VICTORIA

NATIONAL REGISTRATION AND ACCREDITATION SCHEME FOR THE HEALTH PROFESSIONS

Attention: Practitioner Regulation Subcommittee

ADAVB COMMENTARY ON CONSULTATION PAPER RE

Proposed arrangements for handling complaints, and dealing with performance, health and conduct matters

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EXECUTIVE SUMMARY

The Victorian Branch of the Australian Dental Association (ADAVB) supports the key objectives and most of the proposals regarding complaints arrangements under the new National Registration Scheme. Our key concerns and suggestions are:

- Notifiers should not be treated as if they are parties to disciplinary proceedings. This system is about regulating professional standards, not providing a consumer court. Notifiers should not have a right of review where a board or its committee determines no case to answer.
- Panels need 50% of their members to be drawn from the same class and division of the register as the practitioner involved. Most allegations require clinical insight to know whether professional standards have not been met.
- We don't believe the three streams (performance, health and conduct) will be easily separated and most cases will involve at least two streams.
- Unsatisfactory professional performance (as grounds for a charge of unsatisfactory professional conduct) must not arise from mere treatment failure, which can be due to causes other than the health practitioner's care and skill.
- To ensure that the system is credible to health professionals, procedural fairness must be evident.
- The link between this reform and the quality and safety agenda is most noteworthy, especially with the Open Disclosure Standard emphasis on moving away from a culture of blaming individuals for adverse events.
- Health funds should not be treated as consumer representatives if they seek to notify a matter. They are usually large corporations seeking to exert commercial control over the market.
- Negative licensing similar to that used in NSW should be considered to deal with unregistered practitioners and with registered persons practicing outside their registered field.
- Mandatory reporting should be restricted to treating practitioners, otherwise associations would be unable to assist many members in need.
- Suspension without hearing for more than three months would be unjust.
- Those involved in health management and assessment must be bound to strict confidentiality or suffer significant penalties for breaches of this.
- A single national health program should be instituted for all registered health practitioners, arranged by the national agency.
- Investigators must be registered in the field they are investigating where clinical judgments are required e.g. infection control, records, drugs and poisons.
- No hearings should be conducted without investigations having been completed.
- Investigators must not make unannounced raids that could affect a practitioner's reputation and livelihood. They should make appointments so that the inspection time does not inconvenience patients.
- Advertising restrictions should be enshrined in the legislation to avoid creating unreasonable expectation of beneficial outcomes.

PREAMBLE

The Australian Dental Association Victorian Branch Inc (ADAVB) welcomes the opportunity to comment on the proposed Complaint Arrangements. ADAVB is the professional association representing both public and private sector dentists in Victoria. The Branch has more than 2800 members which represent over 90% of practising dentists in Victoria.

Ordinarily, when national matters are under consideration, the ADAVB defers to the Federal ADA to make the relevant submission. In this case, because the issues relating to complaint systems vary across jurisdictions, we take this opportunity to provide a separate submission from the perspective of our experience in Victoria. This should not be read as implying that we have taken a parochial view, but rather that the proposals for new national systems can be usefully informed by insights gained in State jurisdictions.

The ADAVB has a Corporate Authorised Representative Agreement with Guild Insurance Limited (GIL) for the administration of a dento-legal insurance scheme for members who choose to use GIL as their professional indemnity insurer (PII). The ADAVB / GIL arrangement provides PI cover for 2227 dentists and 71 dental hygienists, and so is the major provider of dental PII in Victoria.

The ADAVB has conducted similar PI arrangements with a preferred provider of dento-legal cover for around 50 years, having worked in partnership with Lloyds of London, the VACC, the Medical Protection Society (Dental Protection Ltd), and since 2000 with GIL.

Part of our system for dealing with dental consumer issues is a Community Relations function staffed by four senior dentists, who are rostered (each on a part-time basis) to be available to assist dental consumers with their enquiries or complaints. Staff are assigned to assist dental consumers with enquiries and complaints, with a conciliation service offered to seek resolution of disputes between members and their patients.

Information about this service is published on the ADAVB's website (http://www.adavb.net/DentalConsumerHelpline/tabid/609/language/en-AU/Default.aspx)

In addition to the Dental Consumer Helpline and Community Relations Function, where members with GIL cover are subject to a claim or a formal hearing by a court or tribunal, and the matter is covered by the GIL Policy, the ADAVB Defence Committee provides clinical advice to the solicitors engaged by GIL to provide legal representation to the member.

In the light of the ADAVB's extensive experience with and insight into dental consumer affairs and dento-legal arrangements, we therefore suggest we are well qualified to make a contribution to the present consultation.

1. Background

We offer no comment on sections 1.1 – 1.4 of the consultation paper.

1.5 Principles

These principles are supported, although presumably part d. intends to refer to internationally accepted standards. We interpret the focus on public safety and dealing effectively with complaints to refer to complaints about professional performance, conduct and health issues rather than consumer issues, which should be dealt with by other means. Further comment on this matter is provided below.

One aspect of concern is the complexity of the proposed structure and the extent to which this may impact upon the timeliness of complaints handling, with consequent potential for negative impact on both practitioners and the community they serve. While we note comment about deadlines for receipt of advice following hearings, we do not see reference to reasonable timeframes for cases being brought to hearing.

2. Proposed terminology

Proposal 2.1

The ADAVB has been concerned that some proposals have advocated use of the registration boards and their processes as a form of ***consumer complaint tribunal***. Matters regarding fees and expectations rightly belong with Health Services or Complaints Commissions rather than with bodies charged with protecting public health and safety and standards of health care.

The paper suggests that "*If the term 'notification' is adopted, then a definition will be required in the legislation to make clear that it encompasses consumer complaints. Using the term 'notification' for the purposes of legislation does not preclude the Agency and the boards from using every day language in their dealings with consumers, for example, having information on the website for consumers on 'how to make a complaint'.* Any such advice should make it clear that complaints about professional standards are not cases involving adversaries, but rather involve standards bodies assessing whether a standard has been breached.

The ADAVB supports the use of the terms 'notification' and 'notifier' in preference to 'complaint' and 'complainant', as this more accurately conveys the message that the Board is obliged to assess the behaviour of a practitioner against objective standards rather than against the views and judgments of an aggrieved party to what may be a commercial dispute. We therefore argue that the information published about these new arrangements should ***NOT*** make it clear that it

encompasses consumer complaints. Complaints about commercial issues will be referred to Health Complaints Commissioners or their equivalent.

The Boards are not accountable to notifiers for resolution of their complaint as if they are parties to a commercial dispute. This is not well understood by some members of the public , and if the appropriate expectations are not established in the community at large, then disappointment and anger are likely to result. The so-called 'complaints management system' would be better described as 'professional standards management system' as the use of the term 'complaints' suggests to consumers that they are lodging a consumer affairs issue with a regulator who can offer them redress, which the registration boards cannot and should not do.

It is important that the description of the processes and systems being established make it clear to the community and the media that the registration boards are not consumer courts and that notifiers are not parties to a dispute, but rather are drawing the attention of the Board to a possible professional misconduct or unprofessional conduct.

For all of the above reasons, we also support the name of the relevant committee being the 'Notifications Assessment Committee'.

Proposal 2.1.15

The options offered need to be more clearly defined, perhaps by reference to the Australian Citzenship Act (2007) or the Therapeutic Goods Act (1989).

The Australian Citizenship Act assesses **good character** by:

- establishing whether or not an applicant has a criminal record, and the nature of that record, if any;
- establishing whether or not there is other information relevant to the issue of character;
- according procedural fairness to the applicant where there is credible, relevant, and adverse information which the decision maker intends to take into account; and
- considering the full circumstances relating to the relevant matters, including any comments by the applicant, character references, and other evidence of the applicant's behaviour.

Similar expectations should be clearly established with statutory guidance for officials determining such potentially subjective matters in relation to registration of health professionals. One legislative precedent in the health area which may be useful is provided in the Therapeutic Goods Act.

In deciding whether a person is a **fit and proper person** within the terms of the Therapeutic Goods Act , the Secretary must have regard to a wide range of matters as follows:

"(4) Without limiting the matters to which the Secretary may have regard in considering whether the applicant or person is a fit and proper person for the purposes of paragraph (3)(a), (b) or (c), the Secretary must have regard to:
(a) any suspension or revocation of a conformity assessment certificate issued to:
(i) the applicant or person; or
(ii) another person who controls the applicant or person (whether directly, or indirectly through one or more interposed entities); or
(iii) another person whom the applicant or person controlled (whether directly, or indirectly through one or more interposed entities) at the time of the suspension or revocation; or
(b) any conviction, for an offence against a law of the Commonwealth or a law of a State or Territory, against:
(i) the applicant or person; or
(ii) another person who controls the applicant or person (whether directly, or indirectly through one or more interposed entities); or
(iii) another person whom the applicant or person controlled (whether directly, or indirectly through one or more interposed entities) at the time the offence was committed or the time of the conviction; or
(ba) an order requiring any of the following persons to pay a pecuniary penalty for the contravention of a civil penalty provision:
(i) the applicant or person;
(ii) another person who controls the applicant or person (whether directly, or indirectly through one or more interposed entities);
(iii) another person whom the applicant or person controlled (whether directly, or indirectly through one or more interposed entities) at the time the civil penalty provision was contravened or at the time of the order; or
(c) any failure to comply with a condition of a conformity assessment certificate by:
(i) the applicant or person; or
(ii) another person who controls the applicant or person (whether directly, or indirectly through one or more interposed entities); or
(iii) another person whom the applicant or person controlled (whether directly, or indirectly through one or more interposed entities) at the time of the failure."

3. Overview of proposed system

3.1 Background

The three streams suggested (performance, health and conduct) are appropriate, as they deal with professional matters rather than commercial or consumer affairs issues. There are established and satisfactory alternative mechanisms available to consumers seeking remedy for a commercial dispute, and such matters do not belong on the agenda for the new professional standards bodies.

The suggestion that the system has a secondary objective of maintaining "public confidence in the health system as a whole" through "resolving patient grievances in a manner that is satisfactory to those patients" is of concern (see page 10 of the

consultation paper). Not only are consumer disputes inappropriate to be dealt with by the professional registration boards, but it must be recognised that there are a number of people who are unreasonable), some who suffer mental health issues, and others who will never be satisfied with the range of sanctions or responses available to professional disciplinary structures.

Encouraging consumers to think that the boards will be providing them with a dispute resolution service when they are not designed to do so, will lead to a lack of public confidence in the processes. As people can get angry when their expectations are not met, it is vitally important that appropriate expectations are established for the new structures from the outset.

We note that the consultation paper expects that matters will be assigned to one or more of the three streams. We suggest that in reality the lines between the three streams will frequently be blurred. Having conducted a dento-legal scheme for our members for many years, our experience is that most cases involve at least two of the three streams, and some encompass all three.

It will be important to avoid confusion, especially where the matter involves a person who may be impaired. In these circumstances, the practitioner should be entitled to confidentiality and sensitive treatment by the system. Existing legislation provides for this, and we understand that it is intended similar measures will be maintained under the new structures. It would be a retrograde step to establish a system in which a great deal of time and energy had to be expended on procedural questions as to which stream a case belonged in. If this were to happen, it could create lengthy delays. The new arrangements should avoid the allegation that delays are being caused which deny justice to registered persons who are subject to a notification.

3.2 Key features of proposed system

We note that the key stages or steps in the proposed system are:

- Receipt of notification
- Preliminary assessment of notification
- Consultation with HCC or equivalent State and Territory bodies
- Performance management
- Health management
- Conduct management
- Board hearings
- Referral for tribunal hearing
- Monitoring agreements and conditions

The consultation with the HCC is welcomed at the preliminary assessment stage as many complaints will rightly belong with the HCC as a consumer dispute rather than a professional standards matter.

3.3 Proposed definitions for what constitutes a departure from professional standards

The consultation paper notes "(S)ome jurisdictions have a two tiered standard, for example, 'unsatisfactory professional conduct' and 'professional misconduct', others do not distinguish between serious and less serious matters". We agree that these two levels are desirable to acknowledge in the new system.

Proposal 3.3.1

Attachment 1 to the consultation paper states that **'unsatisfactory professional conduct'** includes the following –

a) professional conduct that is of a lesser standard than that which might reasonably be expected of the practitioner by the public or the practitioner's professional peers

We regard this as a self-referenced definition, ending up meaning whatever the members of a panel or tribunal want it to mean. We suggest that for consistency in the interpretation of this definition, cross board professional development activities should be conducted. It will be important that notifiers are made aware that the standard reasonably expected by the public is not one that they determine but one that is set by the Board, including lay appointees.

Attachment 1 notes that '**unsatisfactory professional conduct**' also includes

b) unsatisfactory professional performance

It is important that health practitioners are not charged with 'unsatisfactory professional conduct' when a treatment has failed unless due to negligence or non-adherence to a regulatory guideline. Adverse outcomes can occur due to a wide range of circumstances, not necessarily due to the practitioner's performance.

There is potential for a notification assessment committee to view any treatment failure as the result of "negligence", or from the errors or omissions of a practitioner, when this is known to be untrue.

In a recent article on Patient Safety, Robert Wachter, Professor and Chief of the Division of Hospital Medicine, University of California, San Francisco (UCSF) wrote:

> "*Because patients can be injured while receiving perfect care, it is important to separate errors from adverse events. An error is usually defined as 'an act or omission that leads to an unanticipated, undesirable outcome or to substantial potential for such an outcome'. Adverse events, on the other hand, are injuries due to medical management rather than the patient's underlying illness. Although patients experiencing errors and adverse events may be equally harmed, the distinction is crucial because the fixes may be very different.*" (emphasis added)
> (Source: http://knol.google.com/k/robert-wachter/patient-safety/l8d6CVRe/NRSyrQ#)

Not only are the remedies likely to be different, but the assignment of blame to a practitioner for an adverse event outcome ignores the broader context in which care is provided, which is acknowledged in 'open disclosure' provisions advocated by the Australian Commission on Safety and Quality in Health Care (ACSQHC).

The National Standard on Open Disclosure is described by the ACSQHC as "A National Standard for open communication in Public and Private Hospitals, following an adverse event in health care", and was endorsed by the Health Ministers in July 2003. The Standard states:

> *"In working towards an environment that is as free as possible from adverse events, there is a need to move away from blaming individuals to focussing on establishing systems of organisational responsibility while at the same time maintaining professional accountability. In this context, health care organisations need to foster an environment where people feel supported and are encouraged to identify and report adverse events so that opportunities for systems improvements can be identified and acted on".* (emphasis added)

It goes on to note that:

> *"There is no agreed universal definition of "adverse event". For the purposes of this Standard, an "adverse event" is defined as "an incident in which unintended harm resulted to a person receiving health care.*
>
> *"Adverse events also include harm to patients arising from the environment of care for which the hospital is responsible".*

In an article published in the Medical Journal of Australia, in which the causes of adverse medical events were assessed, the problem with a focus on blaming health practitioners was highlighted.

> *"It is important to recognise that human error is inevitable for even the best-trained and best-qualified healthcare providers. Weed has recently pointed out that the unaided human mind is incapable of performing consistently at the necessary level to provide optimal healthcare. However, other studies have noted that the label "human error" is prejudicial and non-specific; it may retard rather than advance our understanding of how complex systems fail. It is postulated that within complex systems error is a symptom of organisational problems, and this is likely to apply to healthcare. Therefore, we need a healthcare-system response to error that moves the system towards being as "failsafe" as possible rather than one that blames the clinician who may have erred. Examples from the more frequently studied area of adverse drug events would be decision-support technology for antibiotic prescribing, with its demonstrated benefits, and electronic prescribing to reduce prescribing and transcription errors in hospital."* (emphasis added)

Source: An analysis of the causes of adverse events from the Quality in Australian Health Care Study, Ross McL Wilson, Bernadette T Harrison, Robert W Gibberd and John D Hamilton, MJA 1999; 170: 411-415

All of the suggested triggers for a charge of **'unsatisfactory professional conduct'** offered in paragraphs c) – k) of Attachment 1 to the consultation paper are agreed.

As regards paragraph g), while this is agreed, the subjectivity of this charge is of concern. Reasonableness is a matter of opinion as for a) above.

As regards paragraph h), this too is agreed however once again the term 'may' suggests a subjective judgment being made.

ADAVB also agrees with the definitions or triggers for **'unsatisfactory professional performance'** and **'professional misconduct'** listed in Attachment 1.

4. Notifications

4.1 Who may make a notification?

Health funds should not be treated as consumer representative organisations because the main ones are very large corporations which are motivated by profit and shareholder value rather than public spiritedness. Their approach to a practitioner whose treatment profile does not align with their average is to describe this as fraud (at worst) or aberrant (at best) when in fact there are numerous legitimate reasons why a practitioner's treatment profile may differ from the health fund's norm. These reasons include socio economic factors and practice demographics, such as immigrant presence or a large percentage of population from countries known to experience poor dental hygiene.

Health funds have proven that they are hostile to clinical independence and they should be prevented from using disciplinary processes administered by registration boards to achieve their commercial goals.

4.2 In what form may a notification be made?

Proposal 4.2.1 Agreed

Proposal 4.2.2 Agreed

4.3 What sort of matter may be the subject of a notification?

Proposal 4.3.1 Agreed

Proposal 4.3.2 We strongly support this measure as we do other recommendations made by the Victorian Health Services Commissioner in her report of the Inquiry into Noel Campbell.

4.4 Mandatory reporting obligations

ADAVB supports the inclusion of provisions similar to Section 36 of the Health Professions Registration Act 2005 which deals with the reporting of ill-health of health practitioners. It imposes a reporting obligation on registered medical practitioners who are treating a registered health practitioner who has seriously impaired ability to practise or registered student to undertake clinical training. The medical practitioner is obliged to report the practitioner or student to the responsible board.

Members of the ADAVB are encouraged to contact our office or our Member Assistance Program (MAP), which since April this year has been provided by IPS Worldwide, in order to seek counselling about a performance, health or conduct issue. Experienced, registered psychologists - employed by IPS Worldwide - provide completely confidential counselling for a wide range of issues, such as:

- Relationship problems
- Alcohol and drug issues
- Concerns about children
- Anxiety and depression
- Grief and loss
- Low self-esteem
- Managing conflict
- Handling work pressures

The counselling is conducted in professional offices located throughout Victoria. Telephone counselling is also available around the clock.

Initial reports from IPS have vindicated the establishment of the service. The MAP represents the Branch's commitment to provide all Members with appropriate support mechanisms to maintain professional standards and to contribute to Members' enjoyment of their profession and their life.

Member contact with IPS is only likely to occur when a dentist has reached the end of their own resources to deal with pressures, and they are in great need. The problems encountered by registered health practitioners in their domestic and professional lives will be many and varied, and do not necessarily equate to them being an impaired practitioner.

The system of regulatory control established to protect public health and safety must equally address itself to the welfare of the health workforce. If the people on whom the community depends are not supported through their times of need, then we will all be worse off as those people leave the health workforce and access to care is further compromised.

Professional associations also use registered practitioners as advisors and mentors to help their members in need. These staff, who are appointed to positions of trust, must not be obliged to compromise their role by virtue of compliance with the mandatory reporting requirements.

The new measures under consideration must allow professional associations to use senior members to do this work, supported by statutory immunity as per Section 139 of the Health Services Act in Victoria. This will allow the rehabilitation of registered health practitioners where peer support is provided with a view to helping avoid problems which might lead to poor treatment and/or to loss of the practitioner from the workforce.

Having conferred with Guild Insurance Limited, our recommended professional indemnity insurer, we support their view that Option 1a is preferred, provided there were clear guidelines as to when registered health practitioners should report another registered health practitioner in a treatment relationship, and sensitive support mechanisms were available. We also share their concern that there is "conflict, between the mandatory reporting option set out in 1b and the existing common law and statutory principles of confidentiality and legal professional privilege".

Treating practitioners should be subject to mandatory reporting, but other health professionals should not.

Mandatory reporting of students

Student registration is supported because they are dealing directly with patients during their clinical training and so should be held accountable to similar standards as fully qualified practitioners. Some allowance would be expected because a student has not yet completed their training - they are working under clinical supervision and so in the first instance, questions would need to be raised about the level of supervision.

4.5 Protection for notifiers and registrants

Proposal 4.5.1 Agreed

It should be recognised that notifiers may also include registrants.

We note that circumstances may also arise in which information is provided in bad faith. What safeguards are available to the boards when they suspect this is the case?

4.6 Own motion powers

Proposal 4.6.1 Agreed, provided procedural fairness is maintained.

4.7 Immediate suspension powers

Proposal 4.7.1 Agreed – for periods of up to 3 months only

Suspension of registration seriously affects the practitioner's livelihood, and registered persons are entitled to a speedy resolution of a matter of such presumed seriousness – as is the public. Suspension for a period of three months is already a serious financial penalty, which could cost the private practitioner their business. Certainly longer periods would effectively ruin the practice financially. Where such suspensions need to occur, the relevant board must ensure a speedy hearing of the matter so that the question of guilt or innocence can be determined promptly.

Proposal 4.7.2 Agreed with qualifier

This is agreed provided the review can occur within the three months suggested above.

Proposal 4.7.3 Agreed

Details of the types of undertakings envisaged here would be welcome.

5. Preliminary assessment of notifications

5.1 Powers following receipt of a notification

Proposal 5.1.1 Agreed

5.2 Grounds for a board to refuse to deal with a notification

Proposal 5.2.1 Agreed – except that we also agree to proposal 4.3.2.

We also urge that consumer complaints which do not relate to a breach of professional standard, codes or regulations, all be referred to Health Complaints Commissioners for conciliation.

5.3 Liaison with Health Complaints Commissioners

Proposal 5.3.1 Agreed – see also our comments under proposal 5.2 above.

We note that the HCC or its equivalent may need to call on dental expertise in order to assist with the resolution of disputes between patients and dental care providers. That support is provided to the HSC in Victoria by the ADAVB. Similar provisions may be possible in other jurisdictions.

5.4 Who conducts the preliminary assessment of a notification

Proposal 5.4.1 Agreed

It will be vitally important that persons registered in the relevant field (i.e. the field in which the practitioner is registered) are members of such notification assessment committees, so that sound clinical judgment informs any decisions taken.

5.5 Powers following preliminary assessment of a notification

Proposal 5.5.1 Agreed with qualifier

The power to immediately suspend a practitioner's registration needs to be exercised only in extreme situations where the concern for public safety overrides the normal entitlement to be presumed innocent until a hearing has determined the question of guilt. We suggest that a set of uniform guidelines be developed for consistent reference by all health registration boards.

Proposal 5.5.2

The first of three suggested approaches is agreed, subject to adoption of an appropriate definition of 'not of good character'.

The second is agreed without qualification.

The third is not agreed as we do not see why a tribunal should be involved in an impairment case. Health matters should be subject to confidential processes within the board committee rather than being sent on to a tribunal hearing such as VCAT. This would be an inappropriate use of the very public tribunal process, and the power to cancel registration for health reasons should be sensitively exercised by a board or its nominated committee rather than being determined in a court, unless it is hearing an appeal.

Proposal 5.5.3

In our view, if a notification assessment panel finds no case to answer, then that should be the end of the matter, and no rights of review should apply.

The notifier is not the judge of whether a professional misconduct or unprofessional conduct or impaired practice has occurred. The right of review is an appropriate one in a consumer court where an aggrieved party can pursue their entitlements, but not a professional standards body such as a registration board. This notion is misplaced and it should play no role in the notification system.

5.6 Notifiers' rights of review of preliminary assessment decisions

ADAVB supports option 1. See our comments under proposal 5.5.3 above. The practitioner must have a right of review however, as suggested in 9.6.1 and 10.10.1.

6. Performance matters

6.1 Overview of management of performance related matters

Proposal 6.1.1 Agreed

6.2 Performance management

Proposal 6.2.1 Agreed

Proposal 6.2.2 Agreed

6.3 Performance assessments

Proposal 6.3.1 Agreed

Proposal 6.3.2 Agreed with qualifier

While the provision of a report is agreed, the practicality of the seven day timeline is queried. The proposed discussion between the Chair and the practitioner is supported.

Proposal 6.3.3 Agreed

6.4 Performance panel hearings

Proposal 6.4.1

The ADAVB supports at least half of the panel members being from the same class and division of the register as the practitioner. It would be entirely inappropriate for lesser qualified practitioners, e.g. dental therapists, dental hygienists or dental prosthetists, to be sitting in judgment on a dentist. They would not have sufficient knowledge of the clinical or scientific factors underpinning the dentist's defence. Dentists however would be qualified to be empanelled for cases involving the other

operatives, although this is not likely to be favoured by those occupational groups, hence our recommendation.

6.5 Decisions available to performance panel following a hearing

Proposal 6.5.1 These options are agreed.

We note that further education or supervision may incur costs and we assume that the panel will be empowered to require the registered person to personally fund these activities. We also assume that the intention would be to allow for combinations of these actions to be taken.

Proposal 6.5.2 Agreed

Proposal 6.5.3 Agreed

7. Health or impairment matters

7.1 Overview of management of health related matters

Proposal 7.1.1 Agreed

In respect of health management and assessment processes, we urge that all participants should be required to keep the information they discover about the practitioner confidential. Failure to comply with this provision should be subject to harsh penalties.

Proposal 7.1.2 Opposed

We argue for a third option, which would be much more cost effective due to its even distribution of costs across all registered persons. The Health Professionals Health Program should be arranged by the national agency on behalf of all registered persons, under a central contract. This will allow economies of scale to be achieved and ensure an equitable distribution of costs across all registered persons.

Such a scheme should be available to all registered persons to make use of for a range of purposes affecting their health and wellbeing, and not restricted to circumstances where board committees wish to refer a practitioner due to a health assessment. As with all health issues, prevention is cheaper than cure, and this matter should be addressed proactively on behalf of the health workforce rather than left to individual boards to determine.

7.2 Health management

Proposal 7.2.1 Agreed

Proposal 7.2.2 Agreed

Presumably combinations of these will also be possible.

7.3 Health assessments

Proposal 7.3.1 Agreed

Proposal 7.3.2 Agreed

Proposal 7.3.3 Agreed

Proposal 7.3.4 Agreed

7.4 Health panel hearings

Proposal 7.4.1 Agreed with qualifier

We argue that half the panel should be comprised of practitioners from the same class and division of the register as the practitioner.

7.5 Decisions available to a health panel following a hearing

Proposal 7.5.1 Agreed

Presumably combinations of these would also be possible.

Proposal 7.5.2 Agreed

Proposal 7.5.3 Agreed

8. Conduct matters

8.1 Overview of management of conduct related matters

Proposal 8.1.1 Agreed

8.2 Conduct management

Proposal 8.2.1 Agreed

Proposal 8.2.2 Agreed

Presumably combinations of the above are also possible.

8.3 Investigations

Proposal 8.3.1 Agreed

We urge that wherever possible however, such an investigator should be an experienced practitioner in the field in question. Certainly, alleged infection control and dental records breaches should not be investigated by unqualified (non-registered) persons.

Proposal 8.3.2 Partially agreed

While we support the Board being able to mount an action on its own initiative, we do not support hearings being conducted without investigations. The requirement for the system to be transparent and based on procedural fairness would be breached.

Proposal 8.3.3 Agreed

Proposal 8.3.4 Agreed with qualifier

The circumstances here would have to be rare, and supported by evidence of previous threatening or intimidating behaviour rather than the mere concern that a threat might occur.

Proposal 8.3.5 Agreed with qualifier

The reports to notifiers must not give the impression that they are personally responsible for determining when a matter has been satisfactorily concluded. That responsibility rests with the Board or the tribunal.

8.4 Powers of investigators – search, entry, seizure

Proposal 8.4.1 Agreed with qualifier

Practitioners should be considered innocent pending investigation and hearing. Consequently, all necessary steps should be taken to avoid disruption to the normal operation of the practice and creating any impression in the eyes of patients within the practice at the time that the practitioner is under suspicion or investigation. We suggest that where the practitioner is a private (office based) practitioner, an appointment be made as if for a patient, so that the time is set aside in the appointment book and no patients are inconvenienced by being left waiting for the inspection and search to conclude. Damage to reputation is an extremely serious matter in the health professions and should be respected in the manner of approach to entry, search and seizure.

Proposal 8.4.2 Agreed

8.5 Conduct panel hearings

Proposal 8.5.1 Agreed with qualifier

We argue that half the committee should comprise members from the same classification and division of the register as the practitioner.

8.6 Decisions available to a conduct panel following a hearing

Proposal 8.6.1 Agreed

Presumably, combinations of the above will also be possible.

Proposal 8.6.2 Agreed

Proposal 8.6.3 Agreed. This is essential for the process to be credible.

9. Ensuring accountability, transparency and procedural fairness

9.1 Achieving separation of functions

Proposal 9.1.1

Option 1 is supported, however we suggest that the discussion paper appears to place a heavy emphasis on avenues of redress for disgruntled complainants (following the Victorian model). We are concerned that no complaints system will ever achieve perfection - where every member of society is perfectly happy with it. Given that the paper explicitly states that its purpose is to "protect the public", not to resolve complaints, the ADAVB is concerned that too much emphasis is given to placating people who may simply misunderstand the purpose of the registration system, and seek endless appeals or reviews because they haven't received compensation for a matter that if it were to be addressed appropriately, would be handled in another place (such as the Health Services Commission or a civil court). Some complainants will never be satisfied, and the system could end up consuming a great deal of time and resources trying to achieve the impossible.

The notification assessment process requires the Board to examine the case to see if it involves matters of public protection and professional standards or requires referral to the HCC or its equivalent. If "yes", the Board then deals with the case by whatever its processes are. If 'no", the matter is either dismissed on the basis there is no case to answer, or it is referred to the HCC for mediation or conciliation (not prosecution).

Proposal 9.1.2 Agreed

9.2 Matters involving registrants from different professions

Proposal 9.2.1 Agreed

9.3 Legal representation for registrants at panel hearings

Option 4b is supported in the interests of procedural fairness and protection of individual rights. This also acknowledges the objective of ensuring that the system is recognised as fair and reasonable by registered persons.

9.4 Confidentiality of panel hearings

Proposal 9.4.1 Agreed

The confidentiality of a panel hearing may be required out of consideration for either a notifier or a registered person.

9.5 Status of notifiers at panel hearings

Proposal 9.5.1 Agreed

9.6 Review rights for registrants

Proposal 9.6.1 Agreed.

This appeal right is an essential one in terms of procedural fairness.

9.7 Notice of decisions of hearing panels

Proposal 9.7.1 Agreed

In the event the requirements specified in a code of practice are changed so that a breach for which a person was found guilty would no longer be considered a breach under the revised code or guideline, the same people and organisations originally notified of the breach should also be notified of the changed requirements. We have seen situations in Victoria where practitioners found guilty of a breach of the code of practice concerning the way in which dental therapists and dental hygienists could be utilised up to the year 2000, were still being described as in breach eight years later, when the code had been changed so that the original requirements no longer exist. This is not helpful to the public and unreasonably implies that the practitioners are less than professional, when under present requirements they would be considered to have done nothing wrong.

9.8 Role of Commonwealth, State and Territory ombudsmen

Option 1 is supported in recognition that the national agency, the 10 professional boards and their state committees are all constituted under a national model. It is assumed that this will also avoid multiple avenues for review, which could be confusing, costly and time consuming.

10. Tribunal hearings

10.1 Establishment or continuation of State and Territory tribunals

In Victoria, we are happy for VCAT to continue to be the relevant tribunal.

10.2 Criteria for State and Territory tribunals

Proposal 10.2.1 Agreed with qualifier

We do not see any circumstances in which it could be relevant to notify the HCC.

Proposal 10.2.2 Agreed

10.3 Original jurisdiction of tribunal

Proposal 10.3.1 Option 1 is preferred

10.4 Review jurisdiction of tribunal

Proposal 10.4.1 Option 1 is preferred

There could be no grounds for an HCC to make an appeal as their jurisdiction is consumer complaints whereas the boards are dealing with professional standards.

Proposal 10.4.2 Agreed

10.5 Findings and determinations of a tribunal

Proposal 10.5.1 Agreed

Proposal 10.5.2 Agreed

Proposal 10.5.3 Agreed

Proposal 10.5.4 Agreed

Proposal 10.5.5 Agreed

Where the practitioner is found innocent, they should be exempt from any order for costs.

10.6 Constitution and appointment of tribunal hearing panels

Proposal 10.6.1 Agreed

This is how the VCAT arrangements are working in Victoria under the Health Professions Registration Act 2005.

10.7 Procedure for conduct of tribunal hearings

Proposal 10.7.1 Agreed

These matters have already been adequately addressed in relation to VCAT.

10.8 Status of notifiers

Proposal 10.8.1 Agreed

10.9 Powers in relation to deregistered practitioners

Proposal 10.9.1 Excellent idea

10.10 Review rights from tribunal decisions

Proposal 10.10.1

VCAT appeal rights and procedures are already specified and we have no objection to these continuing to apply as at present.

10.11 Reasons for decisions

Proposal 10.11.1 Agreed

For the public to have confidence in the scheme and for registered persons to see the scheme as being fair and reasonable, external tribunal findings must be published with reasons. We note that matters determined by board committees, including impairment matters, are not covered by this provision.

10.12 Notice of decisions

Proposal 10.12.1 Agreed

We recommend that the publication of details on a website be subject to review by the Board where the practitioner ceases to be registered or where the original requirement which had been breached is no longer specified as a requirement by the Board or the legislation.

11. Offences and regulated conduct

11.1 Current arrangements

We argue that certain of these offences are very minor infringements of requirements and do not justify hearings or even notification assessment panels. They should be described and treated as summary offences, so that where the breach is obvious - e.g. failure to advise change of address leading to failure to renew registration – it should simply be subject to a fine and a caution.

11.2 The IGA

The proposed arrangements affecting the inclusion of a definition of dentistry and optometry are warmly welcomed in the interests of ensuring the public is protected from unregistered persons.

11.3 Holding out offences

Proposal 11.3.1

The whole point of the registration of health practitioners is to allow the public to more readily identify those who are qualified and registered to provide health services in which a person may be harmed. Those who hold themselves out to be registered persons or to be in a class or division of a register to which they are not entitled are treating the system with contempt and undermining the integrity of arrangements designed to protect and inform the public. Such behaviour should be subject to sanctions.

11.4 Practice offences

Proposal 11.4.1 Agreed

11.5 Direct or incite offences

Proposal 11.5.1

The first option is strongly supported as there are a range of circumstances outside the employment relationship that could lead to the quality of care being compromised by others. Office based practice often has contractors working in a practice rather than employees. The difference might be hard to distinguish to an external party,

and the registration board should not be delayed in addressing the substantive issue by having to work out whether or not a person is an employee.

The criteria applied to registered persons in section 3.3 in determining whether some form of professional misconduct had occurred, should also be used where appropriate, to judge the extent to which a non registered person has been directed or incited to behave inappropriately.

11.6 Regulation of advertising

Proposal 11.6.1

Option 3 is strongly supported as the protection of the public from unreasonable expectation of beneficial treatment is a key dimension of professional regulation. Too many advertisements for services offered by health practitioners now feature discretionary and cosmetic treatments, often with unrealistic promises, at the expense of health services. It is essential that the regulation covering advertising services clearly states who is responsible for the advertising – it is particularly important for corporations to name the person who is responsible. We note that this will not necessarily be a registered health practitioner.

11.7 Offences related to enforcement activities

Proposal 11.7.1 Agreed

11.8 Other offences

Proposal 11.8.1 Agreed

Proposal 11.8.2 Agreed

Proposal 11.8.3 Agreed

We support the extension of negative licensing provisions as used in NSW to all jurisdictions. The NSW Code of Practice for Unregistered Health Practitioners is incorporated into the Public Health (General) Regulations 2002 under the Public Health Act 1991. We understand that an alleged breach of the Code is dealt with in a Magistrates Court, with a maximum possible fine of 20 penalty units.

In the context of national registration and complaint systems, this regulatory approach protects the public in their dealings with unregistered practitioners, and also registered practitioners who provide services that are unrelated to their registration.

The ADAVB has seen a number of instances over the years where people who were once registered as dental care providers have taken advantage of patients without being held accountable by regulatory bodies. The Victorian Health Services Commission recently completed an Inquiry (http://www.health.vic.gov.au/hsc/noel_campbell_inquiry.htm) with a key recommendation that the Victorian Government adopt a negative licensing approach similar to that used in NSW.

We suggest that this negative licensing approach should also be considered to exert greater influence over unregistered owners of health practices - including those where registered persons are employed.

The risks posed to the public by practice owners purchasing sub standard or out of date materials, or failing to ensure the maintenance of equipment, should be subject to regulation. These measures should also extend to practice owners, rather than targeting employees of the practice who happen to be registered. Those employees may have little real power to control decisions over the purchase and use of materials - the people who make the decisions should be held personally accountable. They have the same capacity to harm patients treated in their practices as unregistered health practitioners.

11.9 Prosecution of offences

Proposal 11.9.1 Agreed

11.10 Monitoring of registrants

Proposal 11.10.1 Agreed

12. Transition arrangements

Proposal 12.1 Agreed

Practitioners can only be held accountable for breaches which were relevant under legislation applicable at the time of the incident or behaviour which led to a notification. This also means that they must be dealt with according to the same laws, and the powers of any tribunal need to be restricted to those that were available under that earlier law. The transitional provisions are therefore supported.