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26 November 2018

Mr Rod Bogaards
Inquiry Secretary
Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee

Via email: health@parliament.qld.gov.au

MIGA submission: Health Practitioner National Law and Other Legislation Amendment Bill 2018

MIGA appreciates the opportunity to make a submission to the Committee's inquiry into the Health Practitioner National Law and Other Legislation Amendment Bill 2018.

A copy of its Submission is enclosed.

MIGA is a medical defence organisation and medical / professional indemnity insurer advising, assisting and educating medical practitioners, medical students, healthcare organisations and privately practising midwives throughout Australia. With over 33,000 members and a national footprint, MIGA has represented the medical profession for 118 years and the broader healthcare profession for 16 years.

As set out in the enclosed Submission, MIGA has significant involvement in issues around health practitioner mandatory reporting, health and well-being of practitioners more generally and practitioner advertising, regulation and discipline. This includes contributions to the 2017 and 2018 COAG Health Council consultations on treating practitioner mandatory reporting reforms, and the 2017 consultation on title protections.

You can contact Timothy Bowen, telephone 1800 839 280 or emai[redacted], if you have any questions about MIGA's Submission.

Yours sincerely

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MIGA Submission

Queensland Parliament
Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee

Inquiry into the Health Practitioner National Law and Other Legislation Amendment Bill 2018

November 2018

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26 November 2018

Queensland Parliament

Health Practitioner National Law and Other Legislation Amendment Bill 2018

Executive Summary – MIGA's position

1. MIGA supports the general intent of the Health Practitioner National Law and Other Legislation Amendment Bill 2018 (**the Bill**) to reduce barriers to doctors, other health practitioners and students seeking care and to protect the community from unregistered persons who falsely claim to be registered health practitioners.

2. It does however have significant concerns about the Bill's ability to achieve its objectives, particularly practical challenges around interpreting and using its provisions, and potential unintended effects.

3. MIGA does not believe the Bill adequately addresses the barriers to doctors, other health practitioners and students seeking treatment. This poses a significant obstacle to achieving the necessary balance between the paramount need to protect the public on the one hand, and the legitimate interests of health practitioners and students on the other. The proposed amendments are unlikely to minimise the possibility that patients and the community are put at risk by an isolated, unwell practitioner or student trying to deal with their personal health issues without proper support. They cannot ensure that practitioners suffering health conditions but who are fit to work have the confidence they will be able to do so.

4. MIGA's position on treating practitioner mandatory reporting is:
   - (a) Impairment and significant departures from accepted practice should not be grounds for mandatory reporting by treating practitioners – if they are to remain, there is a need for clearer reporting thresholds and further discretionary factors to consider as part of a holistic assessment
   - (b) There should be clearer guidelines on the ethical and professional reporting obligations of treating practitioners around impairment
   - (c) It supports the Bill's proposals involving:
     - i. Mandatory reporting by treating practitioners of substantial risk of harm posed by intoxication and current, and risks of future, sexual misconduct, but sees a need for clearer reporting thresholds for both grounds of reporting and discretionary factors around intoxication to consider as part of a holistic assessment
     - ii. Mandatory reporting obligations for treating practitioners (other than for sexual misconduct) only applying to current actions and future risks, not past conduct
   - (d) Clear and detailed guidance and education specifically for treating practitioners, developed with input from key professional stakeholders such as MIGA, must be provided to the health professions before the proposed changes come into force
   - (e) There should be:
     - a. A nationally consistent National Board health program along the lines of the Medical Council of NSW model for managing impairment and drug / alcohol matters
     - b. More research and monitoring around mandatory reporting perceptions, trends and experiences to feed into guidance, education and further review
     - c. More work on how regulator, workplace and training body obligations and processes around impairment and other health issues can be better harmonised and co-ordinated.

5. On the issue of increased penalties under the *Health Practitioner Regulation National Law* (**the National Law**), MIGA supports the need for effective deterrents against people claiming to be registered health practitioners when they are not. However, it opposes the changes applying to registered health practitioners who make claims in good faith about the training, expertise and experience of themselves or their colleagues. These should not have the potential for significant civil penalties or imprisonment.

MIGA's interest

6. MIGA is a medical defence organisation and medical / professional indemnity insurer with a national footprint. It has represented the interests of the medical profession for 118 years and the broader healthcare profession for 16 years. It has in excess of 33,000 members and policyholders Australia wide including medical practitioners, medical students, privately practising midwives and healthcare organisations.

7. Its lawyers regularly advise its members and clients on mandatory reporting and advertising obligations, and assist those who are the subject of a mandatory report or complaint about advertising to a regulator. Its lawyers have considerable experience across Australia in how health matters are handled by regulators, workplaces and training bodies. Consequently, it is well-placed to compare how different systems balance the needs of public protection and encourage unwell practitioners to seek early treatment. It is also well-placed to assess what are effective and appropriate strategies to ensure accurate, fair and clear advertising.

8. For many years MIGA has had extensive involvement in doctors' health issues. This includes:
   (a) A Doctors' Health Assessment process for its members, developed in conjunction with Doctors' Health SA, encouraging practitioners to undertake a detailed health assessment with their GP, as part of earning MIGA Risk Management Program points which can go towards reductions in insurance premiums
   (b) An interactive Doctors' Health e-book, exploring the importance of practitioner health and well-being and its implications for practice and life
   (c) Its Practitioners' Support Service, enabling members and clients to obtain peer and professional support when suffering adverse health effects from medico-legal processes
   (d) A variety of educational workshops as part of its Risk Management Program.[1]

9. MIGA advocates on matters to do with treating practitioner mandatory reporting, doctors' health and advertising more generally, including in parliamentary inquiries, regulator consultations and forums involving other key stakeholders.

The problem of treating practitioner mandatory reporting

10. MIGA welcomes the Bill's intent to address concerns that mandatory reporting discourages unwell practitioners from seeking treatment because they are concerned any physical or mental health condition they disclose will compel their treating practitioner to make a mandatory report.

11. MIGA is concerned at examples of:
   (a) Practitioner patients hesitant to seek treatment for fear of being the subject of a mandatory report
   (b) Fear amongst practitioner patients about what will happen after a mandatory report, including how it will impact their career and personal life
   (c) Well-intentioned and conscientious treating practitioners grappling with challenges in working out whether a mandatory report is required or misunderstanding the complex requirements of the mandatory reporting regime
   (d) Treating practitioners worried about what will happen if they fail to make a mandatory report if it is later suggested they should have and failed to do so.

12. In some cases, these hesitancies, fears and perceptions may contribute to a range of harms to practitioners, students, their families, patients and the broader community. These could include adverse healthcare outcomes, exacerbation of underlying health conditions, self-treatment and unhelpful impacts on working and personal lives. In extreme cases, there have been suggestions they can lead to practitioner suicide.

13. The protection of patients and the public is paramount. However it is necessary to achieve the right balance between public protection and ensuring unwell practitioners access necessary care and treatment. This balance is not achieved when an impaired practitioner does not seek appropriate medical care. It is far better for those practitioners, those close to them, patients and the public that the affected practitioner receive appropriate treatment. They cannot be left isolated and out on their own, lacking necessary professional support.

14. Mandatory reporting obligations can only work effectively when they are clear, simple and straightforward. The current mandatory reporting obligations for a treating practitioner involving impairment are not. The Bill's proposed changes are insufficient to provide the necessary clarity.

15. Consequently, MIGA was disappointed to see that the proposals it and other key professional stakeholders made to clarify the proposed obligations in the draft Health Practitioner Regulation National Law

[1] More information about these initiatives is available at www.miga.com.au/education/doctors-health

Amendment (Stage 1A) Bill were not accepted, and that the Bill now before the Queensland Parliament is unchanged from that draft bill.

Removing obligations on treating practitioner to report impairment or significant departures from accepted standards

16. MIGA believes a treating practitioner should not be required to make a mandatory report on the grounds of impairment or significant departure from accepted standards.

17. The April 2018 COAG Health Council communique emphasised removing barriers for health practitioners to seek appropriate treatment for impairment. It lacked reference to a continuing obligation to report impairment, but made specific reference to each of the other remaining grounds for mandatory reporting by treating practitioners.[2] MIGA and other stakeholders welcomed this as an intention to remove impairment as a ground for mandatory reporting.

18. Mandatory reporting by treating practitioners involving impairment involves complex judgments which can be difficult to work through, even by senior, experienced practitioners familiar with the regime's requirements. They seem to imply a clarity around risk which can be impossible to assess in any meaningful way.

19. A legislative mandatory obligation cannot deal properly with the wide range of situations treating practitioners are asked to assess around impairment. Inherently, a range of different judgments on similar situations will be reached. This is certainly not an ideal situation for a mandatory obligation.

20. This is also concerning for the well-meaning and conscientious treating practitioner troubled by the possibility of professional criticism and sanction for failing to make a report, or making a report when it was ultimately not considered necessary.

21. Although the Bill intends to create a higher threshold for reporting, the wording of the relevant provisions still create significant scope for varying interpretations of when a particular practitioner or student, or particular circumstances, warrants a mandatory notification. This will be essentially be inevitable whatever legislative reform is attempted.

22. The Bill's Explanatory Notes (p8) refer to the proposed reporting threshold of substantial risk of harm being the same as the current Queensland approach of only requiring reports of impairment posing substantial risk of harm. Notably, no data or other evidence has been provided to indicate whether this different threshold, the same as that proposed now to be introduced more broadly, has reduced barriers in Queensland to doctors and other health practitioners seeking care. MIGA would consider any such evidence to be crucial in determining whether the new threshold will adequately deal with the concerns the Bill is intended to address.

23. Finally, it is unclear how regulators are necessarily better placed than treating practitioners to manage impairment in a co-operative and insightful patient. A practitioner reported to a National Board for impairment would normally be assessed via independent health assessment. How this is better than assessment by a treating practitioner is unclear.

24. MIGA believes the far better course is to build on existing ethical and professional reporting obligations on treating practitioners to deal with impairment. These allow greater scope for the finely nuanced judgments required, and can be better adjusted to reflect the wide range of situations treating practitioners will encounter than blunt legislative solutions can ever be. Proposals for how to clarify existing ethical and professional obligations around reporting impairment issues are set out below.

25. With appropriate guidelines and education rather than a mandatory reporting obligation, treating practitioners will be better equipped to successfully treat impaired health practitioners with the knowledge that they will be able to make a notification to AHPRA if the practitioner's impairment does not respond to treatment and/or the impaired practitioner lacks insight into their impairment and this places the public at substantial risk.

26. Turning to the issue of treating practitioners reporting significant departures from accepted standards posing a substantial risk of harm, it remains questionable how a treating practitioner can assess whether a doctor under their care meets such a threshold. They are often not a professional peer of their patient.

[2] Available at www.coaghealthcouncil.gov.au/Portals/0/CHC%20Communique%20130418_corrected_1.pdf

Rarely would they be practising with them. How practitioner in one specialty can judge this issue in the context of another specialty is unclear. Even for a peer, it can be very challenging to make such a determination.

27. It would usually be a practitioner's professional colleagues, supervisors or others in the workplace, who already have mandatory reporting obligations, who are best placed to judge whether a mandatory report is required for significant departures from accepted professional standards.

Clarifying threshold for reporting impairment

28. If impairment is to be maintained as a ground for mandatory reporting by treating practitioners, further clarification is required to ensure that "*only serious impairments that are not being appropriately managed through treatment or mitigation strategies need to be reported if the safety of patients would be at risk*" (Bill Explanatory Notes, p5).

29. MIGA is troubled by misunderstandings as to what constitutes 'impairment' warranting a mandatory report. This has been incorrectly interpreted as requiring notification of mental health conditions, such as depression or anxiety, when the practice of the practitioner or student is not affected and the public is not put at risk.

30. The reality of the intended higher threshold for making a mandatory report by a treating practitioner is to merely restate current professional guidance and make a change which will be seen by many as a distinction without a difference.

31. Existing National Board *Guidelines for mandatory notifications* already indicate that only the most serious impairments not being managed through treatment need to be reported and that risks appropriately managed through treatment by a fully compliant practitioner do not need to be reported.[3] The proposed threshold of substantial risk of harm threshold merely reinforces this, but in a manner which is not as clear.

32. MIGA is concerned that the substantial risk of harm threshold could also be interpreted by some to mean any possible harms, whatever their nature or likely impact, should be reported so long as they are substantial, i.e. in the sense of being present and likely to occur. It is a concern also raised by other stakeholders in recent consultations. This is clearly not the intention of the proposed threshold, nor does it reflect the current National Board guidelines. This is a significant issue. It reinforces the need for early, clear and detailed guidance and education for the professions, developed with input from key professional stakeholders, including MIGA.

33. To address these threshold issues around impairment, MIGA proposes the following:
    (a) Being clear about what is 'impairment' – as this is defined elsewhere in the National Law, the full definition should be noted next to the mandatory reporting obligation to avoid confusion
    (b) Requiring consideration of context - making it mandatory, not just discretionary, to consider the context of the impairment, its ability to be managed and any other relevant matters
    (c) Additional issues to consider – requiring consideration also of the patient's practice context.

Holistic assessments of intoxication and significant departures from accepted practice

34. MIGA supports the proposals to require mandatory reporting for intoxication based on placing the public at substantial risk of harm by practising whilst intoxicated by alcohol or drugs.

35. 'Intoxication' is not defined in the National Law, but is explained in the AHPRA / National Board guidelines. These guidelines explain that a practitioner is intoxicated "*where their capacity to exercise reasonable care and skill in the practice of the health profession is impaired or adversely affected as a result of being under the influence of alcohol or drugs"* (p7). It would be helpful to note the existence of this definition with the proposed obligation.

36. Although there are suggestions in the Bill's Explanatory Notes of a treating practitioner being able to make a holistic assessment of risk relating to impairment, intoxication or significant departure from accepted standards, this process is unclear and offers significant potential for confusion.

[3] Available at www.medicalboard.gov.au/Codes-Guidelines-Policies/Guidelines-for-mandatory-notifications.aspx, pp4-6

37. A range of factors to consider, such as effectiveness of treatment or engagement in treatment, may be considered in relation to impairment, but no factors, as contextually relevant, are provided for intoxication or practice significantly below standards.

38. Moreover, where there are discretionary factors for impairment, but not for intoxication or significant departures from accepted standards, MIGA fails to see how this holistic assessment can be conducted.

39. Using the example given in the Explanatory Notes (p5), if an impairment issues was related to intoxication or significant departure from accepted standards in a practitioner patient, a treating practitioner would still be required to make a mandatory report if either of the thresholds of substantial risk of harm posed by intoxication or significant departure were met. The fact that a practitioner is engaging in effective treatment for any impairment would not of itself excuse any mandatory reporting obligation on other grounds.

40. This issue could be overcome through the introduction of discretionary factors which must be considered as appropriate for each of intoxication and significant departures from accepted standards, which tie in appropriately with impairment issues.

41. MIGA agrees with the view expressed in the Bill's Explanatory Notes (p12) that the guidance factors specific to impairment do not lend themselves to being automatically applied to other categories of conduct. However, this is why guidance factors specific to intoxication and practice significantly below standards are required.

42. Furthermore, the concept of "*substantial risk of harm*" posed by a significant departure from accepted practice can be challenging to interpret for a treating practitioner who does not see their practitioner patient in their practice context, is commonly not from the same profession or specialty which could assist in making such an assessment, and who is likely to be practising in a different location. Accordingly, appropriate discretionary factors are also required to address this issue.

43. MIGA proposes the following:
    (a) Clarifying what is intoxication in the legislation by referring to AHPRA / National Board guidelines
    (b) Requiring consideration of various issues as appropriate in determining whether to make a mandatory report for intoxication – this would cover:
        a. Nature, extent and severity of intoxication
        b. Extent to which the patient is taking (or willing to take) steps to manage their alcohol or drug issues
        c. Extent to which alcohol or drug issues can be managed with appropriate treatment
        d. Patient's practice context
        e. Any other matter the treating practitioner considers relevant in assessing the risk of harm posed by intoxication.
    (c) If the obligation to report practice significantly below standards by treating practitioners is maintained, there be a requirement for a treating practitioner to consider a range of factors when considering a report based on significant departure from accepted standards, including:
        a. Patient's practice context
        b. Extent to which the practitioner is able to judge this issue when not practising with the patient
        c. Extent to which the practitioner can judge the patient's practices given their own knowledge and expertise.

Sexual misconduct

44. MIGA supports mandatory reporting of current or risk of future sexual misconduct due to a failure to engage in appropriate help or therapy, or put in place an appropriate management plan.

45. There is a lack of clarity about how to determine whether a practitioner patient "*is at risk of engaging in*" sexual misconduct. This could well lead to the difficult situation of a treating practitioner being uncertain about predicting the future, and therefore erring on the side of over-reporting. A wide range of views about what is a future risk of sexual misconduct are likely.

46. The term 'sexual misconduct' is also open to misunderstanding and uncertainty. It is not a defined term in the National Law. In relation to doctors, regard needs to be had to the Medical Board of Australia, *Sexual*

boundaries: Guidelines for doctors.[4] Even these of themselves do not provide absolute clarity, providing only a number of clear examples. Certain extreme behaviours, such as the 'grooming' referred to in the Explanatory Notes, unquestionably fall within this definition. Notably, these are not mentioned in the guidelines. What constitutes 'grooming' is not necessarily clear.

47. Where there is no clear definition of sexual misconduct, there are inherent challenges for well-intentioned practitioners in working out the boundaries of what is, and what is not, sexual misconduct. Inevitably there will be differing views around certain actions and behaviours. An approach of erring on the side of caution may be appropriate for more serious behaviours, but is inappropriate for potential misunderstandings.

48. To address these issues, MIGA proposes clarification of the following:
    (a) The definition of 'sexual misconduct', through noting in the legislation that consideration can be given to how it is defined in AHPRA / Board guidelines
    (b) Assessing the 'risk' of engaging in sexual misconduct – this should be through guidance developed in conjunction with professional stakeholders, including MIGA, the existence of which should be noted in the legislation and indication given that treating practitioners can have regard to it.

Treating practitioner mandatory reporting obligations – other issues

49. MIGA supports the proposals to ensure treating practitioner mandatory reporting obligations (other than for sexual misconduct) only apply to current and future risks, not past conduct.

50. It considers there is a need to clarify what is 'reasonable belief' of notifiable conduct. The legislation should indicate that in considering whether a 'reasonable belief' is formed, AHPRA / Board guidance may be considered. This guidance indicates the need for an objective assessment, based on a reasonable peer standard and involving a stronger level of knowledge than mere suspicion.

51. MIGA also considers it necessary to introduce a reasonable excuse defence to not making a mandatory report. This would be based on good faith belief that a mandatory report was not required.

52. It believes a reasonable excuse defence would reduce potential for over-reporting and 'second guessing' of decisions made by well-intentioned and conscientious treating practitioners based on limited information by others who have the benefit of more information in a different context.

53. Such a defence could also provide significant comfort to practitioner patients reluctant to engage in care through indicating that treating practitioners do not need to unnecessarily err on the side of caution and make an unnecessary mandatory report.

Need for guidance and education before changes are made

54. MIGA welcomes the intent to provide guidance and education materials for health practitioners on the proposed reforms, developed in consultation with key stakeholders.[5]

55. It is imperative that appropriate, detailed guidance and education is provided to the health professions on the treating practitioner mandatory reporting reforms proposed in the Bill before they come into force. They should be specific to treating practitioners and developed in consultation with key professional stakeholders, including MIGA.

56. It is clear that guidance and education is necessary to 'fill in gaps' of the Bill, particularly around terms such as:
    (a) "*reasonable belief*"
    (b) "*substantial risk of harm*"
    (c) "*at risk*" of engaging in sexual misconduct
    (d) "*sexual misconduct*"

    and more broadly around how terms such as "*impairment*", "*intoxicated*" / "intoxication" and "*significant departure from accepted professional standards*" should be applied in various circumstances.

[4] Available at www.medicalboard.gov.au/Codes-Guidelines-Policies/Sexual-boundaries-guidelines.aspx

[5] Introductory speech, Minister for Health and Minister for Ambulance Services, 31 October 2018

57. MIGA believes that the significant period of time between mandatory reporting obligations coming into force in 2010, and the release of the latest AHPRA guidance in 2014, contributed to confusion around mandatory reporting obligations, particularly for impairment.

58. For instance:
    (a) Clarification that a case of risk clearly addressed by being appropriately managed through treatment and which the practitioner complies with fully would not require a mandatory report was only provided in the 2014 version of the guidelines
    (b) Detailed guidance on what constituted a "*reasonable belief*" of notifiable conduct was also only provided in the 2014 guidelines.

    This further guidance has been crucial in reducing (but not eliminating) misinterpretations of mandatory reporting obligations.

59. Unfortunately in MIGA's experience the AHPRA guidance is not well-known amongst the professions. This is reinforced by research based on interviews with health practitioners and medico-legal advisors, which identified a need for:

    "*…greater efforts* [to] *be made to educate practitioners about the scope of their duty under the law. At a minimum, these efforts must provide practitioners with guidance regarding how they approach the more subjective elements of the law, including the concepts of 'reasonable belief' and 'substantial harm'".*[6]

Other necessary initiatives

60. MIGA sees a continuing need for:
    (a) Greater clarity in relation to the ethical and professional reporting obligations of treating practitioners around impairment – these are better ways for treating practitioners to notify impairment if required
    (b) A national health program along the lines of the NSW model managing impairment and drug / alcohol matters **-** having an appropriate process around handling impairment and intoxication matters once reported is imperative - the NSW model is more supportive and peer-driven than its AHPRA / Board counterpart
    (c) More research and monitoring to understand mandatory reporting perceptions, trends and experiences, as part of informing how it is working, education and guidance, and any further reforms
    (d) Co-ordinating stakeholder roles - more work is needed into how regulator, workplace and training body obligations and processes relating to impairment and other health issues can be better harmonised and co-ordinated.

(a) Clarifying ethical and professional reporting obligations

61. Treating practitioners already have certain ethical and professional obligations to report practitioner patients to a regulator.

62. For example, the Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia* (**the Code**) indicates:
    (a) It is a professional obligation to report a doctor whose ability to practise may be impaired and may thereby be placing patients at risk (clause 9.3.2)
    (b) Doctors should
        i. Take steps to protect patients from risk posed by a colleague's ill health
        ii. Take appropriate steps to assist a colleague to receive help if you have concerns about their fitness to practise
        iii. Seek advice from an experienced colleague, their employer, doctors' health advisory services, professional indemnity insurers, the Medical Board or a professional organisation if unsure what to do (clause 6.3).

63. The implications of failing to comply with the Code can be significant. It provides that:

    "[i]*f your professional conduct varies significantly from this standard, you should be prepared to explain and justify your decisions and actions. Serious or repeated failure to meet these standards may have consequences for your medical registration*" (page 4).

[6] Bismark MM Matthews B Morris JM, et al, views on mandatory reporting of impaired health practitioners by their treating practitioners: A qualitative study from Australia *BMJ Open 2016;6:e011988*, p9 – Available at bmjopen.bmj.com/content/6/12/e011988.full

64. The Code is admissible in regulatory or disciplinary matters under the National Law as evidence of what constitutes appropriate professional conduct or practice (s 41, National Law). This can provide a basis for health, performance or conduct action under the National Law, the same implications a failure to make a mandatory report can have.

65. The Code "*complements*" the Australian Medical Association (**AMA**) *Code of ethics*, which requires doctors to "[r]*ecognise colleagues who are unwell or under stress. Know how and when to respond if you are concerned about a colleague's health and take action to minimise the risk to patients and the doctor's health*" (clause 3.2.2). This is explained further in the AMA position statement on Health and wellbeing of doctors and medical students, which provides:

> "*When a doctor has concerns about a colleague's health, there is a legal and ethical responsibility to take action to minimise the risk to patients and the doctor's health. Such action should be seen as an act of caring for which the majority of unwell doctors, many of whom have exhausted their personal resources to deal with their problem, are ultimately grateful*." (p3)

66. These obligations, and similar ones which exist for the other registered professions, are a basis for clarification of ethical and professional obligations around mandatory reporting by treating practitioners. This clarification should be undertaken in conjunction with key professional stakeholders, including MIGA, and followed by education, including detailed guidance and both profession and specialty specific case studies, covering what these obligations require, and the consequences of not following them.

(b) Moving towards the New South Wales approach for handling health matters

67. MIGA supports adopting of the NSW Medical Council health program across the country to deal with matters involving impairment and drug / alcohol issues.

68. In its experience, the Council health program is a considerably more supportive, collegiate and better option than those utilised in other contexts.

69. The Council health program involves:
    (a) Independent Council organised medical assessment, normally undertaken by practitioners experienced in dealing with impairment matters and doctors' health and well-being more generally
    (b) Decision on whether to hold an Impaired Registrant's Panel hearing, with a hearing panel which includes at least one medical practitioner, often a psychiatrist, experienced in impairment and regulatory matters
    (c) A doctor can be assisted by a lawyer or other support person at this hearing
    (d) The hearing provides an opportunity to explore the doctor's background, work, personal life, symptoms and condition
    (e) The hearing delegates then make a recommendation to the Council on whether the doctor or medical student requires any health or practice related conditions on their registration – this would normally include seeing treating practitioners at appropriate intervals and permitting them to report to the Council any issues relating to condition compliance or risk to the public
    (f) Ongoing review within the program, including further consultations with independent Council organised practitioners, and review interviews, usually with the same delegates who conduct the initial hearing where possible
    (g) Exit from the program if and when appropriate.[7]

70. Although AHPRA and the professional boards outside New South Wales have processes in place for dealing with impairment matters, in MIGA's experience these are not as formal, developed or as supportive for a practitioner who is fit to practice within appropriate parameters (if required).

71. Importantly the focus of the Council's health program on supporting a doctor to practice safely and ongoing peer interviews are seen in a positive light by those doctors who go through the program, avoid the perceived 'disciplinary' focus of other processes and allow careful attention to ensuring public protection.

72. Consistently with the process undertaken over 2016 to 2017 by an independent review and the Medical Board of Australia in relation to expertise and experience around cases involving alleged sexual boundary breaches, it would be helpful to review whether regulators have been provided with sufficient experience and resources for impairment matters, given the particular specialty expertise they can require. This is

[7] Further information about the Medical Council of NSW Health Program is available at www.mcnsw.org.au/node/819

not just at board level, but also throughout the organisations involved in dealing with impairment matters, including initial assessment, board briefing and reporting, and monitoring.

(c) Research, monitoring and co-ordination

73. An important part of overcoming issues around practitioners seeking early, appropriate treatment is education around what happens after a report, whether mandatory or otherwise, is made to a regulator, particularly those involving impairment.

74. It is critical to correct the perception, however misplaced, that such a report is likely to be a career-ending event. Explaining in appropriate ways what would normally happen after report is made, particularly positive experiences, may be very helpful.

75. There is a need for dissemination of up-to-data data around treating practitioner reporting, both mandatory and voluntary. Although mandatory reporting data is included in AHPRA annual reports, no details are given around numbers of treating practitioner mandatory reports and outcomes. The latest publicly available data on this is a 2016 study based on 2011 to 2013 data.[8] This pre-dates AHPRA's further guidance on mandatory reporting.

76. MIGA also supports research being undertaken into the experiences of treating practitioners and their practitioner patient who are the subject of a mandatory report by a treating practitioner. This allows analysis of trends and concerns, allow consideration of how to improve processes, where education is required and if further reforms are warranted.

77. More work into how regulator, workplace and training body obligations and processes relating to impairment and other health issues can be better harmonised and co-ordinated is important. There is scope for these stakeholders to work together to determine when a practitioner's issues are better dealt with by a particular body, and how information should be exchanged between interested bodies when required.

Title protections

78. It is imperative to ensure that only registered health practitioners provide regulated health services under the National Law.

79. There are significant risks that doctors and other registered health practitioners could be unnecessarily and inappropriately caught up in these changes.

80. Registered health practitioners who make claims in good faith that either themselves or their practitioner colleagues have certain training, expertise and / or experience could potentially breach ss 115, 117, 118 and / or 119 of the National Law, relating to use of specialist titles, registration of a particular professional division and claims as to a particular type of registration.

81. It is important that registered health practitioners represent their training, expertise and experience accurately and appropriately. There are a wide range of cases where well-meaning practitioners could fail to do so, perhaps through misunderstanding or inadvertence. These are not ones which should involve civil penalties or terms of imprisonment. Instead, they should be dealt with through education and, only if required, disciplinary processes.

82. The following are possible examples of such cases:
    (a) Unintentionally making insufficient efforts to ensure correct category of registration
    (b) Properly claiming certain expertise or experience in a particular specialty field, when not a specialist under the National Law
    (c) Representations in good faith about the training, expertise or experience of a colleague who is a registered health practitioner, which ultimately turns out to be mistaken.

83. MIGA believes these issues should be dealt with under AHPRA's new advertising and compliance strategy under s 133 of the National Law or, if required, through health, performance or conduct action. This is consistent with the current approach for dealing with this type of issue.

[8] Bismark et al, "Reporting of health practitioners by their treating practitioner under Australian's national mandatory reporting law" (2016) MJA 204(1), 24.e1

84. Under ss 117(1) and 119(1) of the National Law, there is already a distinction made between registered health practitioners making certain representations, which do not constitute an offence but for which health, conduct or performance action may be taken, and those who are not registered health practitioners making similar representations, which could lead to a civil penalty.

85. This is a distinction which should be extended to ss 115 and 118 of the National Law to deal with the classes of 'good faith' or 'unintentional' breaches outlined in this submission.

86. MIGA understands that AHPRA and the National Boards may see claims about training, expertise and experience made in good faith and / or without intention to deceive as matters to be dealt with under the advertising provisions, or as health, performance or conduct action. This is not reflected in the title protections provisions as currently worded for registered health practitioners. The National Law title provisions should be amended to reflect such an approach.

87. If the penalty and imprisonment provisions are retained for 'unintentional' breaches of the National Law title protection provisions, detailed guidelines should be developed by AHPRA and the National Boards, with input from professional stakeholders such as MIGA, to identify classes of breaches which should be prosecuted, and when they should be managed under the advertising provisions, or through the health, performance or conduct action.

88. In addition, further education should also be provided to the health professions around how to avoid title protection provision breaches.