Chapter 5

Related matters raised during the inquiry

Introduction

5.1 A number of related matters were raised in during the inquiry. These went to the issue of accountability of the Australian Health Practitioner Regulation Agency (AHPRA), mandatory reporting requirements, the registration of overseas health practitioners and the registration of senior doctors and academic health practitioners.

Complaints handling

5.2 Comments on complaints handling went to two areas: complaints about AHPRA itself; and the handling of complaints about health practitioners.

Complaints about AHPRA

5.3 Submitters commented that there were difficulties in attempting to complain to AHPRA.[1]

5.4 Many practitioners contacted the National Health Practitioner Ombudsman and Privacy Commissioner (NHPOPC). However, submitters commented on the difficulties of contacting the NHPOPC and the lack of resources of that office to deal with the number of complaints received.[2]

5.5 The Australian Health Workforce Ministerial Council (AHWMC) commented that there was concern about AHPRA's handling of complaints about its operations. AHWMC stated:

> The scale of the issue was evident from the number of contacts made with the National Health Practitioner Ombudsman Privacy Commissioner (NHPOPC). Many of the issues raised would, under normal circumstances have been expected to have been resolved by AHPRA in the first instance. However, as a result of frustration on the part of registrants and employers unable to make contact or get satisfactory responses from AHPRA callers resorted to making contact with the NHPOPC. An indication of the improvement in AHPRA operating in this area is the significant decreases in calls to the NHPOPC in recent months about not being able to contact AHPRA.[3]

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1 Royal College of Nursing, *Submission 62,* p. 4.

2 Royal College of Nursing, *Submission 62,* p. 4; Australian Doctors' Fund, *Submission 52*, p. 7.

3 Australian Health Workforce Ministerial Council, *Submission 70*, p. 12.

Complaints about health practitioners

5.6 The AHWMC commented that a significant role for AHPRA is the management of notifications to boards regarding registrant health, conduct or performance. AHPRA inherited all open notifications and disciplinary matters from state and territory boards (other than NSW) at 1 July 2010. AHPRA is currently managing approximately 3000 notifications, including those received since 1 July 2010.[4]

5.7 The Australian Dental Association (ADA) pointed to a number of difficulties being experienced with the complaints process:

- right to respond to a complaint: there are inconsistencies between jurisdictions as to the right to respond to a complaint by a patient;
- response times in the preliminary assessment phase: the response times vary across the jurisdictions from 14 days to 28 days;
- provision of information: the level of information provided to the health practitioner who is the subject of a claim varies from only the name of the complainant or notifier to additional essential information; and
- notification form: the form is prescriptive and 'may lead a notifier to make choices which are not reflective of their actual concerns'.[5]

5.8 The Australian Medical Association (AMA) commented on the need for consistency in complaint handling and the importance of having appropriate complaint handling processes in place. The AMA stated:

> It is vital that the State AHPRA offices, in conjunction with the State Medical Boards, have clear and documented operating protocols to ensure that complaints about medical practitioners are dealt with consistently around the country. As yet, we are not aware that these protocols have been written. They should be drafted and made available for public consultation before being finalised.
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> The importance of operating protocols is highlighted by recent matters where the AMA has evidence of administrative and bureaucratic methods significantly interfering with the normal rights of persons. We also believe that some complaints could have been resolved simply and more efficiently, but have instead been drawn out at the expense of the registrant and AHPRA resources.[6]

5.9 Avant Mutual Group commented that in its view, the complaint handling processes are working well and the processing of complaints appear to be taking no longer, and is often much quicker, than the time taken for processing complaints by

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4 Australian Health Workforce Ministerial Council, *Submission 70*, p. 12.

5 Australian Dental Association, *Submission 34*, pp 5–6.

6 Australian Medical Association, *Submission 23*, p. 8.

some of the previous state boards. However, Avant Mutual Group stated that there is concern that the approaches to complaint handling are not consistent nationally, in particular 'the willingness of some state boards/AHPRA to accept and act on notifications'. Avant Mutual Group voiced concerns that some notifications are generated in other than good faith. However, AHPRA seems to be unwilling to consider the issue of good faith. Avant Mutual Group provided the following case:

> In Queensland AHPRA has given a medical practitioner a notice of its intention to impose onerous and restrictive conditions on the doctor's practice because a current competitor of the doctor (for whom the doctor receiving the notice had once worked), had made a complaint suggesting the doctor was not competent to practice. The time given for the doctor to respond to the notice to show cause was very short. There was no supporting material provided with the complaint. After Avant became involved and senior practitioners had assessed the doctor in question, it was clear that the doctor was competent to practice. However, the expense required to respond to this complaint, which appeared to be based on anti-competitive issues, was significant.[7]

5.10 Avant Mutual Group also noted that other complaints have been made by ex-spouses of doctors during family break-ups and anonymously. Avant concluded 'the necessity for AHPRA to be take care in accepting and acting on such complaints including using its emergency powers as set out under section 156, needs to be emphasised'.[8]

5.11 The committee received a large number of submissions in relation to complaints against privately practising midwives. Homebirth Australia commented that 'the handling of those complaints by AHPRA are of grave concern'.[9] It was submitted that there are individual cases where a midwife has been suspended or had substantial limitations placed on their professional practice pending an investigation of their conduct. The Australian Society of Independent Midwives (ASIM) commented:

> ASIM is aware of a number of individual cases where a midwife has been suspended or had substantial limitations placed on her professional practice pending an investigation into her conduct. ASIM submits that taking such steps before a matter is finalised is a very serious matter and has the potential to destroy a midwife's livelihood. As the National Law recognises, such a step should only be taken when the practitioner poses a serious risk to persons and it is necessary to take immediate action to protect public health or safety. When taking such a serious step it is imperative in the interests of natural justice that the complaint then be dealt with in an expeditious manner. ASIM is aware however of at least one case where a

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7 Avant Mutual Group Limited, *Submission 12*, p. 13.

8 Avant Mutual Group Limited, *Submission 12*, p. 13.

9 Homebirth Australia, *Submission 33*, p. 1.

> midwife has been suspended pending the investigation of her matter for nearly 11 months. This is simply unacceptable.[10]

5.12 It was also argued that the complaint handling processes regarding self-employed midwives are different to those which apply to medical practitioners or nurses. Ms Justine Caines, Homebirth Australia commented:

> We have one midwife who has had a complaint that is not by the current family or any person that is being cared for by her. It is by some third party. It is not based on and does not represent hospital notes that have been gathered. She was then relegated instantly to hospital-based practice, she has lost her livelihood and her clients have lost their care provider. I spoke to a director of obstetrics at a tertiary hospital in Sydney who has 27 years experience, and I said to him, 'In your experience, has this happened to an obstetrician in 27 years?' He said no. He said that the only case he knew of was after five complaints of a registrar made in quick succession; they then took out a management plan and that registrar was put under some sort of supervised practice. However, with homebirth midwives, across virtually every state, we are seeing a considerably different bar.[11]

5.13 The Australian Private Midwives Association provided further evidence in relation to this matter, noting that even if a previous complaint, of which a midwife has been absolved, is on the midwife's record, they are prevented from re-registering:

> ...where complaints have already occurred with a midwife's registration, be it 10 or 15 years ago or whenever it might have been, that triggers a process when they go to reregister, which prevents them from actually reregistering. Even if the complaint had been dealt with and put to the side and they were exonerated, they are still unable to complete a re-registration process. That creates significant difficulty.[12]

Committee comment

5.14 The committee is concerned that AHPRA's complaints handling processes were so inefficient that practitioners had no recourse but to refer matters to the Ombudsman even for matters so trivial as to find a contact number for AHPRA staff. The committee considers that a national organisation should have the highest standards and efficient processes for dealing with complaints.

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10 Australian Society of Independent Midwives, *Submission 45,* p. 3; see also Australian Private Midwives Association, Midwives in Private Practice, *Submission 21,* p. 5; Maternity Coalition, *Submission 40*, p. 3.

11 Ms Justine Caines, Committee Member, Homebirth Australia Inc., *Committee Hansard*, 4 May 2011, pp 34-35. See also Ms Liz Wilkes, National Spokesperson, Australian Private Midwives Association, *Committee Hansard*, 4 May 2011, pp 39 and 41.

12 Ms Liz Wilkes, National Spokesperson, National Spokesperson, Australian Private Midwives Association, *Committee Hansard*, 4 May 2011, p. 40.

5.15 In relation to complaints about practitioners, the committee was provided with many examples of timeframes for resolution of complaints which were not reasonable. The committee notes that complaints are dealt with by the relevant board. However, the administration of complaints is undertaken by AHPRA (except in NSW). The committee is concerned about inconsistency in the application of complaint processes, the prescriptiveness of the application form and the way in which vexatious complaints are handled. The committee considers that further development of the complaints process is urgently required.

Accountability

5.16 The issue of accountability of AHPRA was raised in two areas: first, accountability to the Parliament and secondly, accountability to health practitioners.

5.17 The Council of Australian Governments (COAG) agreed to the provision of $19.8 million with for $12.5 million for practitioner regulation and $7.5 million for accreditation reform. The Commonwealth Government contributed $9.9 million (50 per cent of the total) which reflected the established Australian Health Ministers Advisory Council cost sharing principles.[13] The Australian Health Workforce Ministerial Council (AHWMC) is responsible for the oversight of the implementation of the National Registration and Accreditation Scheme (NRAS).[14]

5.18 The Australian Health Workforce Ministerial Council was established under the *Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008* following signing of, and based on, the agreement between First Ministers to the COAG Intergovernmental Agreement (IGA) for a National Registration and Accreditation Scheme for the health professions (ref. IGA Item 7). The functions of the AHWMC are also outlined in the National Law sections 11–15 of Part 2. The Department of Health and Ageing stated that 'the Ministerial Council consists of the Commonwealth, State and Territory Health ministers who remain accountable to their respective Governments'.[15]

5.19 Ms Kerry Flanagan, Acting Deputy Secretary, Department of Health and Ageing, explained that policy advice is provided to AHWMC by the chief executive officers of the health departments. Further, a committee of officials was set up when the NRAS was established. Ms Flanagan went on to note:

> That still exists; it has different membership but it is made up of officials of all jurisdictions in terms of providing policy advice. I would just like to clarify though that the role of the ministerial council...it has an ongoing and defined role but had not intended or expect to continue administrative involvement except as a very light touch. So under the national law

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13 Department of Health and Ageing, *Answer to question on notice*.

14 Ms Kerry Flanagan, Acting Deputy Secretary, Department of Health and Ageing, *Committee Hansard*, 5 May 2011, p. 18.

15 Department of Health and Ageing, *Answer to question on notice*.

> ministers are responsible for approving registration and accreditation standards put forward by the national boards, approval of specialist registration and approval of areas of practice for the purposes of endorsement. Ministers can only give directions to national boards or the national agency under limited circumstances specified in the legislation. So I just want to be clear that when you talk about policy, I suppose the role of this particular council in these arrangements is set out in the legislation itself.[16]

5.20 AHPRA provides its annual report to the relevant minister in each of the jurisdictions, including the Commonwealth, for presentation to their respective Parliaments. AHPRA also indicated that communication with the responsible minister in each state and territory occurs as required and primarily involves the relevant state or territory manager for AHPRA and issues of relevance to the specific jurisdiction.[17]

5.21 AHWMC has monitored the implementation process and in February 2011, AHWMC met to discuss issues arising from the move to the NRAS. The Department of Health and Ageing commented that:

> ...the workforce ministerial council discussed the issues that were being raised by the professions in February...It agreed to have an increased monitoring role over AHPRA and that AHPRA needed to report more closely. It appointed the CEO of the Victorian Department of Health, Fran Thorn, to work with AHPRA to resolve the problems. All ministers agreed that they would make a commitment to seeing what support they could provide to AHPRA through this start-up period.[18]

5.22 Some submitters pointed out that under the old system, registration was handled by state or territory boards directly accountable to the health minister. However, under the NRAS, the system is much more complex and unclear. Mr Stephen Milgate, Executive Director, Australian Doctors' Fund, commented that 'there is no one particular minister or public servant who we can actually approach who had any authority to really control the process'.[19] Mr Milgate went on to state:

> Our major focus of concern is the non-accountability to a legislature of this entire process. We are appealing to all parliamentarians. This has been created outside of the legislative process and outside direct parliamentary scrutiny.[20]

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16 Ms Kerry Flanagan, Acting Deputy Secretary, Department of Health and Ageing, *Committee Hansard*, 5 May 2011, p. 24.

17 Australian Health Practitioner Regulation Agency, *Answer to question on notice.*

18 Ms Kerry Flanagan, Acting Deputy Secretary, Department of Health and Ageing, *Committee Hansard*, 5 May 2011, p. 20.

19 Mr Stephen Milgate, Executive Director, Australian Doctors' Fund, *Committee Hansard*, 4 May 2011, pp 15–16.

20 Mr Stephen Milgate, Executive Director, Australian Doctors' Fund, *Committee Hansard*, 4 May 2011, pp 15–16.

5.23 Mr Milgate concluded that :

> ...we do not believe that any parliamentarian, of any political party in this country, wants an unaccountable organisation running 500,000 health professionals which is unreachable, has nine bosses and is virtually unaccountable by design. We do not believe that is in the national interest...But our essential concern is for public safety, the national interest and the rights of legislatures to hold people accountable for their actions.[21]

5.24 In relation to accountability to the professions within the NRAS, the committee received many comments about the lack of transparency of AHPRA and the lack of consultation with the professions about problems during the implementation phase as well as concerns about the lack of accountability for the accreditation issues.

5.25 In relation to AHPRA, Ms Liesel Wett, Chief Executive Officer, Pharmaceutical Society of Australia, commented:

> Ultimately we would like to see greater transparency and consistency in registration processes and other activities which directly affect health practitioners and the services they then provide to the community; effective and timely responses to queries and in the processing of applications; and better communication with health practitioners as well as stakeholder organisations such as ours.[22]

5.26 Dr Mukesh Haikerwal raised concerns with section 236 of the National law and its effect on accountability. Section 236 shifts liability from people working for or on behalf of AHPRA, known as 'protected persons', to AHPRA itself. Dr Haikerwal's concern was that the practical exercise of s236 will hinder accountability as 'this suggests no accountability for the work or how it is done'.[23] Dr Haikerwal was further concerned that the ministerial accountability arrangements were also unclear.

5.27 In relation to accountability of the boards set up under the NRAS, the Australian Psychological Society (APS) commented:

> It is of concern that the new registration process appears to be dictated by the National Board without due consideration of the practical consequences to health practitioners. "*Continuous development of a flexible, responsive and sustainable Australian health workforce"* has in our experience, not been contemplated in the implementation of the National Scheme. Nor does the operation of the National Scheme to date have any apparent transparency or accountability.[24]

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21 Mr Stephen Milgate, Executive Director, Australian Doctors Fund, *Committee Hansard*, 4 May 2011, pp 19-20.

22 Ms Liesel Wett, Chief Executive Officer, Pharmaceutical Society of Australia, *Committee Hansard*, 4 May 2011, p. 8.

23 Dr Mukesh Haikerwal, *Submission 69*, p. 5.

24 Australian Psychological Society, *Submission 36*, p. 9.

5.28 The Australian College of Mental Health Nurses (ACMHN) suggested that communications between nursing organisations and the National Nursing and Midwifery Board did not meet the standard required under the National Law when consulting on registration standards. For example, there appears to be no mechanism to inform stakeholders that a consultation is taking place other than publication on the website and 'usually this has been in association with inappropriately short periods of time for consultation'.[25]

5.29 The ACMHN went on to comment:

> This type of process limits robust consultation, reduces transparency of process and can inadvertently encourage bias.[26]

5.30 However, the Australian Doctors Trained Overseas Association (ADTOA) supported the new NRAS arrangements regarding accountability, and characterised it as a 'significant improvement':

> A significant improvement in the national scheme is that now there are standards outlined in the National Law that are supposed to guide the policies and actions of the professional boards regarding transparency, accountability and fair due process. In addition the Board's policies/action cannot breach anti-discrimination law. This is a significant improvement over the former system where there was little if no oversight of the separate Medical Boards, and minimal avenues for meaningful input from the government and other key stakeholders.[27]

5.31 Yet this support was not without criticism. The ADTOA noted that in order for international medical graduates, or IMGs, to challenge board actions where the IMG believes the board has not followed its own policy, the IMG would themselves need to pursue the matter through the courts:

> This begs the question how can the Medical Board continue to act in a manner that contravene the standards that are supposed to guide their actions? Also how is it possible for AHPRA to be able to implement policies that may be in breach of anti-discrimination law? Unfortunately the only way to challenge potentially unlawful actions/policies is through legal channels. As already mentioned, given the overwhelming costs involved, legal action is not a realistic option for most IMGs.
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> Secondly, currently there is no mechanism in place to enforce these standards, and/or make judgments as to whether these standards have, or have not been met. This is a bit like having a speed limit but no speedometer and no police available to enforce it!

5.32 AHPRA provided the following comments about accountability:

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25 Australian College of Mental Health Nurses, *Submission 58*, p. 8.

26 Australian College of Mental Health Nurses, *Submission 58*, p. 8.

27 Australian Doctors Trained Overseas Association, *Submission 63,* p. 11.

> AHPRA and the National Boards are committed to transparency and accountability in all their functions, as well as delivering high standards of service. AHPRA, together with all National Boards, have adopted a Complaint Handling Policy and Procedure (the Complaints Policy). This formalises a process through which dissatisfied applicants and practitioners can have their concerns about AHPRA or the National Boards fairly considered and addressed. The Complaints Policy was developed to provide this mechanism and has been in effect since 14 September 2010.[28]

5.33 In order to improve accountability, health practitioner organisations suggested that more formal arrangements be put in place to ensure appropriate and timely consultation between AHPRA and organisations and between the national boards and organisations. Mrs Elizabeth Foley, Federal Professional Officer, Australian Nursing Federation (ANF), commented:

> ...the ANF wishes to take advantage of this inquiry to recommend that AHPRA establish a formal and ongoing advisory committee of the registered professions and soon to be registered groups. This committee would essentially be an expansion of the existing professional reference group, of which the ANF is a member, whose remit would include discussion of all issues pertaining to the national registration and accreditation scheme.[29]

5.34 The Australian College of Rural and Remote Medicine also called for proactive mechanisms within AHPRA to manage and encourage meaningful consultation, collaboration, communication and feedback about issues.[30] The Australian Physiotherapy Association (APA) also recommended that AHPRA increase its levels of direct communication with the professional associations through the Professions Reference Group (PRG). The APA noted that this group had been convened when the problems with the renewals process were identified. The APA recommended that AHPRA establish this group as a formal advisory committee of the currently registered professions, and soon to be registered professions, to discuss issues related to the administration of the NRAS. Further,

> The PRG has been an effective consultation and communication forum for the registered professions and the continuation of the information exchange within a formal advisory committee to the staff of AHPRA would be valuable to all concerned. The APA believes that such a body would be particularly relevant with the new professions coming into the AHPRA scheme over the next year.[31]

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28 Australian Health Practitioner Regulation Agency, *Submission 26,* p. 23.

29 Mrs Elizabeth Foley, Federal Professional Officer, Australian Nursing Federation, *Committee Hansard*, 4 May 2011, p. 21.

30 Australian College of Rural and Remote Medicine, *Submission 59*, p. 5.

31 Australian Physiotherapy Association, *Submission 54*, p. 5.

5.35 The Optometrists Association Australia proposed that AHWMC should consider establishing a standing advisory group by which advice from the professions regulated by AHPRA can be taken into consideration for the future direction of the Agency and its dealing with the regulated professions.[32]

5.36 The ACMHN recommended that consultation could be improved through the provision of mechanisms through which consultation can take place, more information about the consultations taking place, and more time for consultation.[33]

Committee comment

5.37 The evidence received highlighted a significant lack of accountability of AHPRA to the various jurisdictions and to the professions which will fund the NRAS. The committee considers that AHPRA should establish professional consultative groups. Such a mechanism would improve communications between AHPRA and professional organisations and help to quickly identify shortcomings in AHPRA processes.

Senior doctors and academics

5.38 A matter raised with the committee was the effect of the NRAS on senior doctors and academics. In relation to senior doctors, the arrangements have now changed, and any doctor retiring after the implementation of the new arrangements is unable to retain limited prescribing and referral rights, unlike doctors who retired before the new system was put in place. Professor Claire Jackson, President, Royal Australian College of General Practitioners, commented that there appeared to be no evidence why this change had been made except because such a registration category had not been allowed in some jurisdictions and stated:

> We believe that it is because in some states the legislation was to allow retired doctors very limited prescribing and referral rights and in others it was not, and so they removed the rights across the board. So we have two classes of retired doctors now. There was absolutely no evidence that the college could uncover, despite repeated requests, that there were any dangers, or safety or other related issues, with these very, very limited rights for retired doctors, for their family members only. So it was not an evidence based decision. Finally, it is very expensive for these doctors to remain in a practising category even if they are only doing occasional clinical sessions. They have to undertake a full 130 QA and CPD points, professional development points, per triennium, which will cost thousands of dollars. They need to retain their registration at a significant level.[34]

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32 Optometrists Association Australia, *Submission 37*, p. 4.

33 Australian College of Mental Health Nurses, *Submission 58*, p. 8.

34 Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 4 May 2011, p. 30.

5.39 Professor Jackson went to comment that this was a loss to the profession:

> Most of our senior doctors have said to us that this is now such a financial impost that, for the small amount of teaching and mentorship they wish to continue doing, they will not be able to sustain it. These are the giants of our profession. They have 40 years of clinical experience, which often far outstrips the sort of experience we have with all the scanning pathology and other issues available to us now, and we really, really want to strongly remonstrate that we should review this decision, acknowledge there is no evidence to it and reinstate these very senior, very experienced doctors to support us in our profession going forward.[35]

5.40 The Australian Doctors' Fund (ADF) also raised concerns in relation to the difficulties faced by senior doctors, from 55 years of age and above, who want to continue to work, but are unable to obtain an effective classification to work and are therefore 'being forced out of the profession'.[36]

5.41 Both the Medical Deans Australian and New Zealand and the Australian Dental Association (ADA) commented on the registration of academic staff. The Medical Deans noted that under the current regulations, doctors who contribute on an occasional basis to the teaching of medical students outside a clinical context are considered to be 'practising' under the interpretation of the regulations and were subject initially to full registration fees. However, after representations a voluntary agreement by the Medical Board of Australia (MBA) saw the fee reduced to $125 for doctors undertaking only teaching or examining/assessing. Further consultations by the MBA will look at the current definition of 'practice' and make a recommendation to the Ministerial Council.[37]

5.42 The ADA similarly pointed to the financial disincentives of full registration fees for dental academic staff.[38]

Committee comment

5.43 The committee is concerned that there is no flexibility for health practitioners wishing to teach and mentor students or to practise in a limited way. This will have a detrimental impact on academic institutions and the health workforce. The committee therefore considers that greater flexibility in the categories of registration is required and that the AHWMC should address this matter urgently.

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35 Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 4 May 2011, p. 30.

36 Mr Stephen Milgate, Executive Director, Australian Doctors' Fund, *Committee Hansard*, 4 May 2011, p. 16.

37 Medical Deans Australia and New Zealand, *Submission 32*, p. 3.

38 Mr Robert Boyd-Boland, Chief Executive Officer, Australian Dental Association, *Committee Hansard*, 4 May 2011, p. 72.

Mandatory notification

5.44 The National Law includes provisions for mandatory reporting of health practitioners by another practitioner after forming a reasonable belief that such conduct is 'notifiable'. Notifiable conduct includes practising while intoxicated by alcohol or drugs; and placing the public at risk of substantial harm because the practitioner has an impairment or the practitioner has practised in a way that constitutes a significant departure from accepted professional standards.

5.45 Concern was expressed that the mandatory notification requirements were overly prescriptive and may prevent practitioners from seeking assistance.[39] The Royal Australian College of General Practitioners (RACGP), for example, argued that the mandatory reporting requirements were 'likely to have the opposite of the intended effect' in that health professionals would be more likely to conceal their impairments from colleagues:

> This will exacerbate the issues and drive them underground, rather than decrease the risks to patients, the public, the practitioners themselves, and their colleagues. Only the current system of collegiate support and peer review can ensure that impairment issues will be dealt with in the patients' interest.[40]

5.46 Dr Stanley Doumani, Australian Doctors' Fund, commented:

> One of the things that I do is carry the phone for the ACT Doctors' Health Advisory Service. I have noticed that since AHPRA and mandatory reporting commenced, there has been a dramatic fall in the number of calls that I have been getting. That troubles me because I worry about my colleagues not seeking help when they need it.[41]

5.47 Dr Mukesh Haikerwal also pointed to the requirement to notify conduct which constitutes a 'significant departure from accepted professional standards'. Dr Haikerwal argued that:

> Combined with the subjective test intrinsic to the notion of "reasonable belief", the threshold for the requirement of triggering notification is low. It follows that the mandatory notification process is potentially open to abuse by claims made in bad faith with the intention of adversely affecting the registration status and the subsequent employability of a health practitioner.[42]

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39 Mr Robert Boyd-Boland, Chief Executive Officer, Australian Dental Association, *Committee Hansard*, 4 May 2011, p. 72.

40 Royal Australian College of General Practitioners (RACGP), *Submission 46*, p. 5.

41 Dr Stanley Doumani, Director, Australian Doctors' Fund, *Committee Hansard*, 4 May 2011, p. 16.

42 Dr Mukesh Haikerwal, *Submission 69*, pp 1-2.

5.48 He went on to note that overseas trained practitioners were particularly vulnerable to such claims. Dr Haikerwal argued that the National Law 'does not offer any definition of reasonable belief or significant departure from accepted standards of professional conduct'.[43] He also stated that there are penalties for an employer not reporting an instance of notifiable conduct. Dr Haikerwal asserted that:

> These new provisions promote a culture that resorts to peer reporting for fear of legal repercussions...or as a method of filtering out those practitioners struggling to gain integration and acceptance within the profession or indeed another avenue for employers to act against an employee without first initiating normal workplace processes.[44]

5.49 Dr Haikerwal citied a case of mandatory notification where even though the practitioner had been exonerated by AHPRA, 'there was no recognition [by the agency] that this was a most distressing situation that needed to be handled with care and sensitivity'. Dr Haikerwal summarised his view of AHPRA's conduct in this particular case:

> ...the attitude has been high handed, officious, thoughtless, unprofessional, unforgiving and the principles of natural justice, access to common law rights, the presumption of innocence have been ignored. There is no respect as the notion is one of absolute power which cannot be questioned. An expectation that the high handed manner must be tolerated and there will be no detractors for fear of retribution from the Agency.[45]

5.50 Associate Professor Rait of MDA National Insurance also told the committee of his concern about a situation where a practitioner under psychiatric care was reported to AHPRA to be 'at risk' by the treating doctor. It was believed that as a consequence of this, the practitioner took his own life. Associate Professor Rait emphasised that the implications for the therapeutic relationship under the mandatory obligations are clearly very serious.[46]

5.51 MDA National's submission noted the potential for vexatious complaints under the current system and also pointed out that the mandatory reporting provisions were not included in the legislation adopted by Western Australia:

> We understand there are instances where the provisions have been interpreted or implemented in such a way to disadvantage individuals to the extent that there is potential that impaired doctors may have been reluctant to self refer for help because of the risk of being reported to AHPRA. We remain of the view that such is an unintended consequence of the legislation and yet it remains to be addressed on a national basis and yet we note that

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43 Dr Mukesh Haikerwal, *Submission 69*, p. 3.

44 Dr Mukesh Haikerwal, *Submission 69*, p. 4.

45 Dr Mukesh Haikerwal, *Submission 69*, p. 5.

46 Associate Professor Rait, President, MDA National Insurance, *Committee Hansard*, 5 May 2011, p. 12.

> in Western Australia mandatory reporting of colleagues by treating doctors has been removed.[47]

5.52 Mr Boyd-Boland, ADA, suggested that an approach similar to that taken in Western Australia would be preferable:

> We are concerned that some of the mandatory reporting requirements are preventing some practitioners from seeking assistance from other health practitioners to deal with the potential for impairments. You may know that in Western Australia the legislation there is slightly different and we have sought to have that Western Australian variation adopted nationally.[48]

5.53 The RACGP went further and recommended that the National Law should be amended 'to exempt the health professional's treating doctor from mandatory reporting under section 141 of the legislation'.[49]

5.54 APS was particularly concerned about the impact of mandatory reporting requirements on psychologists who provide services for the Family Court of Australia.[50] The APS Family Law and Psychology Interest Group made similar comments, explaining that:

> Psychologists who undertake assessments in family court matters are routinely regularly reported to AHPRA following family court assessments.
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> This has been recognised internationally in family law to be reflective of the nature of Family Law processes, and generally represent the litigant's attempt:
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> - To invalidate the opinion of the clinician,
> - To use legal leverage by excluding the psychologist from future court proceedings, and
> - To gain revenge and retribution on the psychologist when the opinions expressed in reports do not favour them.
>
> AHPRA fails to consider the particular professional, financial and physical risks for psychologists specialising in Family Law and the potential for competing responsibilities between their duty to the court and current parameters for professional practice.[51]

5.55 While not suggesting that Family Law psychologists be exempt from complaints, it was suggested that AHPRA needed to change the way it handled the complaints process:

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47 MDA National Insurance, *Submission 20*, p. 3.

48 Mr Robert Boyd-Boland, Chief Executive Officer, Australian Dental Association, *Committee Hansard*, 4 May 2011, p. 72.

49 Royal Australian College of General Practitioners, *Submission 46*, p. 5.

50 Australian Psychological Society Ltd, *Submission 36*, p. 11.

51 APS Family Law and Psychology Interest Group, *Submission 10*, p. 1.

> We submit that there needs to be some mechanism where these complaints are screened to avoid wasting time, energy and money in undertaking investigations where the litigant obviously has malicious motives.
>
> ...AHPRA also routinely ignores the rights of other parties and children involved in assessments. It is typical practice for AHPRA to rely on the complainant's view without seeking input from the other party and to demand files and reports without consideration for the other participants' rights and our ethical and legal responsibilities to them.[52]

5.56 The submission from Medical Deans Australia and New Zealand emphasised that the mandatory notification obligations also apply to education providers of medical students when it is suspected that a student's ill health may be placing the public at risk. The Medical Deans considered that an appropriate 'feedback mechanism' needs to be put in place:

> ...back to the host education provider (i.e. the institution that the student is enrolled at). The universities have a duty of care to its [sic] students and Medical Deans feel it is imperative for universities to be informed of any student reported to AHPRA to allow the university to be able to offer appropriate support and care to that student.[53]

Committee comment

5.57 The committee notes the issues raised in relation to the mandatory notification requirements. This is a difficult area of regulation and the safety of the Australian public must be paramount. However, the committee considers that there is merit in examining the operation of the mandatory notification regime in the National Law in comparison to that operating in Western Australia.

Overseas trained health practitioners

5.58 The committee received evidence of the difficulties experienced by overseas health practitioners (mainly medical practitioners and nurses) seeking registration in Australia. Some of these difficulties were similar to those experienced by other health practitioners during the registration process including inappropriate delays, inaccurate advice, and lost documentation. Rural Health Workforce Australia commented that the delays and AHPRA's inability to provide a timeframe for processing registrations, made it very difficult for IMGs to plan their arrival in Australia and also made it difficult for employing practices to plan. Such delays result in problems for both the medical practice employing the IMG and for arrangements for supervision and mentoring of the new doctor.[54]

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52 APS Family Law and Psychology Interest Group, *Submission 10*, p. 2.

53 Medical Deans Australia and New Zealand, *Submission 32*, p. 4.

54 Rural Health Workforce Australia, *Submission 49*, p. 3. See also Rural Workforce Agency Victoria, *Submission 50,* p. 8.

Case study 5.1

An overseas qualified nurse (Sweden) applied for registration in October 2010 and was informed the assessment process could take up to three months. The nurse continued to check on her application and was informed in November that the application was straightforward and was in the final stages. The nurse was told this several times, however in December was informed that AHPRA had not started the application process (at this time AHPRA indicated, assessment takes three months from when they start the process). The nurse contacted the ANF (Victorian Branch) who subsequently contacted AHPRA to be informed that overseas applications had been put on hold to deal with domestic applications. The nurse received her registration on 21 March 2011, six months after initial application.

Source: Australian Nursing Federation, *Submission 57*, p. 4.

5.59 The Melbourne Medical Deputising Service (MMDS) commented that when dealing with AHPRA nothing has been forthcoming in the way of options or possible solutions. MMDS commented that the delays may result in English tests expiring requiring IMGs to go through the process as again. The same comments were made in relation to Certificates of Good Standing required by international health practitioners.[55] The Rural Workforce Agency Victoria commented that process time for general registration is currently six weeks and limited (Area of Need) is currently taking up to three months. There are also Medicare and Department of Health and Ageing requirements which add to the time taken for IMGs to commence practice. An application can take six to eight months to gain approval and the Agency noted that by this time practices in rural areas may lose a candidate.[56]

5.60 However, there were a range of matters particular to overseas trained health practitioners which were brought to the committee's attention including the new English test and changing registration requirements.

5.61 Avant Mutual Group commented that one of the issues facing IMGs who arrived in Australia before 2007 has been the frequent changes in policy concerning demonstration of competence. Initially, the only requirements were for the practitioner to be supervised and for the supervisor to provide reports to the relevant medical board about the international graduate. In 2007 a requirement was introduced (in some jurisdictions) that IMGs pass particular Australian qualifications within four years. In 2009 (in some jurisdictions) a requirement was introduced that the IMGs had to demonstrate certain progress towards passing the Australian qualification. Then at the end of 2009 at least one jurisdiction introduced a requirement that IMGs sit the Structured Clinical Interview (SCI) if they had not passed an Australian qualification.

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55 Melbourne Medical Deputising Service, *Submission 28*, p. 8; Rural Workforce Agency Victoria, *Submission 50,* p. 7.

56 Rural Workforce Agency Victoria, *Submission 50,* p. 8.

5.62 Avant Mutual Group concluded that these changes made it very difficult for many IMGs who had worked safely and competently in Australia for many years, including in areas where Australian graduates would not work, believing they met the relevant (pre-2007) requirements. However, the some IMGs are now required to invest considerable additional time in order to comply with the frequent changes post 2007. This often posed additional stresses on the doctors and their families in adjusting to their new life in Australia.[57]

5.63 The MMDS also commented on the difficulties facing IMGs and stated that IMGs face a 'maze of complex information' with each step in the process long and frustrating. The overall financial cost for IMGs is many thousands of dollars and they do not understand why everything is so hard when dealing with the relevant assessment and entry systems not the least of which is AHPRA.[58]

5.64 Another example of problems was provided by Rural Health Workforce Australia which noted that if an overseas trained doctor wishes to move from one employer/location to another they are required to submit a new registration application and fee in some jurisdictions, while in others they are only required to submit a change of circumstances form. Rural Health Workforce Australia concluded that this is 'yet another example is that the registration processes are differing in lengths of time and are differing in cost across jurisdictions'.[59]

5.65 The RACGP also noted that IMGs suffered particular consequences after the new system was introduced, and those in Western Australia and Queensland seemed to be most affected:

> These are doctors who have been on temporary registration arrangements and who, due to the new arrangements, very suddenly were informed that they could not be re-registered because they had not completed their fellowship. Fellowship exams occurs several times a year, and it did not give them time to complete their fellowship prior to the cut off. So the college has spent most of its effort around this issue working with the Medical Board of Australia to try to support our international medical graduates—particularly those in rural and remote areas, where they are 45 percent of the workforce in both those states—to get through to their fellowship as quickly as possible so that they do not miss out on registration.[60]

5.66 The Royal Australian College of General Practitioners also commented on the inconsistency of approach: in Queensland, IMGs are often subject to ongoing progress requirements on their limited registration, whereby failure to meet the progress

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57 Avant Mutual Group, *Submission 12*, p. 5.

58 Melbourne Medical Deputising Service, *Submission 28*, p. 7.

59 Rural Health Workforce Australia, *Submission 49*, p. 2.

60 Professor Claire Jackson, President, Royal Australian College of General Practitioners, *Committee Hansard*, 4 May 2011, p. 31.

requirements can result in refusal to renew the doctor's registration. The RACGP stated that 'there are no such national requirements in place, and inconsistent processes from state to state both contradict the concept of national registration, and cause unnecessary difficulties for the profession'.[61]

English language requirement

5.67 The new English language skills registration standard introduced with the NRAS was canvassed in many submissions. The ANF for example, commented that it had 'created enormous concern, confusion and distress for those international students who had undertaken courses in Australia'. Of particular concern was the change in rules so that students, who had incurred significant cost in undertaking courses and who had expected to be registered at the completion of the course, could not do so. The ANF stated that the situation was 'compounded by inconsistent information posted on the AHPRA website in the form of the English language skills registration standard and the FAQs (frequently asked questions) section'. The ANF also noted that not only overseas students but also many Australian citizens, not having completed their secondary school education in English, were also caught up in this 'debacle'.[62]

5.68 The ANF considered that AHPRA was slow to respond to its concerns regarding inconsistencies in the English language skills registration standard and that although a review of the standard has been undertaken, AHPRA has indicated that 'the current standard would remain in place despite the review and that the outcome of the extensive consultation process remains pending'.[63]

5.69 The ADTOA argued that there are two major concerns with the English test. First, the standard of English expected of IMGs applying to work in Australia is equivalent to what would be expected of a professor teaching in an Australian university. In fact, according to a number of language instructors, many native English speakers, including health professionals, would struggle to pass the test. Secondly, the test results are only valid for two years even if the IMG has been living and working in Australia.[64]

5.70 The Medical Deans Australia and New Zealand commented on the English test in relation to students from overseas who are university-trained in Australia. The Deans were of the view that the regime is onerous for these students, given that overseas students who graduate in Australia have already faced several tests including stringent entry requirements for international students into medicine (including rigorous English skills assessment undertaken through the medical school admissions process) and the subsequent teaching and assessment in English over a 4-6 year period

61 Royal Australian College of General Practitioners, *Submission 46*, p. 4.

62 Australian Nursing Federation, *Submission 57*, p. 6.

63 Australian Nursing Federation, *Submission 57*, p. 6.

64 Australian Doctors Trained Overseas Association, *Submission 63*, p. 2.

of the medical program. Despite the MBA partially addressing these concerns for students graduating in 2010 through a 'one-off transition process', the Deans remain concerned that the underlying problem caused by such an onerous condition remains. Consequently, 'in the longer term Medical Deans believes these regulations should be eased permanently for students undertaking their entire studies at an Australian Medical School'.[65]

Pre-employment structured clinical interviews (PESCIs)

5.71 Pre-employment structured clinical interviews (PESCIs) were introduced in 2008 as a tool to screen potential IMGs for their suitability for area of need positions prior to starting work in Australia. The PESCI involves an oral exam where candidates are asked questions about cases. Submitters voiced concerns about the PESCI in relation to efficacy, timing and portability of results.

5.72 The ADTOA commented that the PESCI should not be used for registration as this type of exam has shown to be difficult to standardise and is subject to bias. ADTOA commented that

> Despite the fact that the PESCI was never designed to be a high stakes assessment, and the fact that it had not been properly standardized on Australian trained doctors, AHPRA started to use the PESCI to assess IMGs who were already working in Australia, some of whom had worked for as long as 25 years in this country. A large number of these IMGs failed the PESCI and were subsequently de-registered.[66]

5.73 The ADTOA pointed to problems with the PESCI including frequent rule changes, procedural irregularities and inappropriate assessment, barriers to meaningful appeal and changes to timetables without explanation.[67] The ADTOA recommended that an international health professional advisory and advocacy committee be established. The committee would:

- monitor the Professional Boards and other contracted accreditation authority’s adherence to standards as outlined in the national law including potential breaches of anti-discrimination law;
- gather data and provide information about the impact of Medical Board policies/decisions on IMGs as well as the potential impact on the Medical workforce particularly on rural communities;
- liaise with the Medical Board and other accreditation groups (AMC, colleges) regarding any new policies that could potentially impact on IMGs;
- provide recommendations as to how to better support IMGs in the Australian workplace;

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65 Medical Deans Australia and New Zealand, *Submission 32,* pp 1–2.

66 Australian Doctors Trained Overseas Association, *Submission 63*, p. 1.

67 Australian Doctors Trained Overseas Association, *Submission 63*, pp 3–6.

- provide information/advice/guidance to IMGs regarding registration/accreditation issues/problems; and
- provide some form of legal assistance/advice to IMGs regarding appeals.[68]

5.74 MMDS also pointed to inconsistencies in the management and scheduling of PESCIs and that there is inconsistency in the way PESCI providers ensure that interview content is relevant. For example, the RACGP (SA) is an accredited PESCI provider and the panel of assessors rightly require full information (position description, support and supervision/mentor mechanisms) about the position for which an IMG is being considered. However, this is not the case for the Health Workforce Assessment Victoria which refuses any information about the position or available support systems for which the doctor is being considered. MMDS commented that differences in the way medical registration is handled at the state level seems inconsistent with the intent of national registration.[69]

Case study 5.2

Only four applicants who were supported by the New South Wales Rural Doctors Network (the RWA in NSW) undertook an AHPRA-NSW PESCI in the 6 months from 1 July to 31 December 2010. These applicants waited an average of 6 weeks from lodging their PESCI paperwork to being notified of the PESCI date. Applicants were given an average of 2 weeks notice before the PESCI and more than 7 weeks (more accurately between 4 and 13 weeks) to be advised of the outcome; even though they were advised at the interview they will be notified within two weeks. Two other OTDs supported by NSW RDN withdrew their applications for PESCIs in NSW, citing it was too complex, frustrating and taking too long. The lack of enough sittings of a PESCI panel in NSW over this time meant that RDN was very restricted in the number of applicants it could support for registration.

Source: Rural Health Workforce Australia, *Submission 49*, p. 2.

5.75 MMDS also raised concerns about the PESCI waiting list in Victoria. MMDS has referred to the Health Industry Ombudsman the case of one IMG who lodged an application in August 2010 and who at 13 January was still 'some way down the PESCI waiting list'. The doctor then applied to sit the test in South Australia and did so in March 2011.[70]

5.76 The Albury-Wodonga Regional GP Network commented that PESCI's for limited registration doctors are non-transferrable between states contradicting a national registration system. This was of particular concern and affected GPs in the Albury-Wodonga region.[71]

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68 Australian Doctors Trained Overseas Association, *Submission 63*, p. 12.

69 Melbourne Medical Deputising Service, *Submission 28*, p. 9.

70 Melbourne Medical Deputising Service, *Submission 28*, p. 8.

71 Albury-Wodonga Regional GP Network, *Submission 30,* p. 2. See also Rural Workforce Agency Victoria, *Submission 50,* p. 10.

Committee comment

5.77 The committee notes that overseas trained practitioners form a crucial part of the delivery of health services to Australians, particularly those in rural and remote areas. The committee is therefore deeply concerned that registration processes appear not to be applied consistently and that delays by AHPRA have resulted in practitioners having to re-submit various certificates and has adversely affected their ability to commence employment.

5.78 The committee concludes that this is an area where AHPRA must significant improve its performance. Further, the committee considers that updates on the registration of overseas trained practitioners should be considered by the Australian Health Workforce Ministerial Council on a regular basis. AHPRA should also establish a Key Performance Indicator on this category of registration and report outcomes in its annual report.

Criminal history declaration

5.79 The registration process requires that health practitioners provide a criminal history declaration. Evidence provided indicated a lack of flexibility in AHPRA processes in implementing this requirement in addition to poor administrative arrangements.

5.80 The ANF, for example, provided two examples about the difficulties experienced by their members in relation to the criminal history declaration:

- a member who applied for registration as an EN in December 2010, tried many times to contact AHPRA regarding the status of their application. They were informed that AHPRA was waiting on a criminal history check (even though the applicant had no criminal history) and that they were processing hospital employed applicants before those working in aged care. The ANF commented that this determination by AHPRA that one sector was more important than another is not acceptable; and
- a nurse member was contacted by AHPRA about non-disclosure of an allegation of a criminal offence. The allegation occurred thirty years previously and was dismissed in court. The nurse was told they had to provide a statutory declaration as to why they did not disclose the allegation and a separate statement of the circumstances of the case. The nurse was told they must deliver these documents to the AHPRA office and that fax/emails were not acceptable. The nurse lives in a rural area, which led to loss of income to attend the AHPRA office.[72]

72 Australian Nursing Federation, *Submission 57*, p. 5.

5.81 While the committee is fully supportive of such a requirement, the processes implemented by AHPRA in relation to this requirement have resulted in difficulties in terms of inconsistency.