunal decisions relating to a member where there has been an adverse finding.
51. Should the National Law be amended to expand the type of information recorded on the national registers and specialist registers?	No. See further below answer to question 53.
52. What additional information do you think should be available on the public register? Why?	Not applicable.
53. Do you think details, such as a practitioner's disciplinary history including disciplinary findings of other regulators, bail conditions and criminal charges and convictions, should be recorded on the public register? If not, why not? If so: • **What details should be recorded?** • **What level of information should be accessible?** • **What should be the threshold for publishing disciplinary information and for removing information from a published disciplinary history?**	The purpose of the register is to allow the public and employers to check if a practitioner is qualified and fit to practise in a competent and professional manner. If the regulator is of the view that the practitioner is qualified and fit to practise having taken into account the information it has (including their disciplinary history etc), then adding this information to the register is unfair and beyond the purpose of the register. It is open to misinterpretation. Practitioners are entitled to a presumption of innocence until proven guilty. This is fundamental legal right. Accordingly, it would be unfair to a practitioner for bail conditions and criminal charges to be recorded on the register given the impact that this could have on themselves and their practice. See further below regarding removing information from the register.

General comments

- The need for transparency of information should not be at the expense of fairness to the practitioner. A practitioner has right to privacy and confidentiality, and the right to the presumption of innocence until proven guilty.
- Bail conditions and charges are based on allegations only. As noted in a recent Canadian case in the context of interim conditions, "they have the potential to greatly harm a doctor's reputation and to do so quite unjustly if the underlying allegations are not made out."
- Adverse findings/conditions/undertakings and other disciplinary information should not remain on the register indefinitely. Regulation needs to be proportionate. Once the need for public protection is no longer demonstrable, then leaving the information on the register becomes purely punitive.
- We submit that AHPRA should adopt an approach analogous to the spent convictions legislation that applies to criminal matters. Under this legislation convictions are expunged from a person's criminal record after a period of 10 years (assuming there have been no other offences during that time). The aim of spent convictions legislation is to prevent discrimination, by limiting the use and disclosure of older, less serious convictions and findings of guilt.
- If people with criminal convictions are permitted to get on with their lives without the stigma attached to a criminal conviction, practitioners subject to disciplinary action should be entitled to benefit of a similar approach.
- Information should only remain on the register for as long as the information is current. Thus if a practitioner has a condition on their practice or has given an undertaking, if once that condition or undertaking expires and

is no longer required, then it should be removed from the register. This is currently the practice of AHPRA and the National Boards and it should remain. • In Australia, reprimands are removed after five years as long as there have been no other relevant events. In Ontario, information may be withheld from the register after six years (see clause 23(11) of the *Health Professions Procedural Code*). We suggest that a similar timeframe of five or six years would be appropriate to adopt in Australia. • Details about impairment and health-related conditions and undertakings should not be published on the register, as per the status quo, to protect the privacy of the practitioner.	
54. Should s. 226 of the National Law be amended to: • **broaden the grounds for an application to suppress information beyond serious risk to the health or safety of the registered practitioner?** • **require or empower a National Board to remove from the public register the employment details (principal place of practice) of a practitioner in cases of domestic and family violence?** • **enable National Boards not to record information on, or remove information from, the public register where a party other than the registered health practitioner may be adversely affected?**	Yes. We agree that the current powers under section 226 are too narrow and that section 226 should be amended as proposed, for the reasons outlined in the consultation paper.

Section 7.2: Use of aliases by registered practitioners

55. Should the National Law be amended to provide AHPRA with the power to record on the public registers additional names or aliases under which a practitioner offers regulated health services to the public?	Yes.
56. Should the public registers be searchable by alias names?	Yes.
57. Should the National Law be amended to require a practitioner to advise AHPRA of any aliases that they use?	Yes.
58. If aliases are to be recorded on the register, should there be provision for a practitioner to request the removal or suppression of an alias from the public register? If so, what reasons could the board consider for an alias to be removed from or suppressed on the public register?	Yes – where there are privacy or security concerns for the practitioner including where there is a serious risk to the health or safety of the registered practitioner or a member or members of their family (as per question 54 above).
59. Should there be a power to record an alias on the public register without a practitioner's	No comment

consent if AHPRA becomes aware by any means that the practitioner is using another name and it is considered in the public interest for this information to be published?	

Section 7.3: Power to disclose identifying information about unregistered practitioners to employers

60. Should the National Law be amended to enable a National Board/AHPRA to disclose information to an unregistered person's employer if, on investigation, a risk to public safety is identified? What are your reasons?	No comment

Other comments

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31 October 2018