Submission from the Medical Practitioners Board of Victoria

to the Senate Community Affairs Committee Inquiry into:

The National Registration and Accreditation Scheme for Doctors and other Health Workers

30 April 2009

The Medical Practitioners Board of Victoria (MPBV) is a statutory authority established to protect the community and guide the medical profession.

The MPBV registers doctors, investigates complaints about doctors, monitors the health of doctors who are ill and may be unfit to practise medicine, and develops guidelines for the profession.

The Medical Practitioners Board of Victoria is pleased to be offered the opportunity to make a submission to the Senate Community Affairs Committee Inquiry into the National Registration and Accreditation Scheme for Doctors and other Health Workers.

The MPBV notes that the terms of reference of the inquiry are as set out below, and offers its comments accordingly.

1. Terms of Reference

The design of the Federal Government's national registration and accreditation scheme for doctors and other health workers, including:

a. the impact of the scheme on state and territory health services;
b. the impact of the scheme on patient care and safety;
c. the effect of the scheme on standards of training and qualification of relevant health professionals;
d. how the scheme will affect complaints management and disciplinary processes within particular professional streams;
e. the appropriate role, if any, in the scheme for state and territory registration boards; and
f. alternative models for implementation of the scheme.

2. Comments from the MPBV

A single process and consistent standards for registration and accreditation for doctors across the country is welcomed by the MPBV. However, these reforms represent a shift in professional accountability and a major change in the way the health professions are regulated in Australia. It is vital that professionals within medicine remain integral in all new processes and arrangements, to ensure high standards of medical training, practice and conduct. At the same time, consideration must be given to the public as a key stakeholder in professional regulation and a fair balance between expert practitioner involvement and consumer involvement should be included in the design of the scheme. Community members should be represented on each national board, alongside a majority of health practitioners from that profession.

The MPBV would also draw the Committee's attention to the May 2001 Discussion Paper of the National Competition Council, Reforming the Regulation of the Professions, which stated that "*the primary objective of this regulation of the profession is to protect the welfare of consumers of professional services and to protect the wider public.*"

2.1 The impact of the scheme on state and territory health services

While the MPBV is not a health service provider, it is noted that there would be significant advantages to the state and territory health services, the public and health practitioners generally in the implementation of a national registration and accreditation scheme.

The key benefits of the scheme for health services are:

- Consistently high national standards for health practitioners, thereby improving patient safety;
- Decreased administrative burden and standardisation of registration requirements for health practitioners which will lead to greater mobility, flexibility and improved workforce supply; and
- One point of contact for health services in relation to health practitioners, which will improve the provision of timely and comprehensive information provision to health services.

2.2 The impact of the scheme on patient care and safety

The MPBV is of the opinion that proposed scheme will provide improved and effective procedures for registration and complaints handling in each State and Territory. There will be an office of the scheme in every State and Territory that will provide a single point of contact for consumers, including patients, and health practitioners alike. By definition, this office will have a greater capacity (and likely experience) than is currently the case with eight or ten smaller, local profession-specific offices. This will clearly be so in smaller states / cities and jurisdictions. In addition, the proposed scheme will provide for consistent and higher national standards for health practitioners and rigorous assessment of overseas trained practitioners. The cumulative effect of these structural and process changes will be improved patient safety.

2.3 The effect of the scheme on standards of training and qualification of relevant health professionals

The MPBV believes that the accreditation of medical education and training courses throughout Australia should be undertaken by a body that has a comprehensive understanding of the environment of accreditation and registration. Its independence (including from medical boards/councils ('boards'), governments, medical schools, the medical profession and representative bodies) should never be compromised. However, it must have the capacity to work productively with a wide range of stakeholders. The Australian Medical Council (AMC) currently operates very effectively in this environment and the MPBV would recommend that it continue to perform the accreditation function for medicine under the new scheme.

Thought might be given to asking the AMC to lead and advise other professions, especially the smaller professional groups, in the accreditation function relating to their professions, due to its considerable experience and success in this important area.

2.4 How the scheme will affect complaints management and disciplinary processes within particular professional streams

The primary aim of the new legislation is to protect the public and this is appropriate. A secondary but important aim is to maintain and enhance professional standards, for the benefit of the community. Accountability to the community and the profession is crucial.

Except for a very small proportion of complaints in which the practitioner is found to have engaged in serious unprofessional conduct, most notifications to the MPBV have the potential to be resolved in a constructive and mutually beneficial manner that enhances professional standards, while acknowledging and addressing the concerns of notifiers and protecting the community. This is borne out by the MPBV experience over the 12 months to September 2008, in which 67% of notifications investigated were determined to require no further action or no further investigation. Only 6% related to matters of serious misconduct.

One of the most resource intensive activities currently undertaken by the MPBV is the investigation of notifications and actions arising from the investigation. The consultation paper on *Proposed arrangements for handling complaints, and dealing with performance, health and conduct matters,* issued by the Practitioner Regulation Subcommittee of the Health Workforce Principal Committee on 7 October 2008 confirms that investigation by the Boards will continue to be undertaken. This is one of the main ways in which the Board protects the public.

Through this national process, there is an opportunity to reinforce that health regulatory boards are protective jurisdictions. This is confirmed by accepted legal precedent (refer *Ziems v The Prothonotary of the Supreme Court of New South Wales* (1957) 97 CLR 279. In this case, the High Court of Australia dealt with the question of whether a man should remain registered as a lawyer. Dixon CJ stated at 286 "The jurisdiction the court exercises has nothing to do with punishment. The purpose of the power to remove from the roll of barristers is simply to maintain a proper standard….")

The principal role of health regulation boards is not to punish practitioners. This is the role of the courts. While in serious cases, practitioners may feel that boards' actions are punitive, boards should be clear that their actions are always aimed at protecting the public from the specific doctor and, by way of example, giving a signal to the profession about what are acceptable – and unacceptable – professional standards.

The outcomes of all investigations should be to protect the public. Except in the few serious cases in which a board might put limits on or alter a practitioner's registration, the public is better served by boards focusing on outcomes that are constructive and aimed at enhancing the individual practitioner's professional standards. The MPBV believes strongly that remediation, education and defined and relevant counselling are preferred outcomes to reprimands and cautions.

Except in serious cases of unprofessional conduct, which will continue to be dealt with under the present arrangements of state based tribunals, boards should aim to manage most matters referred to them in flexible and constructive ways, with a view to achieving improvements in behaviour or performance which ensures that the public is protected.

The language in the legislation will also influence notifiers' expectations. Terms such as "enhancing professional standards through the management of notifications" rather than "disciplinary action" and "education and counselling" rather than "sanctions" are helpful when explaining to notifiers the likely outcomes of a notification to a board. It also explains the reasons for the board's actions. It means that notifiers are more likely to have reasonable expectations of the investigative process and less inclined to expect deregistration or suspension for relatively minor issues. The MPBV strongly recommends that this approach be adopted under the new national arrangements.

Notifiers

The proposed role of consumers / notifiers in the new national registration and accreditation scheme has not been well defined to date. This may reflect a shift in the community's expectations of their role and their rights in a board's investigative process. The changing role of the notifier needs to be reflected in the new national legislation.

The ability of the health professions to meet changing community needs and to maintain high professional standards of conduct and performance is only possible through ongoing community participation. By raising concerns and providing information to the relevant boards, notifiers play a vital role in the regulation of the health professions. Individuals who notify boards of their concerns about a medical practitioner should be regarded as performing an important

community service that contributes to the protection of the public and the maintenance of professional standards.

Traditionally, medical regulation has focused on receiving complaints, investigating complaints and, if there has been a substantial departure from accepted practice, imposing a sanction on the practitioner. It was first necessary to prove that breaches of standards were quite serious before action was taken. In effect, the 'bar' was set relatively high before boards could act to protect the community. More recently, boards have tended to act to address apparent breaches of professional standards that do not match the reasonable expectations of the community and the profession. In the past, the role of the notifier was to provide information to boards and as such, the notifier had a role, but not rights.

It is well accepted that community expectations have shifted. Consumers and members of the community expect and are encouraged to be involved in their health care and therapeutic decision-making. Patient-centred care is a vital tenet of modern medical practice. Consequently, notifiers also expect to be more involved when something goes wrong in their health care.

The legislation needs to articulate the role and the rights of the notifier. If notifiers are given certain rights of review, their role has changed from the "provider of information" to having some participation in the process. This is a somewhat contemporary notion and appropriate in the current cultural environment. The limits of the notifier's rights of participation and explicitly defined standards and outcomes, however, become important in managing the notifier as a participant in, and not a driver of, the process.

The MPBV supports notifiers having an acknowledged and defined role in the investigation process, with appropriate levels of access to information and involvement in consultation and explicit rights of review of decisions. To ensure transparency and accountability, the MPBV believes it is preferable that the reviewer of board decisions be completely independent of the board and not appointed or managed by the board.

Management of notifications

The MPBV notes that it is proposed in the Health Workforce Principal Committee consultation paper on *Proposed arrangements for handling complaints (*October 2008) that there be three separate pathways in dealing with notifications about practitioners:

1. Professional Conduct
2. Professional Performance
3. Health

It also notes that it is proposed that there is flexibility in moving between the various pathways.

The proposed process is quite similar to that under the *Medical Practice Act 1994* (Vic) (MPA), the legislation under which the MPBV operated until 2007. It is important to note that the *Health Professions Registration Act 2005* (Vic) (HPRA), under which the Victorian health regulation boards have been operating since 1 July 2007, has enabled much more progressive and constructive approaches in the investigation and management of notifications. The MPBV believes that this has been to the benefit of both notifiers and practitioners, particularly given that the notifier has no direct role in any performance or health assessment of a medical practitioner and receives no feedback on the outcome of any such assessment.

From the MPBV's experience, some of the issues that arose with having three separate streams under the MPA included:

- **Many notifications received by the MPBV are about the standard of care provided by the practitioner (some 60% in 2007-08).** These are best dealt with in a 'performance framework'. After investigation, the overwhelming majority of these notifications lead to an outcome of "no further investigation". The only investigation process defined by the MPA for performance investigation was a performance assessment. However, it would have been unnecessary, inappropriate, impractical and financially irresponsible, to require all of these practitioners to undergo a performance assessment.

  Expressed in a slightly different way, most of the notifications received by the MPBV are not particularly serious in a regulatory sense, though it acknowledges the serious impact on the individual patient or notifier. They involve concerns about the performance of a practitioner, in a single instance. It would be inappropriate to propose that the only option available in such a case would be a performance assessment.

  Therefore, it is recommended that if a decision is made to continue with separate streams, the performance stream should include the explicit ability to investigate the concerns, in the same way that "conduct" is investigated. This should include the appointment of an investigator.

  As proposed, it is appropriate to have a range of determinations aimed at education, remediation and alteration of the scope of practice. We strongly caution against the development of strategies to deal with "low level complaints" that lie outside the legislation. This approach is not transparent and perpetuates the attitude of "doctors protecting doctors".

- **Many notifications received by the MPBV did not fit cleanly into one category.** Some notifications are clearly defined. For example, allegations of sexual misconduct or serious breaches of legislation clearly relate to a doctor's conduct. However, many notifications received by the MPBV do not fit cleanly into one category. The boundaries between low level conduct and performance issues can be, and often are, blurred. This is acknowledged in the definition of unprofessional conduct including unsatisfactory professional performance.

  By way of example, a notifier may be unhappy with the standard of care they received but may also allege that the doctor was rude. It is preferable to deal with the notification in its entirety rather than splitting it into two separate investigation streams, with potentially two investigators – one working on the "conduct issue" and the other working on the "performance" issue. Clearly, this approach is not consistent with protecting the community, and would not meet the notifier's expectations about resolution of the issues and would not help to raise professional standards.

  It would be an even less constructive approach to deal with the "conduct issue" first and then refer the matter for management of the "performance issue" in a serial manner. This would prolong the investigation, increase the possibility of omissions in the investigation and would lead to the potential for multiple or inadequate determinations being made for a single incident.

- **The need for an integrated and holistic approach was identified**. The MPBV has on occasion received notifications in which a conduct investigation, a health assessment and performance assessment were all indicated. Under previous legislation, these each occurred in isolation. In contrast, under the HPRA, a single investigator investigates the notification and is assisted by other specialist staff who arrange and coordinate the health and performance assessments. The health and performance assessments inform the conduct component of the investigation, leading to a coordinated outcome that takes into

consideration all elements of the notification. It also takes into account concerns about the doctor's health and has a remedial focus if issues of performance are found. Overall, the public is better served because in addition to dealing with the specific concern, the practitioner's performance has been managed and appropriate and constructive or supportive action can be taken.

- **The need for outcomes in relation to the behaviours of the medical practitioner**. Under the MPA, a performance investigation examined the practitioner's performance but did not specifically examine and reach a conclusion about the notification that triggered the investigation. While this is consistent with the Board's primary aim of protecting the public, notifiers tended to feel that they had not been taken seriously and felt aggrieved that their specific issues were not considered important enough to investigate. This feedback arose even when the notifiers were informed about the performance assessment and its outcome.

  The process of consecutive, rather than concurrent investigations was bureaucratic, prolonged the investigation significantly and if there were issues of both conduct and performance, it was usual to abandon the conduct investigation without a finding. This was unsatisfactory for both notifiers and practitioners and did not result in improved practice.

  It is the MPBV's belief, formed after specific feedback from its Community Consultative Committee (CCC), that a streamlined approach to investigations rather than a split approach minimises the stress and inconvenience experienced by the notifier and more effectively protects the community.

Preferred alternative

It is proposed that the legislation be created with sufficient flexibility to enable both:

1. Distinct pathways, as has been proposed in the Health Workforce Principal Committee consultation paper on *Proposed arrangements for handling complaints (*October 2008); or
2. A single investigative pathway in which health and performance assessments are available tools to inform investigations.

The available outcomes should be identical, regardless of pathway.

The MPBV believes the benefit of the second alternative is that the investigation is dealt with in a more holistic, effective and efficient way. This approach particularly has the potential to develop a comprehensive and integrated response to the issues raised by a notification that transcends a narrow and artificial construct of separate pathways.

Applying this principle, all relevant elements of a notification are addressed concurrently, giving rise to a more efficient and timely investigation. The notifier also receives feedback about the particular incident that they expressed concern about and whether the MPBV found the practitioner's conduct or performance to be deficient. Rather than "trawling" for material to inform a hearing, as has been suggested in the consultation paper, it should be explicit that the purpose of performance and health assessment during the investigation of a notification is to inform the board and to assist in the resolution of the issues in a constructive way. Even when an incident might give rise to a hearing, the information obtained during a performance or health assessment can inform the determination, rather than the findings. For example, a catastrophic but isolated lapse in performance might have occurred. If a performance assessment confirms that the practitioner's performance is generally satisfactory, or if remedial action was taken after the performance assessment, a tribunal hearing the matter would reasonably conclude that further education was unnecessary. Therefore, assessments are used in a way that is

consistent with the protective jurisdiction of health regulation boards, while also raising professional standards.

To ensure that the processes are not abused, the decision to proceed to an assessment could be made by the relevant statutory committee.

Panels should also be able to request that a practitioner undergoes a health or performance assessment as a part of the proceedings, rather than as an outcome of proceedings. This can inform the determination of the panel, aimed at constructive outcomes. For example, if a panel is hearing that a practitioner has treated a patient in a way that is not evidence-based and the doctor admits that this is his/her usual practice, it is reasonable to request that a performance assessment be undertaken to determine whether there are other aspects of his/her practice that are not evidence-based and are perhaps unsafe. A determination can therefore be made about alteration of practice and education so that the public is protected from any unsafe practice.

2.5 The appropriate role, if any, in the scheme for state and territory registration boards

The MPBV notes the details in the Inter-Governmental Agreement (IGA) relating to National Boards. In particular the MPBV notes that the IGA provides for the creation of profession specific National Boards. It further notes that members of the relevant professions will form the majority of each Board. For each profession, the Boards:

- will oversee development of standards for registration and accreditation
- will oversee registration and accreditation functions, including individual registration and accreditation decisions
- will decide on committees needed to perform these functions
- may delegate powers to State and Territory committees, and
- can provide policy advice to Ministers.

The Medical Board of Australia should be able to delegate matters to State committees and use the State committees to undertake specific functions (e.g. professional standards investigations). Clarifying the respective – and relative - accountabilities and responsibilities of national and state boards is of course critical. To a large extent, this will also influence the workload and therefore remuneration of members at each level.

The MPBV supports the proposed structure (National Boards supported by State-based committees) which allows decision-making on registration applications (both routine and non-routine applications), and conduct/performance and practitioner health matters to occur at the State and Territory level.

In order to be able to effectively manage the day to day registration functions, it is imperative that a responsible board has the power to delegate its registration powers and functions under the legislation to a member of a committee or person employed by the National Agency.

It is, however, noted that a simple duplication of the current existing State and Territory boards combined with a National Board will be cost prohibitive for a number of professions, increase the bureaucracy and limit the efficiencies proposed by the scheme.

2.6 Alternative models for implementation of the scheme.

The MPBV welcomes the proposed new framework and sees it as providing an opportunity to rationalise and enhance the regulation of the health professions, supported by the development of a national structure. It offers the chance of uniting all ten professions in a new regulatory arrangement which will provide for the establishment of a new era of mutually beneficial

professional regulation. For the new arrangements to achieve their stated goals, the model must allow for professional and community stakeholders to be given an opportunity to contribute equally to an environment of co-regulation where each can have input and ultimately derive shared benefit. This will provide a setting where greater efficiencies, economy of effort and positive outcomes for both professional and community stakeholders are achieved.

The MPBV feels that the proposed model will not only achieve this but also provide scope for sharing resources and working towards developing common high standards of training, conduct and performance assessment across all health professions. Any model for national regulation needs to demonstrate the capacity for recognising, combining and building on current best practice in the various jurisdictions. It needs to provide an opportunity whereby contemporary principles of professionalism and accountability are identified, fostered and articulated into a coherent national statement. To achieve this, the medical profession, with its well established and refined regulatory practices, is well placed to assume a leadership role in this endeavour.