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23 July 2009

Senator Moore
Chair
Senate Standing Committee on Community Affairs
PO Box 5100
Parliament House
CANBERRA ACT 2600

Dear Senator Moore

Thank you for providing the Medical Indemnity Industry Association of Australia (MIIAA) with the opportunity to provide evidence to the Inquiry into the National Registration and Accreditation Scheme for Doctors and other Health Workers. During our evidence we undertook to provide some additional information to the Committee. We have now undertaken the necessary consultations, and provide the following information to assist the Committee.

1. Inquiry level to peer support programmes

We were asked to provide information on the contact made by medical practitioners to groups such as the Doctors' Health Advisory Service. We have consulted the NSW and Victorian Services who have advised us:

1. The Victorian Doctors Health Programme supports, monitors progress, gets reports from treating specialists and assists doctors in their return to work where appropriate. In the past 12 months this service:
   a. Has received approximately 16 telephone calls per month, or 190 for the year
   b. Noted that approximately two-thirds of all telephone contacts resulted in face to face consultations where the service's clinical staff performed assessments to determine the most appropriate response to their problems. The Service does not treat the doctors, but rather refers them to appropriate specialists.
   c. Undertook 10 face to face assessments per month. Since 2005 they have seen in excess of 100 new face to face contacts per year.
   d. Believes that there would be approximately 25 follow up visits per month for ongoing participants in the programme.
   e. Doctors who present to the Service are supported to get a GP and referred to specialist counselling and medical treatment services selected from a panel of specialists chosen for their expertise.

2. Approximately 120-150 doctors contact the NSW service for assistance each year.

Each support programme operates in a different way, but the initial contact is always via telephone.

As we indicated in our evidence, we believe that the Doctors' Health Advisory Service (by whatever title it has in each State) fulfils an important role in providing advice and assistance to doctors. We believe that the services should be exempted from mandatory reporting because of the important confidential clinical role they play in referring doctors in need for assistance.

2. Number of claims made and policies written

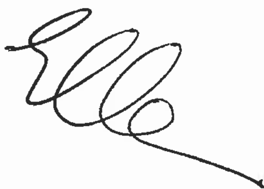
Information on the number of medical indemnity policies written is not publicly available due to the competitive nature of the industry. The Department of Health and Ageing may be in a position to provide you with information on policies written by virtue of the reporting which each insurer must provide to the Department. Paul Currall at the Department would be in a position to provide this information to the Committee we believe.

The ACCC Medical Indemnity Insurance Report – Sixth Monitoring Report reported that in 2006-2007 the ultimate number of claims was 2561.

3. Conclusion

The MIIAA would be happy to address any other issues upon which the Committee may require advice as it considers the range of matters raised at the Inquiry. We have also attached to this letter our supplementary submissions on Bill B which reflect our submissions to the NRAIP on the Bill.

Yours sincerely



Ellen Edmonds-Wilson
Chief Executive Officer

NATIONAL REGISTRATION AND ACCREDITATION SCHEME FOR DOCTORS AND OTHER HEALTH WORKERS

MIIAA SUBMISSIONS ON THE EXPOSURE DRAFT OF THE HEALTH PRACTITIONER REGULATION NATIONAL LAW 2009 TO THE SENATE COMMUNITY AFFAIRS COMMITTEE

23 July 2009

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HEALTH PRACTITIONER REGULATION NATIONAL LAW

Submissions of the Medical Indemnity Industry Association of Australia

INTRODUCTION

The Medical Indemnity Industry Association of Australia (MIIAA) is the peak body for the Australian Medical Indemnity Industry. The members of the MIIAA include Australian based medical indemnity insurers and medical defence organisations. Members of the MIIAA represent about 75 per cent of insured medical practitioners in Australia.

MIIAA has attended both National and State Forums on the Health Practitioner Regulation National Law (National Law Bill), and has informed itself of the issues surrounding the National Law Bill.

It makes these submissions which are directed to specific issues which affect the way in which the operations of its members are conducted. These submissions are in response to the letter from the Committee Secretary dated 18 June 2009 inviting us to provide additional comments on issues of concern arising from the release of the exposure draft of the National Law Bill.

1. MANDATORY REPORTING

Division 3 of Part 8 of the National Law Bill and in particular, Clause 156 provides, subject to identified exceptions, for mandatory reporting of *reportable conduct* as that term is defined in Clause 6.

MIIAA makes submissions about two aspects of the mandatory reporting requirement, namely the definition of *reportable conduct* and the wording of the exceptions to Clause 156.

In making these submissions, MIIAA makes clear that it accepts that the principle of mandatory reporting is an appropriate one which has regard to the necessity to place a high emphasis on the protection of the public when considering the practise of health practitioners.

Definition of *reportable conduct*

The purpose of protecting the public would not be capable of being given effect to, if the mandatory reporting scheme were to result in an overwhelming number of reports, the great majority of which would not need to be acted upon for the purpose of public protection.

The current definition in sub-clause (d), attempts to restrict the reports to those which are appropriate by using the term "substantial harm". The definition is in these terms:

> *Reportable conduct, in relation to a registered health practitioner, means the health practitioner has:*
>
> ...
>
> *(d) placed the public at risk of substantial harm because the health practitioner has practised the profession in a way that constitutes a departure from accepted professional standards*

As expressed, every breach from accepted professional standards must be reported where there is a risk of substantial harm. The principal difficulty with this definition is that the phrase *accepted professional standards,* whilst an entirely appropriate one, describes a concept which is itself often the subject of debate and uncertainty because of the nature of legitimate variations in professional practice, and the fact that professional practice does and will change over time.

If reports are mandated of every departure from those standards, no matter how minor, then reports will be made of matters where the departure is debateable because it reflects a legitimate variation in practice.

MIIAA submits that the purpose of the provisions would be better met if the definition were to be further clarified by requiring reporting only of significant departures from acceptable professional practice, so as to avoid any prospect of an over reporting occurring because of legitimate differences in practice.

An amended definition by adding the words highlighted would achieve this purpose:

Reportable conduct, in relation to a registered health practitioner, means the health practitioner has:

...

(d) placed the public at risk of substantial harm because the health practitioner has practised the profession in a way that constitutes a departure, to a significant extent, from accepted professional standards

Clause 156

This clause fixes the obligation upon a registered health practitioner to report the defined conduct.

Sub-clause (4) provides for exemptions from the reporting obligation. MIIAA is concerned that the precise terms of these exemptions do not achieve their purpose. There are two reasons for this.

The first is that, in the course of the business of a professional indemnity insurer, reportable conduct may come to the attention of a health practitioner engaged in the affairs of an insurer who is not an employee of the insurer. By way of example, medical indemnity insurers, regularly constitute case committees (or claims committees) which consist of medical or other health practitioners, and which consider the approach which the insurer should take to particular claims. It is of the essence that these committees have available all of the facts upon which to undertake their consideration. As well, in the course of the administration of the affairs of an indemnity insurer, the board of directors, may come to learn, when considering the risks to the organisation arising from particular claims, of reportable conduct. The members of committees and directors are not employees, but are engaged in the business of the insurer. There is no reason in principle to differentiate their position from that of an employee of the insurer.

The second is that the concentration upon the terms legal proceedings and provision of legal advice are apt to create confusion and an unnecessarily artificial internal division about the circumstances in which an insured makes a notification to an insurer.

Some relative minor wording changes can be made to Sub-clause (4) which will have the effect of addressing the concerns described above. An amended definition by substituting the words highlighted, or deleting those marked, would achieve this result:

(4) Subsection (2) does not apply if:

(a) the first health practitioner:

(i) is engaged in the business of an insurer that provides indemnity insurance that relates to the second health practitioner, and

(ii) forms the belief the second health practitioner has behaved in a way that constitutes reportable conduct as a result of a disclosure made by a person to the first health

practitioner ~~in the course of a legal proceeding or the provision of legal advice~~ arising from, or in connection with, the insurance policy, or

(b) *the first health practitioner forms the reasonable belief in the course of providing advice, or expressing an opinion, in which the reportable conduct is an issue for the purposes of a legal proceeding or the preparation of legal advice, or*

(c) *the first health practitioner is a legal practitioner and forms the reasonable belief in the course of providing legal services to the second health practitioner ~~in relation to a legal proceeding or the preparation of legal advice~~ in which the reportable conduct is an issue.*

As can be seen, the change in Clause 4(a)(i) is sufficient to cover those providing services on claims committees or as directors. The other changes seek to ensure that a disclosure made by a health practitioner to the insurer for the purposes of the indemnity policy (such as on an annual renewal form), or the services provided by the indemnity insurer (such as risk management advice) is exempted from mandatory reporting.

The MIIAA submits that exemptions should also be provided for health practitioner spouses, treating doctors and other professional services, such as Health Advisory Services, College performance support and assistance programmes and peer review processes.

2. INDEMNITY INSURANCE

The MIIAA has concerns about the provisions of the National Law Bill which deal with indemnity insurance. These provisions are to be found in Division 1 of Part 7 of the National Law Bill.

MIIAA accepts that it is appropriate for an assessment to be made for the purposes of the registration of a health practitioner as to the identity of the insurer providing indemnity cover and the adequacy of an indemnity policy. However the current wording of Clause 73 permits the creation of inconsistency between the scheme created by the National Law Bill and the existing statutory scheme for medical indemnity insurers which is created by the provisions of the Medical Indemnity (Prudential Supervision and Product Standards) Act 2003 (MI (PS & PS) Act).

Division 1 of Part 2 of the MI (PS & PS) Act makes provision with respect to the prudential arrangements which are appropriate for a medical indemnity insurer. Section 28 gives the administration (and, thereby, the effective supervision of compliance) of these requirements to the Australian Prudential Regulatory Authority (APRA), a specialist body with expertise to deal with these matters.

Part 3 deals with the minimum standards appropriate for insurance cover. Section 30 of the MI (PS & PS) Act gives the administration of Part 3 of the act to the Australian Securities and Investment Commission (ASIC).

Both of these bodies in the exercise of these functions are subject to Ministerial direction.

If the existing clause 73 remains in the National Law Bill, then there is no necessity for a National Board for a health profession to make a determination which is consistent with a determination made under the MI (PS & PS) Act, so far as an insurer offers medical indemnity insurance. Equally, there is no reason to require a dual compliance and supervisory scheme where one already exists. Clearly, additional and unnecessary costs and expenses, and potential for inconsistency and confusion ought to be avoided.

MIIAA submits that the better way to approach these requirements, particularly having regard to the complexities of uniform Australia-wide legislation requiring state and territory

legislatures to agree on like amendments to the National Law Bill once enacted, is for the necessary requirements for mandatory professional indemnity insurance to be contained within Regulations which are made pursuant to the Regulation making power in clause 285 of the Bill.

Those regulations ought deem as acceptable for the purposes of the National Law Bill, any professional indemnity insurance arrangement which complies with the provisions (from time to time) of the MI (PS & PS) Act. As well, the regulations ought deem as acceptable for the purposes of the National Law Bill, the various State based indemnity schemes which operate for the benefit of health practitioners working in the public health systems of the States.

As well, MIIAA submits that the National Boards are not the most appropriate bodies to undertake the oversight of, and supervision of, indemnity insurers where specialist Commonwealth bodies already exist for that purpose. The appropriate supervisory bodies are APRA and ASIC as provided for in the MI (PS & PS) Act. Having a number of different National Boards exercising supervision over the professional indemnity insurance arrangements also carries with it a risk of inconsistency between the National bodies which would add significantly to compliance costs for an insurer offering cover to more than one health profession.

The proposal of the MIIAA could be implemented by a minor change to the existing Clause 73 (1)(b) of the National Law Bill, so that it reads:

(1) Professional indemnity insurance arrangements in force in relation to an individual are appropriate for the purposes of registering the individual in a health profession only if:
(a) the arrangements will not expire before the end of the individual's period of registration, and
(b) the arrangements comply with the Regulation.

The MIIAA would be happy to assist in the discussion of, and the development of, a Regulation which would be appropriate in the circumstances, having regard to the needs of the various health professions, the nature and extent of existing indemnity insurance arrangements, the existing State and Territory based schemes and the commercial practicalities of ensuring viable and effective indemnity insurance cover.

3. COMPLAINTS, PERFORMANCE, HEALTH AND CONDUCT

The Ministers saw as key factors in the further development of a new registration scheme:

- Assurance that public protection is paramount;
- Maintenance of a high degree of transparency; and
- That the scheme be appropriately accountable.

It is accepted that professional regulation is focused on public protection. Due process requires checks and balances. It is vital that appropriate rights of review and appeal mechanisms exist. There should also be appropriate distinction between the investigative body and the decision maker. We believe that the proposed processes lack these checks and balances.

Whatever pathway is taken, whether it is through disciplinary, performance or health, the individual health practitioner needs to be protected appropriately. Protection in this context does not imply protection from appropriate accountability. Rather it involves protection from:

- Unfair process:
- Denial of natural justice;
- Trial by media; and
- Scapegoating.

The protection of the individual can only occur if there is a clear differentiation between the different pathways within the complaints section that is Part 8 of Bill B.

It is internationally recognised that there is a distinction between misconduct and poor performance. Medical Boards look at elements such as reckless practice, unethical, wilful or criminal behaviour for misconduct. In contrast the performance pathway is there to encourage an underperforming doctor to reach the appropriate standards of clinical performance. In the proposed national law, performance seems to be regarded as a less serious form of misconduct. This appears to be a backward step in modern regulatory reform.

Health

MIIAA submits that health/ impairment should not be seen as part of the disciplinary pathway but a separate pathway. The health program should deal with impaired practitioners in a constructive, non-disciplinary manner. The aim is to ensure the practitioner's fitness to practice and is designed to protect the public while maintaining impaired doctors in practice through rehabilitation and recovery. MIIAA submits that the health pathway must be strictly independent of the conduct and performance pathways. If there are conduct or performance issues, the matter should be referred back through the separate pathways.

The MIIAA submits that the definition of disciplinary body should be amended as follows:

disciplinary body *means:*
(a) a professional standards panel, or
~~*(b) a health panel, or*~~
(c) a responsible tribunal, or
(d) a Court, or
(e) a health complaints entity.

The MIIAA submits that Clauses 203-208 simply represent an alternative conduct pathway and do not address the intention behind a health program to provide structured support to the health practitioner.

Professional Misconduct and Unprofessional Conduct

MIIAA submits that professional misconduct and unprofessional conduct should represent significant departures from acceptable standards of conduct and not reference to a mere act of negligence. The difficulty with the proposed legislation is there has been a movement away from the language of professional discipline and has adopted in part terminology relevant to civil liability, blurring the boundaries between two legal processes.

The MIIAA submits that the definitions should be amended as follows:

professional misconduct*, of a registered health practitioner, includes:*

(a) *unprofessional conduct* ~~*by the practitioner that amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience, and*~~ *of a sufficiently serious nature to justify suspension of the practitioner from practising or the removal of the practitioner's name from the register, and*

(b) *more than one instance of unprofessional conduct that, when considered together, amounts to conduct* ~~*that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience, and*~~ *of*

a sufficiently serious nature to justify suspension of the practitioner from practising or the removal of the practitioner's name from the register, and

(c) *conduct of the practitioner, whether occurring in connection with the practice of the health practitioner's profession or not, that is inconsistent with the practitioner being a suitable person to practise the profession.*

unprofessional conduct*, of a health practitioner,* ~~*means professional conduct that is of a lesser standard than that which might reasonably be expected of the health practitioner by the public or the practitioner's professional peers, and*~~ *includes the following:*

(aa) *professional conduct that is of a significantly lower standard than that which might reasonably be expected of the practitioner by the practitioner's peers;*

(a) *a contravention by the practitioner of this Law, whether or not the practitioner has been prosecuted for, or convicted of, an offence in relation to the contravention, and*

(b) *a contravention by the practitioner of:*

(i) *a condition to which the practitioner's registration was subject, or*

(ii) *an undertaking given by the practitioner to the National Board that registers the practitioner, and*

(c) *the conviction of the practitioner for an offence under another Act, the nature of which may affect the practitioner's suitability to continue to practise the profession, and*

(d) *providing a person with health services of a kind that are excessive, unnecessary or otherwise not reasonably required for the person's well-being, and*

(e) *influencing, or attempting to influence, the conduct of another registered health practitioner in a way that may compromise patient care, and*

(f) *accepting a benefit as inducement, consideration or reward for referring another person to a health service provider or recommending another person use or consult with a health service provider, and*

(g) *offering or giving a person a benefit, consideration or reward in return for the person referring another person to the practitioner or recommending to another person that the person use a health service provided by the practitioner, and*

(h) *referring a person to, or recommending that a person use or consult, another health service provider, health service or health product if the practitioner has a pecuniary interest in giving that referral or recommendation, unless the practitioner discloses the nature of that interest to the person before or at the time of giving the referral or recommendation, and*

(i) *unsatisfactory professional performance that, or more than one instance of unsatisfactory professional performance that when the instances are considered together, demonstrates that the knowledge, skill or judgment possessed, or care exercised by, the practitioner in the practice of the health profession is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.*

Complaints

MIIAA submits that if a complaint is to be made verbally the complainant must follow up the verbal complaint in writing for the complaint to be acted upon. This avoids the danger of a complaint being investigated on the basis of a single telephone attendance note of someone's version of events. MIIAA submits the following amendment:

Clause 153 How complaint is made

(1) *A complaint may be made to the National Agency:*

(a) *verbally, including by telephone, or*

(b) in writing, including by email or other electronic means.

~~(2) A complaint must include particulars of the ground on which it is founded.~~

(2) *If the complaint is verbal it must as soon as practicable be put in writing and include particulars of the complaint.*

MIIAA submits that giving a copy of the actual complaint to the health practitioner will allow the practitioner or student to respond to the complaint more effectively, rather than relying on facts and issues furnished by someone's version of the complaint. The following amendments should be made:

Clause 160 National Board to give notice of receipt of complaint

(1) A National Board must, within 28 days after receiving a complaint about a registered health practitioner or student, give written notice of the complaint and a copy of the complaint to the practitioner or student.

(2) The notice must advise the registered health practitioner or student of the nature of the complaint.

(3) Despite subsection (1), the National Board is not required to give the registered health practitioner or student notice of the complaint and a copy of the complaint if the Board reasonably believes doing so would:

(a) prejudice an investigation of the complaint, or

(b) place at risk a person's health or safety or place a person at risk of intimidation or harassment.

In relation to Clause 165 (4), MIIAA submits that the description 'from most serious to least serious' is not clear if the health complaints entity has investigative powers of its own.

MIIAA submits that effective allocation of resources requires that complaints which are more appropriately dealt with by other means or bodies such as Medicare Australia should be referred to the appropriate body. The following addition should be made:

Clause 167 Rejection of complaint

(1) A National Board may decide to reject a complaint it receives if:

(a) the Board reasonably believes the complaint is frivolous, vexatious, misconceived or lacking in substance, or

(b) given the amount of time that has elapsed since the matter complained of happened, it is not practicable for the Board to investigate or otherwise deal with the complaint, or

(c) the person to whom the complaint relates has not been, or is no longer, registered by the Board and it is not in the public interest for the Board to investigate or otherwise deal with the complaint~~.~~, or

(d) there is satisfactory alternative means of dealing with the matter by the complainant

Suspension

MIIAA submits that the Board should only have powers to suspend a practitioner immediately, and in the absence of a hearing, if the practitioner's continued practising poses a grave and imminent risk of harm to either the practitioner or another person or in prescribed circumstances. In all other circumstances, the practitioner should be afforded an expedited hearing before the Board. Furthermore, it should be required that the Board take the action which in the circumstances is the least onerous action necessary to protect the public. This would mean that where conditions can be imposed it would be preferable to do so rather than suspending the practitioner.

MIIAA submits behaviour constituting unsatisfactory professional performance would not meet the threshold required for immediate suspension. This is another example of blurring the pathways.

Clause 168 Immediate suspension or imposition of condition

(1) This section applies if a National Board reasonably believes that:

(a) a registered health practitioner or student poses a serious risk to persons because the practitioner or student has, or may have, behaved in a way that constitutes ~~unsatisfactory professional performance~~, unprofessional conduct or professional misconduct, and

(b) immediate action is necessary to protect public health or safety.

In relation to Clause 170, MIIAA submits that it is inappropriate that a matter could be referred directly to a tribunal on the basis of a preliminary assessment without an appropriate investigation.

MIIAA submits that the tribunal may consider the finding of unprofessional conduct sufficient without any additional orders.

MIIAA submits that Clause 173 should be amended as follows:

Clause 173 Action that may be taken by tribunal

(1) If the responsible tribunal makes a decision referred to in section 172(a) to (d) in relation to a health practitioner it ~~must~~ may:

(a) require the practitioner to undergo counselling, or

(b) caution the practitioner, or

(c) reprimand the practitioner, or

(d) impose a condition on the practitioner's registration, including, for example:

(i) a condition requiring the practitioner to complete specified further education or training within a specified period, or

(ii) a condition requiring the practitioner to undertake a specified period of supervised practice, or

(iii) a condition requiring the practitioner to do, or refrain from doing, something in connection with the practitioner's practice, or

(iv) a condition requiring the practitioner to manage the practitioner's practice in a specified way, or

(v) a condition requiring the practitioner to report to a specified person at specified times abut the practitioner's practice, or

(vi) a condition requiring the practitioner not to employ, engage or recommend a specified person, or class of persons, or

(e) require the practitioner to pay a fine of not more than $30,000 to the National Board that registers the practitioner, or

(f) suspend the practitioner's registration for a specified period, or

(g) cancel the practitioner's registration.

(2) If the responsible tribunal decides to impose a condition on the practitioner's registration under subsection (1)(d), the tribunal must also decide a review period for the condition.

(3) If the tribunal decides to cancel a practitioner's registration under subsection (1)(g), the tribunal may also decide to:

(a) disqualify the practitioner from applying for registration for a specified period, or

(b) *prohibit the practitioner from using a specified title or providing a specified health service.*

MIIAA submits that two assessors be appointed to avoid the perception of bias and Clause 175 should be amended as noted below:

Clause 175 Appointment of assessor to carry out assessment

(1) *If the National Board requires the registered health practitioner to undergo a performance assessment, the Board must appoint ~~an~~ two assessors to carry out the assessment.*
(2) *The assessors must be registered health practitioners who are members of the health profession for which the National Board is established but are not members of the Board.*
(3) *The assessors' fee for carrying out the performance assessment is to be paid by the National Board.*

With regard to Clauses 175-179, the MIIAA is concerned that it appears that, on the basis of one report and a discussion with the health practitioner, a practitioner can be found guilty of unprofessional conduct and be subject to sanctions without any formal right of reply or possible hearing.

MIIAA submits that if a matter has been properly heard before a professional standards panel then it would be inappropriate for the matter to be referred to the National Board for investigation and the following amendment should be made:

Clause 190 Action by professional standards panel at end of proceeding

(1) *If a professional standards panel makes a decision referred to in section 189, the Board must decide:*
 (a) *for a decision referred to in section 189(1)(a) or (b):*
  (i) *to require the practitioner to undertake further education or supervised practice, or*
  (ii) *to counsel the practitioner or refer the practitioner to another person for counselling, or*
  (iii) *to approve an undertaking given by the practitioner to the National Board that established the panel, or*
  (iv) *to impose a condition on the practitioner's registration, or*
  (v) *to refer the practitioner to the National Board for a health assessment, or*
  ~~(vi) to refer the matter to the National Board for investigation, or~~
  (vii) *to refer the matter, or part of the matter, to the responsible health complaints entity, or*
  (viii) *to refer the matter to another entity for investigation, or.*

Division 12 Miscellaneous
Subdivision 2 Review of conditions and undertakings

Clause 141 Removal of condition or revocation of undertaking

(1) *This section applies if a National Board reasonably believes:*
 (a) *that a condition imposed on the registration of a registered health practitioner or student registered by the Board is no longer necessary, or*
 (b) *that an undertaking given to the Board by a health practitioner or student registered by the Board is no longer necessary.*

(2)	*The National Board may decide to remove the condition or revoke the undertaking.*
(3)	~~*However, the condition or undertaking may not be removed or revoked during a review period applying to the condition or undertaking.*~~
(4)	*As soon as practicable after making the decision the National Board must give notice of the decision to the registered health practitioner or student.*
(5)	*The decision takes effect on the date stated in the notice.*

Comment:

MIIAA submits that there is no necessity in these circumstances to wait for the review period to expire.

Should you have any queries in relation to this submission contact should be made with:

Ms Ellen Edmonds-Wilson
Chief Executive Officer
MIIAA

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