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HEALTH AND ENVIRONMENT COMMITTEE

Members present:
Mr AD Harper MP—Chair
Mr SSJ Andrew MP (virtual)
Ms AB King MP
Mr R Molhoek MP
Ms JC Pugh MP (virtual)
Mr ST O'Connor MP

Staff present:
Mr K Holden—Committee Secretary
Ms A Groth—Assistant Committee Secretary

PUBLIC HEARING—INQUIRY INTO THE HEALTH PRACTITIONER REGULATION NATIONAL LAW AND OTHER LEGISLATION AMENDMENT BILL

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 8 JUNE 2022

Brisbane

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WEDNESDAY, 8 JUNE 2022

The committee met at 8.31 am.

CHAIR: Good morning. I declare open this public hearing for the committee's inquiry into the Health Practitioner Regulation National Law and Other Legislation Amendment Bill. I am Aaron Harper, member for Thuringowa and chair of the committee. I would like to start by respectfully acknowledging the traditional custodians of the land on which we all meet today and pay our respects to elders past and present. We are very fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander people, whose lands, winds and waters we all now share. With me today are Rob Molhoek, member for Southport and deputy chair; Stephen Andrew, member for Mirani, who is joining us via videoconference; Ali King, member for Pumicestone; Sam O'Connor, member for Bonney; and Jess Pugh, member for Mount Ommaney, who is substituting for Joan Pease today and joining us via teleconference.

This hearing is a proceeding of the Queensland parliament and is subject to the parliament's standing rules and orders. Only the committee and invited witnesses may participate in the proceedings. These proceedings are being recorded and broadcast live on the parliament's website. Media may be present and are subject to the committee's media rules. Please have all mobile phones turned off.

DEVA, Professor Anand, Macquarie University (via videoconference)

FAUX, Dr Margaret, Synapse Medical (via videoconference)

CHAIR: Welcome. Thank you for your submission. We will start with an opening statement and then we can move to questions.

Dr Faux: Thank you, committee, for giving me the opportunity to present to you today. I would first like to acknowledge the Gadigal people of the Eora nation where I sit and pay my respects to their elders past and present. I will tell you a little bit about me. I have 40 years experience working in the Australian health sector. I am a registered nurse, lawyer, health insurance law academic and the founder and CEO of Synapse Medical, and I have recently been awarded a PhD on Medicare claiming and compliance. My doctoral research included a very wideranging review of Australian health regulation. My concerns about this bill relate only to the proposal to lift the current testimonial ban.

I am particularly motivated to assist the committee today because, like all Australians, I was shocked by the horrific conduct demonstrated in the *Four Corners* program 'Cosmetic Cowboys' last year, and I am gravely concerned that lifting the testimonial ban will worsen an already poorly controlled environment. Firstly, I will provide a little context and definition. Ahpra's advertising guidelines, which I am sure the committee is aware of, specifically guideline 4.3.1, which is titled 'What is a testimonial?', state—

The National Law does not define 'testimonial', so AHPRA and the National Boards have adopted its ordinary meaning of a positive statement about a person or thing.

It goes on. For clarity, my submission today follows Ahpra's definition and refers to a ban on positive testimonials only. There is no barrier to patients, of course, sharing information online, including negative testimonials; they do that now via Google reviews and on various other platforms such as RateMDs. Of course, no doctor would willingly post a negative testimonial about themselves on a website they control.

With that context in mind, I want to say a few words about the operation of the health market more broadly. Buying health is not like buying a TV. When we buy health, we do not buy the characteristics of what we purchase. There is very little to recommend a colonoscopy. What we instead buy is the promise of an outcome, which is usually some improvement in our health. The problem is that we do not know whether we need what is being sold to us or whether it will provide the outcome we want. We do not have equal information or bargaining power. Throughout the academic literature which I reviewed in my doctoral studies, this is called information asymmetry. It

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is an irrevocable truth and one of the key reasons the health market does not behave like other consumer markets and therefore cannot be compared to them. The explanatory memorandum to this bill states—

> … testimonials will be treated the same as other forms of advertising. This is consistent with the treatment of testimonials under general consumer law.

I am very concerned by this commentary because it suggests a lack of understanding of this fundamental and key difference between the health market and general consumer markets. On the basis that regulatory reforms should always be evidence based, it must be accepted, surely, that permitting potentially fake or otherwise buyers' testimonials can only make patients less safe because it worsens information asymmetry. We have over four decades of health economics and health system literature that puts this beyond any doubt. In fact, there is a broad global consensus that anything that can be done to reduce information asymmetry and empower consumers to make informed decisions about their health should be strengthened, not weakened.

Following the *Four Corners* program last year, a number of reviews into the cosmetic industry were commenced and are in progress, so the timing of this decision is, I find, somewhat confusing. For example, if the findings from those reviews are that the testimonial ban should remain in place, what will happen? Will Ahpra bring this bill back? Having removed section 133, will it be reinstated? Surely it would be more sensible to delay this decision at least until the reviews have been completed and all the information is at hand.

My final point and area of concern, before concluding and handing over to Professor Deva, is that I am very concerned about bringing testimonials within the broad definition of 'misleading and deceptive conduct' and that that may worsen the current overlap between the ACCC and Ahpra. I outlined that in my submissions. The ACCC is clearly the most skilled regulator in bringing actions for misleading and deceptive conduct, not Ahpra, but I would suggest to you that that is another reason to delay this decision: to allow time to bring the ACCC into the conversation so that we can carve this up and determine who will have jurisdiction over this offence of misleading and deceptive conduct to ensure patient safety does not fall through the cracks.

In conclusion, as we saw on 'Cosmetic Cowboys', some doctors are blatantly breaking the testimonial ban and advertising requirements with impunity, putting patient safety at risk in exchange for likes, follows and fame. On *Four Corners* I described the cosmetic industry as like the Wild West but without the sheriffs. I am very concerned that lifting the testimonial ban will make this worse. It will be like the Wild West but without sheriffs or deputies, both having handed over their badges to the cowboys. There will be effectively no rules and no police, just anarchy. If we are serious about keeping patients safe, I submit that the proposal to lift the testimonial bans should be rejected. At the very least, I urge the committee to consider delaying this decision pending further consideration. Thank you very much for your time.

Prof. Deva: I am so grateful for the committee allowing me some time to express my opinions. They align very much with Dr Faux's views as well. I want to acknowledge the Dharawal people, the custodians of the land on which I sit right now, and their elders past and present. My background is that I am a professor of plastic surgery. I have worked in the public, private and academic sectors throughout my career, which is more than 20 years old now. For my sins, I have had a long interest in breast implants and done a lot of work on the science of breast implants and the consultation of breast implants, and more recently I have worked in partnership with NSW Health to set up integrated breast health centres. This has provided me a front seat to witness some of the damage that has been caused by this industry. I agree completely that the timing of this seems very much out of keeping with the rest of the amendments proposed within this regulation. I completely agree that there needs to be tightening, particularly around the activities and the scope of practice of some of the doctors, some of my colleagues.

It was with some surprise that I read this amendment, so what I wanted to speak about today was my personal experience of what I see in my practice and also the impact particularly on women—vulnerable women—who are at the mercy of some of these very commercially driven sales and marketing tactics.

The ban on testimonials currently forms part of Ahpra's regulations around medical advertising. As you will know, any health service marketing its product should not be false, misleading or deceptive; offer a gift, discount or other inducement; use testimonials or purported testimonials; create an unreasonable expectation of beneficial treatment; or encourage the indiscriminate and unnecessary use of a regulated health service. I put it to you, members of this committee, that every single day these principles are being breached, particularly in the more commercial aspects of

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medical practice. By not enforcing behaviour in this sector and by not perhaps taking those who willingly breach this and holding them to account, we are asleep at the wheel. We are almost by default encouraging people to pursue more aggressive marketing tactics in order to lure patients into treatments they do not fully understand.

We have seen over 800 women who have had breast implant fails over the last three years since we started the service. We are about to present our data at the upcoming scientific meeting of our society next Friday. The majority of these women have no idea about the risks of these devices. The majority of these women are lured into this sector by glossy claims and advertising which are not based on reality or evidence or in fact based on underlying skill or training. The consequences of not policing this adequately and not enforcing these standards are that these women are now harmed and will require multiple revision surgeries. These are young women whose lives are essentially turned upside down through no fault of their own.

I think it is our responsibility as professionals, as lawmakers, as regulators, to really look hard at the more commercially driven areas of medical practice. I come from a long line of doctors—I am a fourth generation doctor—and I fear that by lifting this ban we are moving medicine into other aspects of commercial and consumer practice, rather than what it should be, which is a patient centred profession where healthcare providers look after patients and provide them with good, unbiased and unqualified support so that they get the best treatment in order to live both longer and with a better quality of life.

I agree completely with Dr Faux that we should put this aside for the moment. I personally think it should not be lifted. In the context of the current Ahpra inquiry, it would be very sensible, I think, to wait until the commissioner, Ken Brown, has a chance to look at submissions, particularly in this area of practice in cosmetic surgery, particularly where it pertains to advertising for medical services. This is the pointy end, really. Await what Ahpra's recommendations are in terms of regulating this sector because it will have implications for the rest of medicine. My concern is that if this ban is lifted, through this amendment, it might push other areas of medicine into a more commercial practice. We are starting to see in some aspects of orthopaedic surgery, weight loss surgery and bariatric surgery where commercial models of advertising and marketing are luring patients in with various schemes and claims that are not based on any reality but are based purely on commercial gain. That it will impact on more patients being put in harm's way.

In conclusion, from my experience in this area, from my submission to Ahpra and from my own concerns about medical advertising in the broader sense, I would urge you to put this aside, await the findings of Ahpra and, hopefully, ultimately with their findings, continue to look more closely not just at keeping the ban on testimonials but also at these practices and regulating them.

CHAIR: Thank you. On that last point you made on your submission to Ahpra, would you be able to share that with the committee?

Prof. Deva: Yes, indeed. I did include a copy of my submission with Professor Ashton.

CHAIR: That was a very good background of the history of cosmetic surgery. There is definitely a theme going through a lot of the submissions on the points you have both raised. We will move to a question from the deputy chair.

Mr MOLHOEK: Thanks for joining us today. Could you explain how the AMC accreditation works? You say in your submission that a lot of practitioners of cosmetic surgery are not necessarily accredited under the AMC. I am wondering what the difference is between those who have that accreditation and those who do not.

Prof. Deva: That is a good question. It goes into a long discussion about who is best (inaudible) these procedures. In terms of AMC accreditation, the process of becoming a specialist in any particular practice of medicine needs to go through a process of selection, training and certification. That certification is run through colleges of specialty training that are accredited by the Australian Medical Council. In order to get that approval, there needs to be a robust process of evaluation and assessment so that once a person gets a recognised specialist qualification they are then safe to practise in that particular area of specialty.

For cosmetic surgical practice, there has not been a real clear definition as to what that standard occurs. Through the college of surgeons there are specialist surgeons who gain accredited training and certification to perform invasive surgical procedures, of which within cosmetic surgery there are some. That remains the only AMC accredited pathway towards getting recognised training.

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When you go into an area like breast augmentation—that is, enlargement of the breast using a breast implant—this is the No. 1 cosmetic procedure that is performed worldwide. It is the No. 1, I guess, demanded procedure in this sector. When you look across who is performing this not just in Australia but worldwide, you see a failure to actually enforce a certain minimum standard of selection, certification and training. In Australia it is the AMC that decides that standard. It is a very varied number of practitioners in terms of their skill and their training, and ultimately this impacts then on safety when some of these invasive procedures are performed.

We have seen the consequence of this through the Cosmetic Institute class action here in New South Wales. I do not know if the members are aware of the class action that is currently facing the courts—where a commercial practice was built based on non-trained and non-credentialed practitioners putting implants in and in fact in unlicensed facilities. It was horrific, you might say. The consequences of that are that many, many women have been harmed through that process and the company is under liquidation and is currently facing a class action to cover remedial surgery to the thousands of women who have gone through that clinic.

You can see that there is a need, I think, to put a floor under what is recognised in certified training in this particular space. Ultimately, in terms of how that is done, I think it should be done through the AMC, which is the recognised authority that certifies programs of training and specialists' training.

CHAIR: I will move to a question from the member for Pumicestone because we are pretty limited on time.

Ms KING: Thank you both for your very extensive submissions. It is certainly an issue that has come to my attention previously. In your view, are there jurisdictions that have an appropriate limitation on practitioner advertising, especially in the realm of cosmetic surgery, and how is that playing out in practice? When I was doing some research for today's hearing I went to a website, which I will not name, that is a user based community that is filled with testimonials, including for Queensland based practitioners. Seemingly, they are not induced by practitioners; they may be, of course. Where does it work well? How would a continuation of existing testimonial laws protect patients when testimonials are clearly everywhere? I would like to hear from both of you.

Dr Faux: That is an excellent point. Let me just speak to personal experience for a moment before looking at the legal ramifications and how we protect patients. My company, Synapse, works in other countries. I do a lot of work in India and also in Dubai and the Middle East. I have an office in Dubai and will be heading there next week as it happens. What you will often see in some of these other countries—and obviously I am very alert to it when I am moving around these other countries—is billboards, no less, on major city roads with very agreeable looking doctors. One billboard in particular sticks out in my mind, with a very agreeable group of cardiologists saying, 'We're the best cardiologists in town. 27,000 Google reviews can't be wrong.' It is this type of predatory marketing that is actually well documented in the literature as being quite dangerous to patients.

Your point is well made. It is not perfect. The ban on testimonials is not perfect. It is not everything that we need to do to keep patients safe, but it is something. We are talking here, as I explained, about positive testimonials only. You are quite right. Patients do share and should be permitted to continue to share information online about their experiences—they expect that—including negative testimonials, which it appears you may have been reading.

Ms KING: I saw both.

Dr Faux: This is preventing a doctor or health practitioner from cherrypicking positive testimonials and placing them on a website or platform that they control. I think that is the key difference.

Prof. Deva: I would draw your attention to the Ahpra submission that you have a copy of. It lists quite a few proposed reforms. For this area, and I think it is an excellent (inaudible), there are some real points where a difference can be made almost immediately. I will leave you to read that.

Ultimately, I think there needs to be better surveillance of practices. Ahpra needs to be given resources—or if it is the ACCC—to be able to look through what is out there and then ultimately to also be given teeth such that people who knowingly breach the principles of advertising in health care and the use of surrogate or real testimonials are held to account. I think that is really part of the solution. There is no point putting guidelines in if they are flaunted every single day because it actually weakens the capacity to bring change into the sector.

CHAIR: I thank you both for your contributions this morning. They were very insightful. I thank you for your submissions as well.

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MONTEVERDI, Ms Lidia, Representative of Medical Law Special Interest Group, Australian Lawyers Alliance (via videoconference)

CHAIR: Would you like to make an opening statement?

Ms Monteverdi: Thank you for the opportunity

The current reporting system relies upon notifications of breaches, and this is a difficult position as often healthcare consumers—the public—do not know whether an advertisement is in compliance with regulations or not. The same applies to testimonials if they were permitted to be used in advertising health services. It is for this reason that preventive measures, such as those that are already in place with respect to testimonials, should stay in place. We believe there is a substantial power imbalance between medical practitioners and prospective patients. Removing the ban on the use of testimonials in the advertisement of health services in Australia risks further tipping the power scales away from the public and thus decreasing public safety. I thank you for the opportunity to appear before you and make this opening statement on behalf of the ALA.

Mr O'CONNOR: You touched on what the UK does with the ban on advertising to under-18s. Can you expand on that a little bit? Are there any other jurisdictions you are aware of that you think do a better job at regulating this?

Ms Monteverdi: I will deal with the second part first. I am not aware of any other jurisdictions that have in place similar regulations to the UK. Perhaps if I could take the UK aspect on notice and provide a more fulsome answer in due course to the committee, I think that might be best.

CHAIR: Thank you.

Ms KING: Your submission has a particular emphasis on social media. Given that social media is a profoundly unregulated platform already, and consumers have significant ability to generate testimonials for a range of reasons of their own and that is not very transparent to consumers, how do you feel matters would be different if these changes were passed?

Ms Monteverdi: What you have just said is the issue in a nutshell in the sense that social media is already so unregulated. The proposal, if it were passed, would mean that Ahpra would have a much larger field to monitor, investigate and look into. I note that in its submission Ahpra said that it has finite resources and is focusing on the more serious aspects of breaches to advertising regulations in Australia. Quite frankly, any testimonial breaches on social media would not fall into that 'serious risk' category, so I think it would continue to be an unregulated area and it would increase the potential for public harm.

Ms KING: You have talked about Ahpra's approach to regulation being reactive. Is Ahpra only empowered to act on complaints? Is there any ability to be proactive if something comes to Ahpra's attention without a notification?

Ms Monteverdi: Not that I am aware of.

Mr MOLHOEK: In some of the submissions there was discussion around financial incentives that are offered to practitioners and the fact that they are not always disclosed. What would some of those incentives look like for practitioners?

Ms Monteverdi: Financial incentives in what way?

Mr MOLHOEK: From some of the suppliers. Some of the medical suppliers apparently offer incentives to the practitioners of cosmetic and other treatments. I know that you have not referred to it, but I wanted to ask previously and we ran out of time. Do you have any knowledge of what those sorts of incentives would look like? How is that detrimental to the patient if they are not aware of those incentives?

Ms Monteverdi: I suppose I can only speak generally in terms of my experience on the other side of the fence as a medical negligence lawyer rather than a medico. My understanding is that, for instance, some suppliers will sponsor or provide products at a reduced rate in order to effectively sign on that practitioner. It potentially has an impact because those products may not be the best product for the particular procedure or fit for the purpose for which they are going to be used but because the practitioner is getting either a kickback or a reduced fee they use them anyway.

CHAIR: What steps would you like to see Ahpra take to ensure public safety when regulating medical advertising, including the use of testimonials?

Ms Monteverdi: We think Ahpra needs to be better resourced in terms of better funding. Ahpra also needs to be allowed to take a proactive approach to advertising breaches. Attached to our submission is a policy paper called *Facing the facts*. Within that paper we have made some

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suggestions about the types of things that Ahpra could do. For instance, we have suggested that each year a practitioner goes to renew their registration they be required to put down every website or social media site they use as part of their practice. This will allow Ahpra to at least have a list that is linked to a practitioner that can be monitored at some stage. We have also made a suggestion that the practitioners fill in a declaration of sorts to say that they are complying with advertising regulations. Again, that is a bit of a softer approach but certainly it does put the onus back on the practitioner.

Mr O'CONNOR: Even though Ahpra struggles to regulate the current environment, as you say, with a lack of resourcing, it is your view that at least having the ban sends a message and practitioners know what is and is not allowed, so removing it would make it more of a free-for-all—even though they cannot regulate it adequately at the moment?

Ms Monteverdi: Yes, that is correct—in a nutshell.

Ms KING: You may need to take this on notice, but how will bans on social media advertising to people under 18 work, given social media is—

CHAIR: Uncontrolled?

Ms KING: Well, 'uncontrolled' is not quite the word. There are regulations that mean that under-13s are not meant to sign up for a Facebook or Instagram account, for example. Do you know what steps practitioners in jurisdictions where those under-18 bans exist take in order to have a social media presence or how they distinguish between their under-18 non-target market and the people they are lawfully allowed to advertise to who are over 18?

Ms Monteverdi: I am going to accept your invitation to take that one on notice. I will provide you with a response.

Ms KING: That would be great. Thank you so much.

CHAIR: We are almost out of time. Can we have responses to questions on notice by this Friday, 10 June?

Ms Monteverdi: Yes, absolutely.

Mr O'CONNOR: It is sort of the same question, because it was about the UK. Could we just have more detail on that?

Ms Monteverdi: Sure.

CHAIR: Thank you very much for your contribution this morning. We appreciate it.

Ms Monteverdi: Thank you very much for having me.

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KENNEDY, Dr Daniel, President, Australian Society of Plastic Surgeons (via videoconference)

CHAIR: Welcome. Would you like to make an opening statement?

Dr Kennedy: I would. Thank you for the opportunity to address the Health and Environment Committee at this public hearing. We support the AMA's concerns, but our society has specific concerns about proposed changes to section 133 of the national law to remove the prohibition against using testimonials in advertising regulated health services. This prohibition was intended to preserve the fiduciary duty of the profession to put the interests of the public good above our own self-interest, whilst the removal of this prohibition encourages a market force approach, allowing the pursuit of self-interest. The stated reason is that the law is too hard to enforce. If I ask you all whether you go to a good dentist, almost everyone in the room will say yes, but you do not know—and nor do I—because we do not have the skills to assess their work. We rely on proxies like, 'Did she hurt me? Were the rooms clean? Did he charge enough to make me think it is an exclusive practice?'

The change from fiduciary duty to market forces in the provision of health care undermines our robust health system. The market views become a dominant world view and the public may expect testimonials on a doctor's website, but there are significant problems to consider with the use of testimonials. There is the validity and credibility of testimonials, especially when sourced and filtered through a third-party provider who might charge a six-figure sum to practitioners to present their practice with solid, five-star reviews. This commercial system is already open to abuse and in use, and removing the current restraints will likely worsen the problem.

Secondly, the Ahpra review of cosmetic surgery is underway and is expected to make recommendations about advertising. It would be appropriate to see what risks to public safety the review identifies. Thirdly, the ability of unqualified practitioners to work outside their area of training, as illustrated in the *Four Corners* program 'Cosmetic Cowboys', by building a practice on testimonials is a significant problem. Fourthly, there is the difficulty the public has in assessing surgical and medical competence which makes them rely on other characteristics that they can assess as a proxy for competence, such as presentation of rooms or politeness of staff. Finally, a patient who provides a review of their cosmetic surgery has typically only had the experience of the procedure with one practitioner one time and has no yardstick for comparison. It is not the same as the process of choosing a new car.

I know that cosmetic surgery is just one area to be affected by this legislation, but it is important as patients have notoriously been misled in the past. Rather than removing the restriction on using testimonials in advertising, I suggest that it is imperative to remove the commercial operators from the space or, at a minimum, have a disclaimer that these reviews have been sourced and filtered via payment to an agency. I suggest that the vigilance be focused on truth in advertising and resourcing compliance. Thank you.

CHAIR: Thank you very much, Dan.

Ms KING: Could you tell us a little more about the Australian Society of Plastic Surgeons? Do your members tend to be plastic surgeons in that more conventional or more traditional sense of reconstructive and reparatory surgery as opposed to cosmetic, or does your organisation cover all of those options?

Dr Kennedy: We cover all of those options. The Australian Society of Plastic Surgeons represents about 500 plastic surgeons Australia-wide, and they are all FRACS surgeons. Some of them do not practise cosmetic surgery; probably the majority do practise at least some cosmetic procedures. We have a sister society, the Australasian Society of Aesthetic Plastic Surgeons, which we are strongly associated with, and they share many of our members but of course have New Zealand members as well.

Ms KING: To what extent have your members expressed this view? Have you consulted with them?

Dr Kennedy: Yes. There are definitely some of our members who would prefer to see these restrictions dropped, but they are in the minority. We have had a discussion at council about this. Whilst there are certainly some councillors who have concerns about the ongoing restrictions on testimonials making this an unfair playing field, because those who do not comply with the rules seem to have an advantage, the majority of councillors and the majority of members whom I have spoken

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with have said that they see this as a way of departing from a professional relationship and moving more towards a less well structured relationship—a removal of those professional boundaries that keep patients safe and professionals safe.

Ms KING: We have heard from some submitters already—and they have been mentioned in our submissions—equivalent concerns about the removal of testimonials for bariatric surgery. You may or may not feel able to comment, but perhaps you could comment on to what extent you consider that the consumer market for those two types of procedure has equivalencies?

Dr Kennedy: I think there are a lot of equivalencies. I think bariatrics has a very similar profile. I think eye surgery does, particularly in those refractive areas. I think IVF does. I think there are large numbers of areas in medicine that will tend to become entrepreneurial. The hearing aid market, while it is not a doctors' market, has become very entrepreneurial. I think the difficulty comes in equating the quality of the advertising with the quality of the service. It is just not accurate.

Ms KING: I think that is a very interesting point: the quality of the advertising becomes a proxy for the quality of the service. Thank you for expressing that so succinctly.

Dr Kennedy: You are quite right. There are definitely members who are supportive of dropping this restriction, but I would confirm that they are in a minority. Even they would have concerns about the ongoing truth in advertising and the ongoing, as it were, not allowing practitioners without qualifications to pretend that they have them and not allowing practitioners with qualifications to overinflate or exaggerate their qualifications.

CHAIR: In your opening remarks you mentioned dentists. I know that a lot of the submissions are around cosmetic surgery, I believe based on the program that you mentioned, 'Cosmetic Cowboys'. Do you think the area of medical advertising should be banned across the entire medical cohort or just cosmetic surgery?

Dr Kennedy: We are now getting into my opinion rather than necessarily—

CHAIR: I am sorry—the alliance.

Dr Kennedy: That is okay. I think it serves the patients best if there is no advertising. That would be my position as a professional.

Mr ANDREW: On improved patient outcome, there is no relationship or link, is there? That is my main concern. It is about the improved patient outcome, but I see that there is nothing there that really constitutes anything on that side of it.

Dr Kennedy: No.

Mr ANDREW: As the member for Pumicestone said, the glossier brochure is not going to give anything, really. The fact that they have spent more on advertising does not mean to say that that doctor is going to give you a better outcome. Thank you for that. I appreciate all the information.

Mr MOLHOEK: It would be interesting to more broadly discuss the ethics around advertising. In terms of the opinion you expressed before, is there a place for some advertising so that consumers could be more aware of risks? I understand on the one hand people are advertising because they want more business but on the other side of the argument, and playing devil's advocate for a minute, there would be value in consumers being better informed also, wouldn't there?

Dr Kennedy: I would absolutely agree with you. I think information is one thing; I think enticement is another. Advertisements that provide solid information so that people are better informed do provide a service to the community, whereas advertisements that try to induce or entice a person to have a procedure do not do anything for their health.

CHAIR: In your submission you state that the introduction of testimonials will require a more nuanced approach than currently adopted by Ahpra. How do you think Ahpra should regulate the use of testimonials and what do you consider are the main issues that Ahpra will need to address?

Dr Kennedy: I think in the current situation it is quite simple: if a doctor has a testimonial on their website that is wrong, whereas the nuanced approach would be: if a doctor has a testimonial on their website, is it a false one, is it a sourced one, is it a resourced one, is it a paid one—as in, paid to the third-party provider—is it representative, has it been filtered? There are all sorts of difficulties that Ahpra would face ascertaining whether that meets their overall standards. At the present time it is a blanket: no, you cannot do it.

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Mr ANDREW: Dr Kennedy, in the past have you ever seen situations, with your cohort or external from your cohort, of unqualified practitioners using these methods behind the scenes? Have they been caught doing this? Have there been any cases where people have been caught using this situation or using social media to promote themselves and they are unqualified?

Dr Kennedy: Absolutely. There are very many examples of this. People have built whole practices without qualifications using social media, using testimonials. There were some improvements in the situation I think in 2015, when these regulations came in. Nonetheless, it has gone on on those platforms that are more difficult to track and to watch, like Snapchat and private chats and so forth—things that disappear or are behind passworded closed doors.

CHAIR: That is a really good point, actually. It is just about impossible to police and monitor.

Dr Kennedy: I agree. I understand that this may come in. I think if it does we just need to be cautious about how the enforcement goes on. I do understand that there is a public appetite for it, but I would say you cannot choose your doctor on Yelp because it is just not the same as buying a radio. It is a very different set of parameters that you are assessing.

Mr O'CONNOR: Dr Kennedy, one of the key issues that you highlighted was the need for the information available to prospective patients or customers to be research based and scientific. How would you improve the literacy of the general public so they are able to understand that? Even the research that a practitioner chooses could align with what they are pushing anyway. How would you regulate that? If you have a scientific journal article there, the general public will not be able to read and comprehend it. What advice do you have on that?

Dr Kennedy: I think you are absolutely right: these websites and so forth need to be in plain English, but I think the difference between information and enticement is reasonably obvious to Ahpra. It is important to say that when people are seeking to influence a patient who is not otherwise considering a procedure to have that procedure, whether it be directly in the wording of their website or whether it be in response to the post that a patient has made, it can be very problematic and damaging to that person's psyche. I know that it happens in consultations when somebody comes along to discuss their face and a practitioner will talk about their nose or their legs or what have you. The same thing can happen in the online community: when a person posts a photograph, they can become enticed to have something that they were not originally concerned with. That is very problematic from a professional standpoint, from the fiduciary duty standpoint.

Ms KING: Dr Kennedy, I am aware of websites that practitioners themselves may put together where they provide before-and-after photographs of cosmetic procedures. I recall one in particular from the information we received for today's session. It seemed to be saying, 'This was a good outcome; this was an average outcome; this was a below average outcome. Photographs shared with permission.' In your view, would that be an appropriate provision of information about example surgeries, which is effectively a testimonial, I suppose?

Dr Kennedy: I would not put that in the category of a testimonial because it does not come from the patient. I said before that I would see it as better that we did not have advertising, but I am not for a minute imagining that that is going to happen. I was just stating it as a position that I hold personally. Given that we have advertising, I think it is very important that it is informationally correct and accurate and helpful. I think the sort of website that you have just described is exactly that. I think websites that only show perfect outcomes can be problematic. I think consultations that only stress the benefits and not the complications can be problematic. That is the case whether it is bariatric surgery, eye surgery or what have you. We need to have that balance and presentation of information.

CHAIR: Dr Kennedy, if you go to a cardiologist and you are about to have a procedure with a stent, they will show you a demonstrated online view of a product and how it works so you have faith that that product will balloon in the artery and you will survive, given the benefits and the risks of having that surgery. Putting that in the context of cosmetic surgery, it is still a form of advertising. How do you view that? We are talking about significant life-saving surgery here and people need confidence in that. What are your views there?

Dr Kennedy: As I said, I would regard that as part of the consultation rather than an advertisement. It may be considered as an advertisement for that particular brand of stent but not an advertisement for having a stent versus not having a stent. I have already said that I do not think my position of not having advertising is realistic at all. I am saying that, from a high-ground point of view, that would be one way to do it. Having information on products that people might have implanted is incredibly important. The TGA has policies on those particular presentations and what information

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people have to receive prior to having mesh inserted, an implant inserted or what have you. I am very supportive of those registers that keep the public safe and the information process that has to be involved.

No, I am not in any way objecting to informative videos on stents or on any product that might be implanted. However, it is the testimonial issue: it is not the doctor or the practitioner telling a patient that this is how it is; it is the other member of the public who may not be in a position to assess whether this hip implant or that hip implant is better but are going on the sum total of experience of one procedure to say the DePuy is better than the 'whatever' hip implant.

CHAIR: You articulated that well. There is regulation around those under the TGA, as you said—

Dr Kennedy: Correct.

CHAIR:—versus the unregulated space that we are seeing.

Mr MOLHOEK: My question is not that dissimilar to that of the member for Pumicestone. I am wondering about the practicalities of trying to ban the use of photoshop and enhanced imagery and lighting in the production of before-and-after photos. It is not just photoshopping; it is the light, it is the angle, it is all of that. Should the Ahpra guidelines be are a bit more specific around enhanced imagery?

Dr Kennedy: The Ahpra guidelines do make very specific comment about the photos being comparable, not being retouched, the lighting being comparable and so forth. I think they are very conscious of the tricks that can be played with focal length, lighting, flash photography and so forth to smooth out wrinkles. Certainly the profession is. For example, within my society we have a technical officer who reviews our own members' websites to say, 'Hey, those photos do not match. Those photos are not compliant.' We try to keep our standard high in order to keep our nose clean. I do think there is a way to do it.

Mr O'CONNOR: On the Gold Coast we have quite a few billboards of cosmetic surgeons and I think they are very liberally applying photoshop to the surgeons themselves.

CHAIR: Thank you very much, Dr Kennedy, for your contribution this morning. We appreciate it.

Dr Kennedy: Thank you very much.

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GODDARD, Mr Lyndon, Senior Legal Counsel, Eucalyptus (via videoconference)

CHAIR: Welcome. Would you like to start with an opening statement?

Mr Goddard: Yes, thank you, Chair. Eucalyptus provides telehealth services to Australians. I thank the committee for the opportunity to provide evidence on the bill before the committee today. As we stated in our written submission to the committee, Eucalyptus's comments are limited to the proposal to amend section 133 of the national law by removing the present prohibition on the use of testimonials in advertising. Eucalyptus supports this proposal. Before I summarise Eucalyptus's position on this proposed amendment, I think it is important to highlight two misconceptions that seem to have permeated a lot of the public commentary on the bill so far.

The first is that the present state of the legislation bans all forms of testimonial advertising. While that is what the words of the national law say, they have to be read in light of Ahpra's interpretation of them as expressed in its *Guidelines for advertising a regulated health service*. The guidelines make clear—and this was a comment made earlier this morning—that Ahpra only considers certain types of testimonials to be caught by the national law, in particular positive ones which include clinical aspects. For example, it says that comments about customer service or communication style that do not include a reference to clinical aspects are acceptable. So it is not the case that all testimonials are currently prohibited, and that is quite apart from the fact that health practitioners are not held responsible for the thousands of testimonials which already appear on third-party review sites that they have no control over.

The second misconception is that the proposed amendment will allow any type of testimonial advertising. It is really important to understand that there will still be numerous protections limiting all forms of advertising of health services, including testimonial advertising. In particular, it will still be illegal to advertise in a way that is false, misleading or deceptive in a way that creates an unreasonable expectation of beneficial treatment or in a way that encourages the indiscriminate or unnecessary use of health services. These protections already exist now and they will still exist if the bill is passed. Consumers are most likely to be harmed by advertising, whatever form it takes, where it is misleading or deceptive. That type of advertising will continue to be prohibited, as it should be.

From Eucalyptus's perspective, there are four main reasons the proposed amendment makes sense. The first is that the current regulatory position is unclear and difficult to both observe and enforce. As I said a moment ago, Ahpra currently only bans testimonials which include clinical aspects, meaning those that refer to a patient's specific symptom, specific diagnosis or specific outcome. While those terms might sound clear in theory, they can be hard to apply in practice. For example, is it okay for a patient to refer to their general symptoms in a testimonial as long as they are not specific? What about referring to a patient's lifestyle changes following treatment? Is that okay if they do not describe the treatment itself? The principles can be hard to interpret, both for the advertiser themselves and for Ahpra in enforcing them.

The second reason is that it is desirable to achieve regulatory uniformity with other forms of advertising. Some of the submissions to the committee, including the one from Ahpra itself, support the fact that the proposed amendment would align the regulation of testimonials with the regulation of other forms of advertising of health services. We think there is an additional benefit which is to more closely align the regulation of health services advertising with the regulation of therapeutic goods advertising. The TGA's advertising code does allow testimonials, with some limits, in the advertising of therapeutic goods. For the companies or practitioners who operate at the intersection of both therapeutic goods and health services—for example, the compounding of medications, vaccination services and others—it is currently necessary to abide by two different and conflicting sets of regulations. Streamlining those rules would make compliance and enforcement much easier without compromising the underlying public policy rationale of ensuring patient safety is protected.

The third reason is that consumers expect and benefit from testimonials. As we all know, the advertising landscape has changed remarkably since the national law was first introduced in 2010. Testimonials are available online, and not just on Australian websites. The lack of borders on the internet obviously means that testimonials about health services are also readily available on sites hosted in other countries. For example, as we heard earlier, they are permitted in the UK with some restrictions. If done properly and safely, testimonials can be genuinely useful for consumers, who increasingly expect them. Ensuring they are done safely is indeed one of the goals of this proposed amendment.

The fourth and final reason is that it is more important that testimonials not be misleading. As I said earlier, if the proposed amendment passes, that does not mean that any testimonial, no matter how harmful, will be permitted in advertising. They will still be subject to the other protections in the

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national law—most importantly, that any kind of health service advertising is not false, misleading or deceptive. There is a clear, objective standard involved in judging whether an advertisement is misleading and it is much more harmful to consumers for misleading advertisements, whatever form they take, to be published than it is for testimonials, including clinical aspects, to be published.

To conclude, the proposed amendment we say would result in a clearer, more uniform regulatory environment which will allow consumers to be better informed while also retaining important provisions that protect them. I would welcome any questions the committee may have.

CHAIR: Thank you very much, Lyndon.

Mr MOLHOEK: The question that is running around in my mind is: if it is so difficult to control the content and the distribution of information, either good or bad, would higher penalties or tougher penalties for misleading and deceptive content be a sufficient incentive to try and discourage the use of misleading content in Australia?

Mr Goddard: It is part of the solution; it is probably not the whole solution, and this bill obviously increases by 12 times the penalties for breaching section 133, so that is another aspect of this bill. Another aspect that has come up in a lot of the committee's submissions is a question of enforcement, and obviously Ahpra ought to be properly resourced, properly funded, in order to regulate as effectively as possible these rules. Obviously Ahpra is never going to be able to scour the entire internet, but it should have enough resources to be able to investigate and enforce these regulations as much as it can. So I think it is a combination of the penalties acting as a deterrent and the regulator being sufficiently resourced to actually enforce them.

Mr MOLHOEK: I note that you say it has gone up 12 times, so it has gone from $5,000 and it is recommended at $60,000. It was probably never adequate at $5,000 given the value of some of the procedures and the gains. Is $60,000 enough?

Mr Goddard: That is a matter for the committee, but maybe not. It is relevant that other regulatory regimes have higher penalties. Maybe it should depend on the value of the service that is being advertised, but there is always some level of arbitrariness in determining a particular figure for a penalty. At the same time, the penalty could be $1 million but if advertisers know that the regulator is never going to detect them then it is sort of meaningless in practice, so that is why no matter what the figure is it has to be coupled with a regulator that has enough teeth.

Ms KING: Thank you for being with us today. I might just ask you very briefly to recap the three protections that will remain against dangerous advertising in the event that these regulations pass. There was false, misleading and deceptive, and I wanted to just make a note of the other two points you mentioned.

Mr Goddard: Yes. They are the ones that are already in section 133 of the national law, so it creates an (inaudible) an unreasonable (inaudible) and if it is treatment advertisements that directly or indirectly encourage the indiscriminate or unnecessary use of health services. There are also some restrictions on gifts and discounts being offered. I think there are a couple of points to make on that. One is that the way this bill would work is that it would regulate testimonials in health services the same way as all other advertisements for health services that are currently regulated, so they currently have those other protections on them.

The second point to make is that—and this was a comment that came up from a few of the other contributors to the committee process—there was a concern that this bill would allow the advertising of health services to be regulated in the same way as the advertising of all consumer goods, and that is not really true because, although it indicates that misleading and deceptive conduct is a prohibition in the Australian Consumer Law that applies to all consumer services, these additional protections are just listed in section 133 of the national law specific to health services. Of course it should be the case that health services, as well as therapeutic goods that have their own regulatory regime, should have a higher standard applied to them than any other type of consumer goods, and that indeed is the case and will continue to be the case if this bill is passed.

Ms KING: As we know, these regulations are part of the national law and every Australian jurisdiction is considering the implementation of them into the individual states and territories. What might the likely outcome be should they be implemented in other state jurisdictions and not implemented here in Queensland?

Mr Goddard: I think from a mechanical perspective, since Queensland is the host jurisdiction it has to go first and then for most other states they then flow through automatically. There are a couple of states like New South Wales that pass their own separate regulations. Clearly, in the internet age, in the context that we are mostly talking about online advertising, it would make no sense to

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have different rules in different states for advertising. That would be even more of a regulatory nightmare for Ahpra and it would be difficult for compliance purposes as well if you do not have state based geoblocked websites that are only available in certain states and not others. You could not really have different rules applying in that context.

Ms KING: Particularly I should think in areas readily accessible to other states. For example, when we think of specifically cosmetic surgery but also bariatric surgery, the Gold Coast is an area where there is a high concentration of providers and you could imagine some unintended consequences, I suspect.

Mr Goddard: Sure, yes, or any other sort of border towns around the country and not just in the online context. There is a national law for a reason and it is certainly ideal that the rules are consistent in all states.

Ms KING: Thank you.

Ms PUGH: I apologise that I cannot be there in person this morning. My question is a very general question and it may not be something that you feel is within your specific expertise to answer. I am just wondering if we have any kind of data or even anecdotal information about the particular cohorts that are being targeted by the current online and social media advertising. Are we seeing it targeted more at younger people or is it very general and very across the board? This is my first day on the committee and I am just interested to find out if we have any of that information.

Mr Goddard: I am not aware of specific data and obviously it is going to depend on what particular health service is being advertised—some health services are more often used by some demographics rather than others—so I do not have specific data on that. Obviously we heard earlier that the UK has imposed a restriction on advertising certain types of health services to under-18s. I do not think that has been suggested in Australia, but that is obviously a possibility. Also in the age of Facebook marketing, the capability is clearly there to target particular demographics but, again, it depends on what the health service is, so I do not know if I can give any more detail than that.

CHAIR: What is going on in the UK is interesting, isn't it? It reminds me of cosmetic shows that are on the television which promote their particular clinics. There is no controlling of those through the media. They are obviously paid through a network, which is interesting. How do you control that?

Mr Goddard: That is right. The UK does allow testimonials in health advertising with some limits, like the one we heard earlier, but there are other limits—for example, that the testimonial has to be genuine. The UK regulator recommends that advertisers retain evidence from the writer of the testimonial so that if the regulator ever asks questions the advertiser can say, 'I have this letter from this person who says, "Yes, I have received this treatment. These are my genuine views," so we are proving the example.' Something not dissimilar exists under the TGA advertising rules. As I said earlier, you can use testimonials in the advertising of therapeutic goods but there are some limits. There is a restriction that the testimonial has to be not paid for. There are other rules saying they have to be genuine and accurate. There are additional ways to ensure testimonials are used appropriately and safely.

CHAIR: I guess that goes to a lot of medication where there is evidence based research that comes in behind.

Mr Goddard: Of course.

Mr ANDREW: You mentioned earlier that the regulators need more teeth. A lot of the other witnesses who have come forward said that to do this we are going to have to have more funding for Ahpra for all these things. The committee has done a number of inquiries recently and we know that the medical system is under a lot of stress at the moment. Do you think this is the time to be ripping the lid off this and pushing this all out there while we are still trying to cope with everything from COVID and we have a lot of other things that are stacking up around the world? Could this put the whole medical system under stress again? What are your thoughts on that? Is the time right or wrong?

Mr Goddard: Ahpra, the regulator, supports this proposal, which is telling in itself. Some of the other submissions to the committee have suggested that if this bill is passed it might be introduced in a progressive way. The introduction might be delivered to give Ahpra enough time to gather more resources to provide education to health practitioners to ensure they are properly across the rules and are abiding by them. There would be some flexibility, I am sure, in the precise timing of implementing these proposals. Another point has been made that the objective reality you have to face is that testimonial advertising is very common on the internet already on review websites that health practitioners do not control, so in essence the horse has bolted.

Mr O'CONNOR: In your submission you cited recent Australian research into the importance of testimonials. Are you able to share a little bit more on notice or can you touch on it a bit further now?

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Mr Goddard: I can take that on notice in terms of a more detailed summary of what the research said. Broadly, it said that consumers find testimonial advertising useful and informative when deciding whether to take on a health service, but they can also be misled by it. That is not surprising. None of those conclusions are surprising. I think if you ask any consumer, no matter what the product is they are looking at, they would often be assisted by getting the views of someone else who had undertaken the same service or virtually the same therapeutic good, for example. It is not super surprising, but obviously the use of them in advertising has to be done appropriately, with safeguards. The testimonials have to be genuine. At the same time, consumers are generally fairly sophisticated and they understand that one person's response to a treatment might not necessarily be the same as theirs, and that goes for any kind of advertising.

Mr O'CONNOR: We heard before that consumers are not adequately equipped to make an assessment of one particular dentist, for example; it all looks the same to them and they are not informed on what is good and what is bad. How would you respond to that?

Mr Goddard: That is one of the benefits of testimonials if they are done appropriately. Of course, there are other forms of advertising that are not testimonials in the healthcare sector that already exist. It is the obligation of the patient to do their research. If it is going to be a large procedure that is going to cost a lot of money that might have consequences for them, patients need to do their research. The more mechanisms they have to do that, the better informed they are likely to be.

CHAIR: Thank you very much for your contribution this morning; it is appreciated.

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PAWSEY, Ms Ashleigh, Union Research and Policy Officer, Queensland Nurses and Midwives' Union

SHEPHERD, Mr Jamie, Professional Officer—Team Leader, Queensland Nurses and Midwives' Union

CHAIR: It is good to see you again. You are regular contributors to the health committee. Thank you for your submission as well.

Mr Shepherd: I acknowledge the traditional owners of the land upon which we meet, the Jagera and Turrbal people, and pay my respects to their elders past and present. The QNMU thanks the committee for giving us the opportunity to present our views on the amendment bill. We are here to represent the views of 65,000 nurses and midwives and our members across Queensland. We recently made a submission to the inquiry regarding the 2022 amendment bill. We also provided a submission to the National Registration and Accreditation Scheme regarding the 2021 iteration of the amendment bill prior to the bill being introduced to parliament.

The QNMU expresses broad support for the most recent version of the bill but acknowledges that a number of the considerations and recommendations raised in our previous submission have yet to be addressed and remain key concerns for the QNMU. Today we will limit our opening statement to the issues raised in our most recent submission and some of the recommendations we consider necessary to improve the operation, fairness and equity of the national law.

The QNMU raises issues with the revision of section 130 regarding scheduled medicine offences. The bill would require health practitioners and students to report offences related to regulated medicines and poisons to the relevant national board. We consider that a scheduled medicine offence should only be reported where there is evidence of repeated offences or misappropriation of medicines. There are many contributing factors to health practitioners mistakenly committing what could be a scheduled medicine offence. Some of those contributing factors are: unsafe staffing workloads, skill mix, lack of in-service education, poor governance, and poor policies and procedures. The QNMU strongly recommends clarity in the legislation between reporting offences where there is evidence of wilful intent as distinct from unintended errors or mistake.

The QNMU continues to recommend that the national law be amended to include the regulation of unregulated health practitioners in a similar manner to currently regulated health practitioners. The national law should reflect the intent and the growing risk of unregulated nursing care workers and the importance of public protection by incorporating those workers, however they are titled, into the regulated nursing profession so they can have consistent minimum standards developed by the Nursing and Midwifery Board of Australia.

We need to make a correction in our most recent submission. We suggested further amendments to section 136 of the national law. That was an error. Instead of section 136 we should have referred to section 113. That prescribes an offence to take a protected title. We recommend and ask the committee to consider amendments to section 113 of the act to protect the use of the title 'registered nurse' or 'enrolled nurse' in response to any other unregistered person or health practitioner holding out to be a registered nurse by way of conduct, not necessarily by taking the title. It is an offence to unlawfully use a protected title, and it would therefore be prudent not to knowingly or recklessly induce a belief that a person is a registrant by way of their conduct. The QNMU suggests such amendments to the bill be considered, and we are happy to provide proposed wording if the committee goes down that path. Finally, we ask the committee to review our previous submission for a more comprehensive understanding of our position. We thank you for the opportunity to speak to you today. That concludes our opening remarks.

Mr MOLHOEK: I have some questions about the registration process. In your submission you raise concerns around revisions to that process and some other things like interim prohibition orders and the reporting of scheduled medicine offences. I am curious; I hope you can explain how the registration process works. How do people get continuity of registration over time? Are there nurses who are registered who perhaps have not practised for a while? I am keen to understand how that process works and who manages it and oversees it.

Mr Shepherd: To get initial registration you have to have successfully completed a qualification that the NMBA, the Nursing and Midwifery Board of Australia, accepts as qualifying for registration. Once you get that registration you can then work as a registered or enrolled nurse or midwife. To continue keeping your registration there are a number of things you have to do throughout the registration year, which runs from 1 June to 31 May each year. Those things include: ensuring you have professional indemnity insurance for the whole period; ensuring you comply with continuing

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professional development requirements, which for most registrants who are nurses, midwives and enrolled nurses is 20 hours of CPD per year; and reporting any change to your criminal history. There is a renewal process that you have to go through. You have to make a statutory declaration that you have complied with all of those registration standards. That is how you continue your registration. There is also a recency of practice requirement. You have to have practised nursing for at least three months full-time-equivalent over the last five years. They are the registration standards you have to comply with each year.

Nurses who have been out of nursing or midwifery for a while can have some difficulty getting back into employment. They might still be on the register, but if they have been out of nursing or midwifery for a while they can have trouble getting employment because they have been out for so long. Whilst perhaps some of their skills have become a bit dusty, for want of a better word, they do not have the opportunity—in Queensland particularly—to do a refresher course at a hospital where they can perhaps go to one of the tertiary hospitals and do a refresher course whereby they get some education and some supervision back into the area of practice they were previously working in. Other states do that, particularly Victoria. When a registrant nurse or midwife has been out of nursing, out of practice, for five years or more and has not completed those three months full-time, it can be quite difficult for them to get back in because they have to do a re-entry course or they have to convince the NMBA that they have been doing sufficient activities that would qualify as nursing or midwifery over the time they have been out. Then they might get a supervised practice program or agreement to get supervised practice, but getting supervised practice from an employer can be quite difficult because effectively for a little while they are almost supernumerary because they are being supervised in what they do by another registered nurse or registered midwife.

Mr MOLHOEK: How does that work across different areas of the health sector? If you are a registered nurse and you were not working in a hospital or you do not direct medical practice—let's say you have gone across into the aged-care sector for a while and you are perhaps not directly nursing but undertaking other broader duties, or you have been in disability services or some other sector—is work in those other areas recognised as part of ongoing practice, or does it depend on the nature of the work? How does that apply?

Mr Shepherd: That is where we see a distinction between recency of practice as a nurse and scope of practice as a nurse. Your recency of practice just means that you have been engaged in nursing for that period of time. Scope of practice is more defined as to what type of nursing you have been doing, and it is more relevant to nursing rather than midwifery. If someone has been working in aged care for a couple of years and they want to go back to work in a hospital, it could be that their scope of practice is not relevant now to the hospital situation and they need to get that supervision to get back into working in that area of practice. The scope of practice is more defined. That is the type of nursing you have been doing, rather than the fact that you have been doing nursing.

Mr MOLHOEK: Does that affect their registration or does it just affect their career prospects in terms of what their CV looks like?

Mr Shepherd: It does not affect their registration, but it affects their employment opportunities.

Mr MOLHOEK: You just mentioned that they have to have indemnity insurance. How do nurses acquire that and maintain that over a period of time? Particularly if they are doing the minimum amount to get by, how do they sustain or maintain indemnity insurance? What sorts of costs are involved in that?

Mr Shepherd: There are a number of organisations which provide professional indemnity insurance for nurses and midwives. The QMNU does. Every member of our organisation is covered by a professional indemnity insurance policy that meets Ahpra's requirements or the national board's requirements, but there are some other organisations that do that as well. If a nurse or midwife is audited by the board and they are a member of ours, we can provide them with a certificate of currency for whatever period it is they are being audited.

Mr MOLHOEK: Is that cost inclusive in their membership or do they pay separately for that?

Mr Shepherd: It is included in their membership fees.

Ms KING: Thank you both for being here and thank you for always coming before us and providing the perspective of nurses and midwifes in Queensland.

Mr Shepherd: Our pleasure.

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Ms KING: I wanted to ask you about your desire that 'registered nurse' become a protected title. Can you give us some examples of situations where that provision of 'registered nurse' as a protected title would provide safety benefits for the community? What kinds of circumstances are there where setting that standard, where 'registered nurse' is a protected title, would make a difference, in your view?

Mr Shepherd: The provisions are in the national law to protect that title of 'registered nurse' and it is in the context of using the title. Wearing a badge saying you are a registered nurse—even saying you are a nurse—is an offence. Through our interactions with members and employers we see people using titles that could imply they are a nurse. An example might be 'Team Leader—Mental Health Nursing' but they are not a nurse. Another example we have seen, particularly in aged care, is unregulated workers being titled 'Team Leader' and wearing a badge 'Team Leader'. If they go to a resident or patient, the patient could deduce a belief that they are leading the team of nurses. They are the sorts of situations that we want to get away from, because there is no requirement on an unregulated worker to redirect that belief that they might be a registered nurse or a midwife.

Ms KING: What you are talking about is an indirect holding-out inferred by conduct but not relating specifically to the title of 'registered nurse'?

Mr Shepherd: Yes.

Ms KING: You are not talking to situations where people are saying, 'As your registered nurse today' when that is not the case; you are talking about situations where the boundaries are blurrier perhaps?

Mr Shepherd: Yes. We have also seen situations wither supervisors who are not nurses are signing forms that imply or infer that they are the nurse manager. Particularly we see that with some workload forms that are coming from multidisciplinary teams where you have mental health nurses working with psychologists and occupational therapists but it might be a psychologist or an occupational therapist who is the supervisor, and if they sign a nursing form it could be easily inferred that they are the nurse manager.

Ms KING: What kind of harm, is it your view, could accrue to the public from that conduct? I recognise that there is a degree of hypothesis about that, but perhaps there are some examples that have come across your remit.

Mr Shepherd: Some of the risks are taken by the patients and residents who will make an assumption that they are a registered nurse and then they will ask them questions that are relevant to nursing and the registrant who is not a nurse will still give them answers that are not necessarily accurate. I have even been in a situation where I have had a supervisor who was not a nurse and who was telling me to do things that I started to think, 'That is not actually consistent with nursing practice,' and I made a call to the development board and found out that that person was not registered as a nurse. I then had to undertake my professional responsibilities to provide a full report of the situation to the board. Someone else who is not that vigilant perhaps would consider that what they are being told is actually the correct thing to do and go and do it and it was actually going to put the patient at risk of harm.

CHAIR: I want to go to page 7 of the submission and talk about the interim prohibition orders. It states—

> The QNMU questions the need to expand the role of AHPRA and other National Boards to issue interim prohibition orders (IPO's) to unregistered practitioners when the Health Ombudsman already has the discretion to handle registered and unregistered health practitioner related complaints.

Do you want to unpack that a little bit for us?

Mr Shepherd: As you know, Queensland and New South Wales have co-regulatory jurisdictions where the other entity from the board has the power to issue those prohibition orders. We would consider that there should be some comment or notation in the national law that differentiates between co-regulatory jurisdictions and jurisdictions that just have the national board or the state board making decisions. It may well be appropriate for the national board in Victoria, South Australia and the other states and territories to make prohibition orders, but we already have an entity in Queensland and New South Wales that can make those prohibition orders and it would not be necessary for the board in those two states to have to do that as well. Most decisions are made by the state board of the NMBA and then are endorsed by the national board, so it is the state boards in Queensland and New South Wales that will be making decisions about interim prohibition orders when another entity already has that power. It might get a bit confusing.

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CHAIR: In respect of your opening statement, I want clarification around the QMNU's view to see more regulation around unregistered carers, which we see a lot of in the aged-care sector and the disability sector. Can you clarify that for us?

Mr Shepherd: What we see, particularly in Queensland—and I believe New South Wales have it as well because they are co-regulatory, but all the states are using, as far as I know, a national code of conduct for unregulated healthcare workers. Number 1 of that conduct says that unregulated healthcare workers must act in a safe and ethical manner. They do not get any context; that is all they get. They may not have any training at all to be working an aged care or even a hospital facility as an assistant in nursing. We would hope that they have at least a certificate III, but even in a certificate III they do not get a lot of context about what is ethical practice.

When I have assistants in nursing and carers coming to me asking me, 'What is safe and ethical practice? How do I find that out?,' I advise them to go straight to the nursing and midwifery board's website and have a look at the codes of conduct and the codes of ethics for nursing because they are the most appropriate ones for them to know about. Because they are working under the supervision of a registered nurse in almost all instances, they need to know what the nursing framework is about. At the moment there is no direction and no clarity for assistants in nursing and carers across the state or across the country on what actually constitutes safe and ethical practice. They just get told they have to practise safely and ethically. They do not know what that means.

CHAIR: We can certainly talk about safe practices after our previous work where we got nurse-patient ratios through in the state-run aged-care facilities, but we cannot control what we saw in the privately run areas where you might have one carer to 70 patients. Anyway, that is work that the committee has done previously. We thank the QMNU for your contributions and submission here this morning. Thank you very much.

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PEVERILL, Mr Dermot, Industrial Officer, United Workers Union

CHAIR: Thank you very much for your submission. Would you like to make an opening statement? Then we can start to unpack some of this.

Mr Peverill: Thank you, committee, for the invitation to attend this morning's hearing. This, I have to say, is not my first attendance before this committee. I have attended recently. In preparation for this morning I recalled, Chair, that you were on the previous committee back in 2017 when the national law was first amended to incorporate members of United Workers Union. That was the paramedicine expansion.

CHAIR: That is right.

Mr Peverill: The United Workers Union does not just represent our paramedicine members employed by Queensland Ambulance Service and other organisations; we also have coverage of a number of health practitioners, the majority of those employed by Queensland Health. From that starting point, we have made submissions in relation to the most recent amendments contained in the bill 2022 on the basis of our coalface experience since the introduction in 2017. United Workers Union works at the coalface with our members, both in Ambulance and Health, in this forum with Ahpra and the Health Ombudsman, and every day we are confronted with the challenges that our members face. That is our starting point for these submissions.

The submissions contain four recommendations. We broadly support the bill on the basis that regulation of paramedicine and in particular health practitioners should be at the forefront of everyone's mind in terms of public safety. We think the regulators are doing an admirable job of doing that. We have made some recommendations in our submission with respect to what we see contained in the bill as some cosmetic changes—nothing substantive. We did include in our submissions, and pointedly so, some case studies which we thought, given that we are at the coalface and have been since at least 2017 with our paramedicine members, were some key examples of what we see as happening with regulation under these national laws.

I have heard already this morning a submission that obviously any regulator is confronted with cost implications, but this is one that we say Ahpra and the Health Ombudsman are not immune to as well. A lot of our recommendations go to the core objectives of this bill, which are efficiency and effectiveness. It is in our members' interests that we see bills passed—while we are commending this bill—that go to the very heart of trying to achieve efficiency and effectiveness, the reason being that that has very clear outcomes for our members. Our members who are in a position where they are the subject of investigations are often confronted with situations where their livelihoods are at risk. Investigations, in our view, have often become protracted. It is certainly in our members' interests that any amendments contained in this bill should achieve those policy objectives of efficiency and effectiveness. We say that that can be best achieved through some of those recommendations.

CHAIR: I am particularly drawn to the case studies and your recommendation 3, which I think has merit. If I read case study 1 correctly, there are some 81 weeks between the paramedic's suspension and the final outcome that no further action would be taken. That is a huge amount of time. For the benefit of members, recommendation 3 states—

Adjusting the drafting in proposed clause 34 to reflect ... that once the decision has been made to impose restrictions, that the restrictions be only to the minimum extent necessary to achieve public safety—

I get that you are right across that—

as follows:

(c) restrictions on the practice of a health practitioner are to be imposed under the scheme:

(i) only if it is necessary to ensure health services are provided safely and are of an appropriate quality, and

(ii) only to the minimum extent necessary to achieve the purposes in (i).

I think that point is taken and it is reflected in each one of those cases. While patient safety is paramount, there should be some balance here. Is it the view of United Workers to increase capacity of Ahpra to move forward these lengthy, drawn-out cases in a more timely manner?

Mr Peverill: Most definitely. I have heard it this morning. I imagine it is a submission you may hear as the day progresses. It is no doubt a submission you hear in other committees. Certainly from our perspective I think our members—and I understand my colleagues from the QNMU have also made some submissions, so it is not just my union but other unions and other representative organisations that I imagine would be seeking that efficiency and effectiveness be paramount in Ahpra's work.

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At the coalface we are seeing—these are just some sample examples. A lot of the work that Ahpra, and the ombudsman for that matter, are performing is being done in an efficient and timely manner, but we do have some examples where that is not the case. We would see resourcing as part of perhaps a suite of assistance that would help the regulators perform those objectives in a more timely way.

Mr O'CONNOR: The real crux of your submission was the toll that the length of time for these notifications to be determined takes on your members. Do you think the proposal before us will speed that up or is resourcing for Ahpra and the OHO the bigger factor in that?

Mr Peverill: I think the funding is probably one of the bigger factors that will ultimately deliver outcomes for our members. Through recommendation 3 certainly, to the extent necessary that Ahpra, and the ombudsman for that matter, approach these matters with that in mind, I think some of these outcomes might be diluted somewhat. Certainly we would not be seeing examples of 81 weeks of health practitioners sitting waiting for outcomes. That has a huge impact financially, emotionally, psychologically and domestically. With that particular example there was a marriage breakdown in the midst of it. To the member's question, ultimately they cannot be delinked. There is definitely a funding component to it.

Mr MOLHOEK: Following through on that particular thought, the OHO presents regular reports to the health committee. It would appear that they seem to deal with things pretty expeditiously and within time frames. Is it the reports to OHO that are perhaps the concern or is it more that Ahpra is the body that needs more resourcing to deal with them more effectively?

Mr Peverill: I think that is a really good question because that goes to the member for Bonney's question. It probably is Ahpra that needs the resourcing. The way the complaints system works is that OHO basically triages the complaint. If it is a very low level complaint, they will very often be able to deal with the issue either themselves or through the employer. It is really when that matter has been referred to Ahpra, so within Ahpra, that we often see bottlenecks with matters that extend to those that you see in our case studies. To answer the question, I think it is Ahpra, yes, that would benefit most from the funding.

Mr MOLHOEK: Excuse my ignorance, but how is Ahpra funded for this sort of work?

Mr Peverill: I think Ahpra is a Commonwealth funded body, so taxpayers fund it. I looked at the OHO annual report. Much like OHO, it is a taxpayer funded body as well. It depends where the money is coming from. I have not looked at the revenues or the pool. I think that is an interesting question in terms of what money Ahpra is allocated and how it is allocated. I am not sure that is within the scope of my submissions or other submissions. Obviously that is a critical question: how Ahpra is perhaps allocating some of its funding. It is really at that coalface case management which is where we see it has its most significant effects on practitioners.

Ms KING: On the issue of reporting, it is the intention of the health system that we have a robust reporting culture to ensure that issues of safety to the public are picked up quickly and dealt with appropriately and efficiently. Obviously there are huge impacts on your members in relation to those reports. I want to ask whether in your view there is a risk, in light of extended investigations or regulatory processes from Ahpra—81 weeks we have seen—that it might limit members or create a reluctance amongst your members to report concerns if they are aware of these very extended processes and how that may impact on a colleague. They may have a concern about a colleague's practice or behaviour that has happened in the workplace, but if they know that they could be restricted from their work for almost two years that may limit their preparedness to come forward with those concerns. Could you provide your thoughts on that matter?

Mr Peverill: It is interesting. Intuitively the answer to that is yes. I think that is a huge risk to the national law in terms of where those delays are occurring. I think it is counterproductive. You will have colleagues who do not have the confidence in the regulator or potentially the law to deal with matters in a timely way and so are more reluctant to report issues. Despite the fact that there are some mandatory reporting notifications and there are self-notification obligations as well, I think intuitively that is a huge risk. Now that we have seen that it is four years since this has applied to some of our members—longer for others—intuitively I think that would be a risk. If something were to happen today, for instance, in a particular station or in a particular hospital or health service where they knew that those kinds of delays were being experienced in investigations, potentially people are going to ask themselves whether or not they make the notification in the first place. I think that principle could be applied across most regulators, I suspect. Intuitively the answer to that would be yes.

CHAIR: I think we have a pretty comprehensive understanding of the United Workers views. Thank you very much for being here today.

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BOULTON, Dr Maria, President, Australian Medical Association—Queensland (via videoconference)

KHORSHID, Dr Omar, Federal President, Australian Medical Association (via videoconference)

CHAIR: Welcome. Thank you for being here today. Who would like to start with an opening statement?

Dr Khorshid: I will get the balling rolling with a brief opening statement. I would like to thank the committee for inviting the AMA to contribute on this very important issue. I would like to start by acknowledging the traditional owners of the lands on which we are meeting today around the country and pay my respects to their elders past and present.

I think it is fair to say that there is not much love for this national regulation scheme in parts of our profession, especially relating to how it impacts on the lives and particularly the mental health of so many of our colleagues and friends and through the almost disproportionate fear that it seems to create. The AMA agrees that the protection of the public is a critical role of the scheme. It is right at the centre of it, remembering of course that this regulator is fully funded by the registrants, not by government. We believe that this role of protecting the public is already well achieved under the current arrangements.

There are a lot of amendments contained in this bill which have far-reaching ramifications for the medical profession and for our patients. It was largely constructed during the height of the pandemic. This has meant that the consultation process, in our view, has been well less than satisfactory. Many of the changes have not been thought through. I think the best illustration of that is this bizarre proposal to remove the current ban on patient testimonials from advertising material. There are really good reasons that this current ban exists. It protects patients, in particular vulnerable patients, from false and misleading advertising. Testimonials are broadly acknowledged throughout our industry as being, even when they are true, quite misleading in terms of how they are presented and whether the individual testimonial applies to the patient who is reading the testimonial and, of course, there is a potential for fake testimonials, which would be extremely difficult to regulate.

We are all very aware of the concerns that have been raised about the practice of cosmetic surgery in this country and the behaviour of some of the practitioners. Allowing testimonials will only make these problems worse and put the public at greater risk, rather than reduce that risk. Certainly from our experience of Ahpra and our understanding of its growing workload, it is impossible that Ahpra will be able to police this change and will be able to make sure that testimonials that do appear are actually true and do not mislead patients. The inclusion of this change in the bill should give the committee significant cause for concern, not just about this amendment but, of course, about the entire bill and the way it has been constructed.

It is vital that the national scheme shows a commitment to impartiality and to due process. It is also vital that the wellbeing and the state of mind of the practitioner are at the forefront of the regulator's and the Medical Board's considerations, particularly investigations that can be very long running and have significant negative health outcomes to the practitioners themselves, even when they come out of the process without a finding against them. Unfortunately, this bill contains amendments that will undermine this impartiality, reduce procedural fairness and have a disproportionate impact on the lives of many doctors around Australia.

I will point out a couple of specific things. The new guiding principle is one of our areas of concern. Clearly, the protection of the public is a critical role of the scheme. However, in relation to the proposed amendments at clauses 33 to 35 to provide that the paramount considerations are of public protection and, importantly, public confidence in the safety of health services, we believe this is unnecessary and will not help the operation of the scheme. The introduction of a main guiding principle complicates what is already a highly complex scheme. If you include public perception in what constitutes a safe service, that is going to make things extremely difficult not just for practitioners but also for the regulator. Of course, public perception, as we have seen throughout the COVID pandemic, can change very quickly even without the facts on the ground changing at all.

The new main principle appears to suggest that we can provide health services in a way that is completely risk free and that we would always choose a lower risk procedure. We do not support this view. We must support patients' choices and for doctors to support patients through that, even where it may be in making decisions that we would not recommend they make, such as having a

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natural delivery even though we recommend a caesarean section or a patient's decision to participate in a clinical trial for an untested new treatment. There is a lot of complexity and a lot of grey areas here. This new guiding principle will only further complicate the application of the national law.

Around public statements, we are also concerned. Throughout the development of these amendments the AMA has on multiple occasions asked for proper, evidence based evaluation of the national scheme. Instead, we have been led through a process where we have had a grab bag of ideas generated without any clear process, without transparency and without evidence. They have been introduced along the way over the few years that this process has been going but without health professionals having any real understanding of why these harsh steps are necessary, especially when you consider the extensive powers that Ahpra and the national boards already have to protect the public if a practitioner poses a serious risk. Of course, the regulator right now will remove registration, suspend it or impose limits on practice if it feels that there is any risk to the public.

Out of all the amendments, the ability of the Medical Board or Ahpra to issue a public warning before a tribunal has completed its actions—in clauses 100 to 102—is really the most troubling. As I mentioned before, we have asked repeatedly for evidence showing the need for this additional power on top of that ability to impose limitations on practice or to suspend registration, but we have not been given any evidence of how this additional power will actually assist in protecting the public. We can only conclude that this lack of evidence is because there is none. We are absolutely of the view that issuing a public warning implies guilt and is likely to ruin a practitioner's reputation and possibly ruin their lives. Even if such statements are withdrawn down the track, it is a completely non-retractable step and will cause irreparable harm to the health and wellbeing of practitioners who may actually have done absolutely nothing wrong. Under the current circumstances the Medical Board can issue a media statement at the conclusion of a tribunal process, and this is something the AMA believes is entirely appropriate, especially in the absence of any evidence that the current system is not working.

Just to conclude, in their briefing on 23 May, the Queensland Department of Health stated that these amendments bring balance to the national scheme in favour of consumers. They then argue that this would not have a significant impact on health professionals due to the small number of practitioners who receive a complaint. We disagree with this statement. Our submission that we have made to this process shows that a high proportion—around five per cent of doctors—are likely to receive a complaint each year. If you add that up over a career, it is very likely that many doctors will receive one or more complaints throughout their career, and the impact of this on the livelihoods, mental health and longevity of practice for doctors cannot be downplayed. The constant state of fear that doctors practise under, waiting for their turn to be next under the Ahpra microscope, weighs heavily across our profession, and we are seeing the impacts of this including in tragic outcomes like suicide of practitioners.

This level of fear and uncertainty is going to be only heightened by amendments—in our view, ill-thought-out amendments—such as these. We do believe there needs to be an appropriate balance between increasing regulatory scrutiny and a power to protect against situations that occur fairly rarely, and we do not believe that these proposed changes deliver that balance.

I would encourage you very much to spend some more time refining this legislation so it will actually improve patient safety and not pose unnecessary risks to the lives and to the careers of doctors and other health professionals who, of course, are so critical to our community. I will hand over to Dr Maria Boulton, President of AMAQ, to make some further introductory remarks.

Dr Boulton: AMA Queensland supports our federal counterpart's submission. However, I would like to use my opening statement to focus on one key area that needs to change, clause 20 of the bill. This clause enables public statements to be made about a practitioner before a finding of guilt. By the very nature of our profession, doctors are motivated to put patient wellbeing front and centre. We welcome having patients' wellbeing at the heart of the scheme. Giving patients robust avenues for investigating concerns over their treatment or a practitioner's conduct is fundamental to a strong healthcare system. The full and fair investigation of a legitimate complaint can provide redress for a harmed individual, highlight flaws in the systems and processes, and field a genuine need for reform in health care. However, this must be balanced with natural justice for practitioners.

Clause 20 would amend section 90 of the Health Ombudsman Act 2013 to enable a public statement to be made about a practitioner before a finding has been made—that is, before a complaint has been investigated and substantiated. Under the proposed amendment, practitioners are given only one day's notice to appeal against a public statement being issued. Clause 100 will facilitate the same amendments in other jurisdictions.

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A pre-emptive public statement can cause permanent and irreparable harm to medical practitioners, with no genuine benefit to patients. It breaches one of Queensland's fundamental legislative principles: that laws should be consistent with the principles of natural justice. Vexatious, frivolous or unfounded complaints can cause extraordinary harm. Even when those types of complaints are kept confidential, they can wreak devastating consequences for practitioners, both personally and professionally. But if this harm is compounded by pre-emptive public statements before a finding is made, the damage is permanent and irreparable.

The measures in proposed sections 90AC and 90AD are profoundly inadequate to protect practitioners from vexatious and unfounded complaints. The requirement for a public statement to be revoked if the grounds no longer exist or never existed is highly insufficient to remedy the harm caused by the public statement. The unfounded accusations will remain available permanently in the public domain. Once something is on the internet, it is there forever.

There are two components to the risks associated with pre-emptive public statements. One is the actual risk of the devastating personal and professional detriment from an unfounded public statement. The second is the extra strain on doctors for fear of this measure being used. This imposes a cruel psychological threat over a profession already under incredible stress. If you watched the ABC's *7.30* on Monday night you would have an insight into the unprecedented stress on the medical profession and the impact this is having on the system and on individual health practitioners. Sadly, this amendment comes at a time when we should be protecting our health workforce and safeguarding their physical and emotional wellbeing.

The proposed amendment could be reversed at no cost to patient safety because robust complaint investigation processes already exist. No evidence has been provided to demonstrate that public statements before findings have been made would provide the public with greater protection. Existing mechanisms can be used to protect the public from a practitioner suspected of causing harm.

In summary, the profession supports the principle of holding doctors to account for their conduct. No doctor would suggest that we should not be held to high standards and complaints scrutinised, but there is evidence that existing safeguards against rogue practitioners are sufficient. This change robs practitioners of natural justice. It exposes them to unnecessary psychological strain and an increased risk of suicide. The proposed change to the legislation will only exacerbate this risk, whether the complaint has a basis or not. Does the government want the blood of doctors on its hands, because that is what it will lead to? The fear of being named, blamed and shamed unnecessarily also has the potential to further deter and demoralise doctors from continuing to work in areas that need us—those needy communities, especially in rural and remote areas. It provides the public with no additional genuine protections against rogue medical practitioners. Thank you for the opportunity to present today. We are now happy to take questions.

CHAIR: Thank you both very much for your opening statements. We will have Ahpra in front of us this afternoon to respond to the clear concerns you have both articulated around public statements. In their submission at page 3 they say—

The threshold for issuing a public statement is, appropriately, set at a high level. We must form a reasonable belief that the person's conduct, performance or health poses a serious risk to others and that a public statement is necessary to protect public health or safety.

Do you agree with that? We will follow this up, but in the last term there was a Cairns dental practice surgery that had to be immediately shut down because there was a risk that patients may have been exposed to hepatitis. We have regulations in the health area for a reason where serious risk is posed. I am trying to get a view from both the federal AMA and the AMAQ of where that line should be drawn. I understand exactly what you are saying in terms of your views. Where do we draw the line?

Dr Khorshid: When it comes to the individual practice of registered health practitioners, the boards can cease their practice immediately and make their practice illegal or they can impose very strict restrictions on a practice. That exists right now without the need to make a public statement. Ahpra and the boards, especially in the early years, had a history of limiting the practice of (inaudible) have huge risk to the society and they were erring on the side of public safety. In doing so, they harmed that practitioner in that they could not continue to practise whilst the process was gone through and, ultimately, they were able to practise again.

In this circumstance, if the bar for making a public statement was, for instance, at a similar level to that imposed on making a decision to cease a doctor practising and to suspend their registration, we have evidence that, in fact, that bar has been crossed in times where there was minimal risk to

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the public. There are even cases of mistaken identity and all sorts of issues that have occurred in the past. There is a very low level of trust within the medical profession that that bar would be set at an appropriately high level.

I think that, in the example that you give of an immediate risk to public health, you might think that at face value is very reasonable, but in fact using its current regulatory tools they could cease that practice from operating anyway as a board, whether it be the regulator, the dentists or other health professionals that may have been in that practice. All of their registration can be affected so they can cease that business from working. If there was a further public health risk more broadly, for whatever reason, of course there are other tools available to public health authorities to make sure that the public is protected. You do not need to make a statement about an individual practitioner's registration status and their risk to the public.

Ms KING: Thank you so much for providing us with the views of your members. I want to reflect on previous circumstances that have come before Ahpra where it was considered that there was a very significant risk to the public. I reflect in particular on the case of the dental surgeon in Cairns which my colleague referred to. In that case, not only was there considered to be a situation of extreme risk; there was also a need to notify members of the public who may have been exposed to HIV or hepatitis through the allegedly unsafe practices of that particular surgery. Would you accept that there are circumstances where a public statement is necessary in order to not only advise the public of risks that could be faced but also advise people who have attended that practice or had treatment from a particular practitioner that they already have accrued a risk that they must manage in their life?

Dr Khorshid: I think the short answer is that that is possible right now. You do not need to change the national law. We have had multiple circumstances in this country where there have been practices such as you have described where there was risk to individuals and the mechanisms exist for those individuals to be contacted or for the media to be used to advise individuals who may have attended a certain practice to seek further medical intervention so that, for instance, treatment for potential hepatitis C could be started early if someone tested positive. There is a time pressure there and you might not want to wait until a disciplinary process has been gone through.

The concern that we have here is that this registration system is about the individual practitioners, their individual practice and their individual status as a registered practitioner. That is really quite different to putting out a public message about a risk to public health, whether it be the health of 50 or 100 or 500 patients who may have been affected by a circumstance. There have been examples of, I think it was, a pathologist who was misreading oncology reports. There have been other (inaudible) concerns. Those have been able to be mitigated to the public in a timely way without the need to name and shame practitioners before there has been any process about their own culpability in what has gone on.

In the example that you give, an individual practitioner working in that practice may have had no understanding of a lack of appropriate processes. They may have been misled by another practitioner within that practice to believe that processes were being appropriately followed. They may have no blame whatsoever associated with the events that have occurred, but you do not know that until you have been through a process. To publicly name and shame that practitioner causes harm without improving public safety.

Mr MOLHOEK: I want to ask some questions around the legislation proposing to open up the pathway in terms of the making of public statements and your comments around natural justice. Do you have any insight as to why the legislation and the national law are proposing that? Is there an alternative view that suggests that perhaps they have been a bit too slow to respond in the past, which is why the pendulum is swinging this way in what is being proposed? I am struggling to understand why we would want to deny people natural justice and why the federal legislation has proposed that and then it has trickled down through this national law?

Dr Khorshid: That is exactly our concern: we do not understand where it has come from and we have not seen any evidence to justify the change in the law. The process through which this legislation has got to this point has been significantly flawed, with each draft being quite different to the last but without any clarity as to how new things were inserted along the way. Really, as a process that has such a big impact on a critically important part of our workforce, being health practitioners, that process is really disappointing. We have expressed that frustration along the way. Here we are, at the very end of the process, with proposed amendments that really, in some cases, harm natural justice for doctors but in the aim of improving patient safety; on the flip side, you have other parts that

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seem to worsen patient safety by allowing testimonials to appear in advertising. It is, we think, a failure of process. Probably somebody thinks it is a good idea. I presume the regulator will explain that to you later today.

From our point of view, we cannot see and have not been given any justification. We have a good, strong track record of supporting appropriate regulation of our profession. It is in no-one's interest for practitioners to practise below appropriate standards. We want to be held to account. We need to be held to account as practitioners in order to maintain our effectiveness in the community. We support the vast majority of the actions of the regulator in holding our members to account, but it has to be within the usual legal and fairness principles that apply to everybody else in the community. That is our concern here.

Dr Boulton: To add to that, in Queensland there has been very little consultation. I heard from the Queensland health advisory group today, the peak body in Queensland that supports doctors' and medical students' wellbeing, and they were not consulted through the process. Once again, they are in agreement with what we have spoken about today.

Ms PUGH: I want to return to some of the comments you made in your opening statement, Omar, regarding vulnerable patients. We all know of the *Four Corners* report—if not the actual show then the story last year about plastic surgery and the high risks that can carry. Certainly that is a cohort that springs to mind when we are talking about vulnerable patients. Can you speak to any increase that you are seeing in vulnerable cohorts where 20 years ago it was not such an issue? Are there any changes and trends that we need to be mindful of moving forward when we are thinking about legislation? I feel that this is a fairly new area. It certainly was not something that I was thinking about as a young person and it definitely seems to be an area of emerging interest in medicine. I am very interested in feedback and comments on that from both of you, please.

Dr Khorshid: There has been a significant change in how the public looks for and receives medical information and medical advice. The rise of social media is having a huge impact on health and medicine, just as it is on the rest of our lives. We have certainly seen through the pandemic that people went to all sorts of different sources to inform their views as to how to make medical choices.

The impact (inaudible) of social media, of websites and of the soft coercion and manipulation of people that occurs on those platforms on vulnerable people is very significant. We have to acknowledge that our health literacy is not really where it needs to be. Throughout the community there are pockets of low health literacy and there are a large number of Australians who are vulnerable to manipulative messages. We believe that the patient testimonials are exactly that sort of manipulative statement. They are very powerful because they explain an individual's experience of a health service, but they are likely to be interpreted by people in ways that may not apply to their individual circumstances.

Of course, patient testimonials that appear on social media feeds that are curated by a practice or a practitioner are going to be heavily curated. You are not going to see a mix of views; you are only going to see one type of view. That will very quickly give a member of the community with lower health literacy or a less sceptical mind the impression that a practitioner is practising a very high standard simply by the patient testimonials. Those testimonials may be real but they may filter out the bad ones, or in fact they may be completely fictitious.

On some of the ratings websites, even with some of the IP controls and things in place, through the cosmetic industry we have heard many stories of family members and staff members posting reviews of cosmetic surgeons in order to manipulate their standing in social media—and that is in the current regulatory environment where testimonials are banned. If you allow testimonials, it will just be fantastic for these cosmetic cowboys, as we call them, who will simply use every technique available to them to increase their market share and make more money out of vulnerable Australians. I think this is a really bizarre direction to be going in if we are trying to improve public safety—in particular, when we have so recently seen the impacts on many Australians of low levels of professional conduct in certain pockets of the cosmetic surgery industry. Maria, do you have anything to add?

Dr Boulton: I completely agree. If the pandemic has shown us anything, it is that health literacy sometimes is not where it needs to be. We know how strong social media can be in influencing people's choices. I guess we have to remember that all of these procedures, especially when you are talking about cosmetic work, are medical procedures and they carry risks with them and they need to be taken seriously.

CHAIR: I think it was Dr Boulton who said there was only one day's notice in terms of the public statements. Is there any compromise there? Do you have a view if it was seven days, or are you just not supportive of that at all?

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Dr Boulton: We do not have any data saying that (inaudible) public statement is actually going to lead to better patient outcomes. In fact, it will be extremely detrimental. We are very concerned about the doctors' resulting health and wellbeing. If as a mum I have a child who is thinking about going into medicine, who would want their child to be faced with that before they are investigated, before they are found to have done anything wrong?

Dr Khorshid: To clarify that, one day is just further evidence of the lack of natural justice. If a practitioner had at least a reasonable opportunity to respond, to put a different position to the regulator or to seek legal advice, that would at least show that the regulator is acting in more good faith, rather than just giving them one day's notice and then, bang, it is out. It is no time to respond. We believe that same attitude is prevalent elsewhere in the bill. This is not the only part of the bill that is lacking in natural justice for what is an extremely regulated profession already.

Mr O'CONNOR: The submission said seven days to respond and then three days notice to publish. Can I clarify that is your position instead of the one day?

Dr Khorshid: Well, that would be a much better outcome, but we believe the provision of public statements at all is the wrong direction to be going in. Certainly, that kind of time frame does not put the public at any increased risk and would give the practitioner a reasonable opportunity to respond.

CHAIR: Thank you. We have gone over time. We appreciate your contributions this morning.

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COLLINS, Ms Anne Marie, President, Australian Association of Psychologists Inc (via videoconference)

CURRAN, Ms Amanda, Chief Services Officer, Australian Association of Psychologists Inc (via videoconference)

CHAIR: Good morning. Would you like to make an opening statement and then we will move to questions?

Ms Collins: Thank you for the opportunity to speak to our response to the proposed changes to the legislation. We have agreed to the changes to the interim prohibition orders and prohibition orders, and we have spoken to that in our response. We have raised some concerns about the information sharing and public announcements about health practitioners who are being investigated or under investigation. Those concerns really go to some issues raised in the past with Ahpra at other Senate committee hearings. That is really in relation to natural justice and a natural justice process. We have detailed our concerns, which are around raising the profile of health practitioners in the public domain when an investigation has not been completed. Our position is that the criteria needs to be very high for those publications to be made. In our opinion, those publications should not be made until an investigation has been completed.

On the issue of natural justice and the approach to investigations under the national law, we did raise with the Psychology Board the possibility of conducting mediations, which is something that happens in all other legal jurisdictions, and I know that this is a quasi-legal jurisdiction. Our opinion about that is that a mediation process for an initial approach to complaints would have the effect of maintaining relationships between health practitioners and the public and would take the emphasis off a very heavy-handed approach to investigating health practitioners. Where there is a serious issue, of course there needs to be a thorough investigation, but the concern we have—and this probably has come to the fore under the pandemic—is that health practitioners are leaving the workforce, they are not staying, and these kinds of approaches do not assist in maintaining and growing a health practitioner workforce.

The information we have is that the national law does not allow for a mediation process to occur as an initial step in an investigation. Our position is that that would not only be cost effective but also help with maintaining positive relationships and the confidence of the public in health practitioners. It is not to take away from the fact that there are some practitioners who obviously need to be investigated because they are at the serious end of allegations. But there is a problem—and it has been stated before—about Ahpra and the process of investigations of health practitioners.

In terms of testimonials and the change of legislation, we have spoken to that too. It is our position that, while testimonials may assist with some of the issues with online posting for health practitioners, there needs to be an education program or sufficient education of practitioners that (inaudible) be compliant with the laws around advertising. It is the same in relation to the mandatory reporting by employers. Some employers are not health practitioners and may not actually be across their requirements to report on health practitioners. We are proposing that there be an education program for employers as well. Did you want to add anything to that, Amanda?

Ms Curran: No. I think you have covered the main points.

CHAIR: We will open it up to questions. Deputy Chair, do you have a question?

Mr MOLHOEK: I am fine.

Ms KING: I thank you both for being with us. I will start by disclosing that in a previous career I was an accredited mediator. I am concerned about your proposal that mediation could play a part in the notification of serious risks to the public. Would you like to elaborate on that so I can make sure I am across exactly what you are proposing around mediation?

Ms Collins: Clearly, if there are serious risks, that needs to go to an investigation. I am a mediator too, and we are well aware of the power differential and how that could be an issue in mediation, but there are also ways to mediate. We are talking about less serious complaints, not extremely serious complaints. It would not be appropriate, obviously, to have a mediation in sexual abuse or the more serious types of complaints—that is true—but there is no process of mediation currently.

Ms Curran: The main idea around this is for the low-level complaints. If a consumer has a concern about billing, should that go all the way through an investigation process and take six to 12 months to resolve, or could that be resolved very quickly through a very short, consumer focused mediation service to speed things up and get things moving within the system?

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Ms KING: Thanks for clarifying. We know that with our single front door for health complaints in Queensland for minor, low-level complaints those complaints end up with the OHO in most cases and there is an opportunity for some kind of resolution. It is not mediation per se, but there are dispute resolution processes that they use. I suppose my concern is that, say, we have an example of a billing matter that has been raised by a member of the public. Worst-case scenario is that improper billing practices might be used as a standard approach by a practitioner and if that single complaint is effectively mediated away then it does present the potential to hide patterns of behaviour from the public which are not in the interests of public safety or public confidence in the health system. I think it is an interesting conversation. I would love your comments on that.

Ms Collins: My comment on that would be that if there is a pattern of improper billing it would become apparent by complaints. It seems as if Ahpra approaches things from the worst-case scenario, especially in those low-level complaints if there is a pattern of billing or there is an issue. My understanding of the law was that when a complaint is made it is not meant to be an avenue to open up other areas of question. I know that is going a little bit away from what you are saying, but if there is a single complaint and it is dealt with by mediation and that is recorded and there are several more similar kinds of complaints about the same practitioner, obviously there is a pattern and there is a problem. What we are talking about, though, and the reason we would like to see the mediation approach used is to ameliorate for health practitioners relationships with consumers and with the Australian public. That is what this is about. The heavy emphasis on a high-level investigation and even publishing details of the investigations before they are completed affects the public's image of health practitioners. It is not in the public interest to do that. It is if there has been a finding.

CHAIR: In your submission you state that the proposed removal of the prohibition on testimonials may impact on the ability of practitioners to remove defamatory and false negative comments. Wouldn't a practitioner be able to complain to Ahpra in such circumstances?

Ms Curran: I am not sure of that process currently. I am not aware of Ahpra ever having been involved in assisting with that sort of matter. I would have to look into that further.

CHAIR: Okay. As there are no further questions, I thank you both for your contributions this morning and for your submission. It is appreciated.

Proceedings suspended from 11.18 am to 11.54 am.

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CLANCY, Dr Patrick, Senior Medical Adviser, Avant Mutual (via videoconference)

HAYSOM, Ms Georgie, General Manager, Advocacy, Education and Research, Avant Mutual (via videoconference)

McDONALD, Ms Cheryl, National Manager—Legal Services, MIGA (via videoconference)

REDDY, Ms Aparna, General Manager Policy, Insurance Council of Australia (via videoconference)

CHAIR: I welcome representatives from the Insurance Council of Australia, MIGA and Avant Mutual. Good morning. Who would like to start with an opening statement? Then we can move to questions.

Ms Haysom: I think the ICA was going to start.

Ms Reddy: Can you hear me? I am not able to see the audio but I presume that—

CHAIR: We can hear you, yes.

Ms Reddy: Great; thank you. I do not have visuals, so I will just have to rely on someone prompting me for a response if I do not respond to visual cues, so apologies in advance. Thank you for inviting us to appear today. The Insurance Council of Australia appreciates the invitation from the committee to address our submission and the submissions of our member insurers for the proposed health practitioner regulation national law amendment bill. I am here today with representatives from Avant Mutual and MIGA that are members of the ICA and that have made submissions. I will leave it to the members to introduce themselves shortly.

The Insurance Council is the representative body of the general insurance industry in Australia and represents approximately 95 per cent of private sector general insurers. The pandemic has highlighted to the community the crucial role played by the healthcare system. Within this system, the ICA represents healthcare indemnity insurers who have a long and important history in providing advice, medical defence and insurance to doctors and other health professionals. Accordingly, the ICA is concerned to ensure good public policy outcomes.

Briefly, I would like to touch upon the three issues raised in the ICA's submission: firstly, the new paramount principle of maintaining public confidence; secondly, removing the prohibition on testimonials and introducing a new requirement to ensure testimonials are not false, misleading or deceptive; and, thirdly, the new discretion not to refer a matter to a disciplinary tribunal on public interest grounds.

On the first, the paramount principle of maintaining public confidence: the ICA is concerned that the case has not been made for inclusion of this principle. Further, the ICA is concerned the principle could lead to unfair outcomes for doctors and medical practitioners, undermining confidence in the legislation. The ICA urges the committee to exercise caution and to recommend the removal of the principle from the bill.

On the second, removing the prohibition on testimonials: the ICA is concerned that removal of the prohibition would place an unreasonable burden on health practitioners, particularly if enacted without a transition and reasonable support for health practitioners. For this reason, we urge the committee to recommend a declaration that there would be no penalties imposed on health practitioners over the first 12 months and that the regulator would provide guidance on compliance over this period.

On the third, the new discretion not to refer a matter to a disciplinary type tribunal: the ICA supports the aim of reducing unnecessary referrals to a tribunal. However, we believe that the threshold is too high and the amendment will fall short of its goal. To enable this amendment, the ICA seeks the development of guidelines in consultation with insurers on the exercise of this discretion that may be included as a provision in the bill. Thank you for the opportunity to address the ICA's submission. I can wait for questions until my colleagues read out their statements, if I may, and introduce themselves.

CHAIR: Thank you. We might go to Cheryl, then Georgie and then Patrick.

Ms McDonald: I am the national manager of medicolegal services at MIGA, which is one of the key providers of medical indemnity insurance in Australia for medical practitioners primarily, but we do have some other healthcare providers as well. I want to thank you for the opportunity to make

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the submission, which I know you have, and the opportunity to appear today. I refer to our submission—dated 6 June and prepared by my colleague Timothy Bowen—which is entirely consistent with what the ICA just said. Our submission focuses on three of the key areas of the bill: paramount consideration of public confidence; clinical testimonials; and not referring matters to a tribunal. I believe that our submission is self-explanatory in relation to the key points.

In relation to the first one, paramount consideration of public confidence: of course we agree it is vital that health practitioners and professionals have the confidence of their patients. That goes without saying. We do see the proposed paramount consideration of public confidence as limited in definition and scope, and with a lack of clear definition and scope comes uncertainty. We do not have a good understanding of how public confidence could be assessed and indeed, if you attempted to define it, what that would actually look like. Our submission goes into further detail about this issue and the challenges we see with this particular term. We are not satisfied that the amendment is necessary. If it is introduced, we suggest that a paramount consideration of integrity of the profession, as distinct from public confidence, might be something to be considered, and then there can be a reference to protecting standards and ethics. This is set out in our paper. We say that the current legislation provides the public with protection and current Ahpra medical board powers are sufficient.

In relation to clinical testimonials, we say it is important to be mindful of the unintended consequences of the removal of the prohibition on clinical testimonials. Testimonials still must not be false and misleading. We say that, in the event this prohibition is removed, practitioners will need to be educated on their ongoing obligations in relation to this aspect. In spite of the attempts and efforts that have been made by all key stakeholders and Ahpra themselves to educate practitioners in this area, we still find ourselves in difficulty. We must say that Ahpra has worked very cooperatively with us and our practitioners to deal with any issues associated with testimonials and advertising. We say that if it is introduced the profession will need some guidelines, assistance and support on what can and cannot be published. We note that Ahpra has acknowledged that.

The last point in our submission relates to not referring matters to a tribunal. In relation to that, MIGA supports the national board having broad discretion not to refer a matter to a disciplinary tribunal. We consider this should be based on there being insufficient public interest as distinct from no public interest in referring the matter. We would always encourage existing protections or alternative actions to be a required consideration in any event before anything is referred to a tribunal. We see this as an improvement. It will assist with workload issues, time and cost and allow consideration of a situation where the professional is not actually an ongoing risk to the public. Otherwise, MIGA endorses completely the submissions made by our colleagues at Avant, who are going to speak next. Thank you for the opportunity to speak today.

Ms Haysom: We appreciate the opportunity to give evidence at this hearing today. I will give you some very brief background about Avant. We are an organisation that provides medical indemnity insurance and other products to medical practitioners. We are a mutual organisation. We are owned by our members and we have over 78,000 members around Australia. We assist and advise our members on a wide range of medicolegal matters, including responding to complaints when a notification is made to Ahpra, medical boards around Australia and the co-regulatory jurisdictions, of course Queensland and New South Wales. In addition to the matters that were raised by the ICA and MIGA we want to highlight a couple of concerns we have, particularly around the issues of public statements and the disclosure of information to protect the public.

While we understand the intent of the proposed amendments, we are concerned to ensure that the national law is proportionate and fair to practitioners, particularly in its impact. In relation to those provisions, the proposal to make public statements, the provision that allows disclosure of information to protect the public, and the power to take action against a practitioner for conduct that occurred before they were even registered as a health practitioner are very broad powers. As currently drafted they are unfair. We are concerned that they could be used in a disproportionate manner and we are concerned to ensure that does not happen. We are also uncertain about how these provisions will interact with existing provisions such as immediate action powers. The board has quite extensive powers in relation to taking action where there is a risk to the public.

In relation to testimonials and advertising, we are pleased to see Ahpra's acknowledgment of the need to have a phased introduction of the new advertising laws and (inaudible) to give practitioners sufficient time to understand the impact of those amendments and for Ahpra to issue updated guidance. We also consider that this bill is an opportunity to revisit the issue regarding mandatory notification and adopt the WA exemption for treating practitioners, as recommended by the recent Senate Community Affairs References Committee in its report of its review of Ahpra. Fear of mandatory reporting is an ongoing barrier to health practitioners seeking appropriate care. Whilst

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we acknowledge that one of the objectives of the national scheme is protection of the public, our view is that this should not be at the expense of practitioners, who provide much needed healthcare services to communities. Every day at Avant we see stressed and distressed doctors who are harmed by the regulatory processes. I will ask Dr Clancy to speak to that in a bit more detail.

Dr Clancy: I would just like to draw your attention to the impact that regulatory complaints have on doctors. I am one of them. When I recently surveyed Avant's lawyers, claims managers and medical advisers, their responses about what impacts they were seeing on doctors were quite overwhelming. When a doctor first contacts us about being the subject of a notification they are often stressed; they are vulnerable; they are really fearful of what is going to happen next. We are regularly seeing significant impacts on their mental health when sometimes they are not getting the care they need. In several unfortunate cases they have taken their own lives, which is really quite sad and distressing.

Doctors are already worried about being struck off when they do receive a notification. They are also worried about having other limits put on their practice or even just having their professional reputation damaged. It is a fair assumption to make that this may worsen with some of the proposals in the bill, particularly in relation to the possibility that they may be publicly named early in the notification process, even before any immediate action or investigation occurs.

As alluded to by my colleague Ms Haysom, I would also just like to point out that I think this bill was a really good opportunity to consider introducing the WA exemption, given the findings of the recent Senate inquiry that were released about two months ago. I think that would give some reassurance to doctors and other health practitioners that they can seek the care they need in an unfettered way without the fear of a third party being involved in that doctor-patient relationship.

CHAIR: Deputy Chair, do you have any questions?

Mr MOLHOEK: Where do you start?

CHAIR: I can say that everything you have raised has been very much replicated in most of the submissions. We have Ahpra and OHO here next, so it will be good to hear from them.

Mr MOLHOEK: I have lots of questions I would love to ask but nothing to do with the national law, to be quite honest. I will defer to the member for Pumicestone. We have canvassed a lot of these issues already this morning.

Ms KING: The one issue that has not come up in previous submissions today is what you describe as the opportunity to revisit mandatory reporting aspects and potentially provide an exemption for health practitioners, as is the case in Western Australia. I understand that you are referring to the need for mandatory reporting where a health practitioner seeks, for example, psychological support in their own right. I wonder if you could explain a little bit more about those issues and the findings of the Senate report for the benefit of the committee.

Ms Haysom: We are really concerned about this. There has been a longstanding fear on the part of practitioners about seeking care. There has been significant consultation around amending mandatory notification provisions, and that has been dealt with over several years. Despite the changes that came in, which did increase the threshold for mandatory notification for treating practitioners—

Ms KING: The perceived risk of serious harm; is that right?

Ms Haysom: Yes, that is correct. I should have explained—

Ms KING: That is the heightened threshold; is it not?

Ms Haysom: That is correct. It is for practitioners who might be seeking care from a treating practitioner. There is an increased threshold, that is correct, for mandatory notification for a significant risk of harm to the public, and there are some factors that need to be taken into account. Those changes were made in 2020, but we are still hearing from our members that they fear seeking care despite those changes and they are not seeking care that they need, particularly around psychological and health issues. We are particularly concerned about that. We think the WA model is the best model.

Ms KING: I might ask you to expand more on the WA model shortly, but I want to ask you whether you think there has been sufficient education to give practitioners some comfort about their protection from mandatory reporting for seeking care when their health situation falls below that threshold of risk of serious harm.

Ms Haysom: There was a lot of work done by Ahpra and us. We were involved in the consultation around the guidelines for mandatory reporting. I think the guidelines are good. They are useful. I think the issue is that practitioners do not know what they do not know. They look at those

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guidelines when it is a just-in-time situation, at the time they need it, and they do not often know they exist. I think there probably could be some more education, but it is hard, in a practitioner's busy day, to educate them about that along with all of the other issues they need to consider in their daily practice.

Dr Clancy: It is also a matter of what education the health practitioners who are patients have. If you can imagine, they are a vulnerable group with psychological problems, for example, and they do not necessarily know the nuances of whether it is going to be a significant risk and what the words 'significant risk' actually mean. They are more worried that the health practitioner they are seeking care from may have to make a mandatory report.

Ms KING: I know it is fairly early days, but have we seen any evidence of an increased preparedness to engage in help-seeking behaviour from practitioners in Western Australia?

Ms McDonald: I do not know the answer to that so I cannot say. Just endorsing what has already been said, we must not underestimate the impact that being the subject of a complaint has on a doctor. We continue to have to ask the very question of our members, 'Do you have your own general practitioner? This is clearly weighing on your mind.' We can give all of the reassurance that they will be supported, that in our experience this matter is not at the upper end of significant and that the complaints will resolve. Be that as it may, it remains concerning that doctors do have a reluctance to treat themselves—not personally—as they would treat their own patients and make appropriate recommendations about the need for support and advice.

With all the education and guidance in the world, it is very difficult to shift that fundamental mentality, if you like, that many practitioners have that 'we are the ones who provide the medical care; we are not the ones who should need the medical care'. It is quite difficult to move that. I completely agree that this is the perfect opportunity to bring in that heightened protection, if you like, and to bring some balance which is very important. That is what this is all about—the balance between patients and the profession.

Mr ANDREW: How many suicides have you seen over the past couple of years? Has there been an increase?

Ms Haysom: I am not sure that we have that data to say that there has been an increase, but we certainly see in our organisation suicides happening from time to time.

Mr ANDREW: How will the implementation of these new amendments affect the risk appetite of insuring practitioners? Will it see insurance premiums go up? Will this put extra load within that realm as far as risk appetite is concerned?

Ms Haysom: I might have to take that question on notice. For example, if we take the public statement provisions, if those public statement provisions go in and there is a show cause process with those statements, that will require practitioners to seek assistance to be able to go through that show cause process. It is another step in the broader regulatory process. That will require assistance and it will take time and what have you. It will potentially add to the numbers of claims and requests for assistance that we will get.

Mr ANDREW: That is what I thought.

CHAIR: Patrick, how long have you been an SMO? Did I hear that correctly when you were introduced?

Dr Clancy: I am a senior medical adviser at Avant.

CHAIR: I thought I heard 'SMO'. It was SMA! I need to get my hearing checked.

Dr Clancy: I have been a doctor for 25 years.

CHAIR: In my former clinical career of 25 to 30 years as well, I saw some colleagues go through clinical investigations. I understand that they are a great deal of stress but I also understand that there needs to be public safety and public confidence. This morning in one of the submissions from United Workers we heard about 80 weeks and 152 weeks where matters have been resolved with no further action required, but the stress involved in going through that is significant. I imagine that would be the same for your colleagues. Can you give some practical examples of that?

Dr Clancy: Again, with that survey I mentioned that I did internally seeking anecdotes, as you will, from the claims managers, lawyers and medical advisers, they really did say that timeliness was a huge issue. They are the ones at the coalface who are speaking with doctors quite regularly and giving them updates that 'there is no update' and that gets really quite distressing. We are aware of very similar time frames to what was mentioned by the United Workers Union this morning.

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On a personal level, I have been the subject of one notification many years ago. Thankfully, it took about six weeks to resolve. I was checking my emails and my letterbox every day. I was really worried about what the process was going to do. I was fairly confident that I was okay clinically, which was reaffirmed by Ahpra. The emotions I went through in that six weeks were really quite dramatic. I can only imagine what it is like if it drags on further and further, because the further it goes on the more you think they would be looking into you further and have some concerns there potentially.

Mr MOLHOEK: There are so many GPs now, and even specialists, who work in multidisciplinary practices, GP supercentres, privately owned practices or corporately owned practices. How do these provisions work in respect of, say, a large practice that is owned with individuals working for it? Does each doctor or practitioner have their own individual insurance or are they covered by the practice? Are there any issues in the legislation that we should be aware of in terms of differentiating between individual doctors and larger scale practices and owners? I imagine there would be practices where, if there were a notification about an individual, they might be inclined perhaps to want to move that person on to save the reputation of the practice. Are there any examples of that or any issues you want to raise in that respect?

Ms Haysom: Individual practitioners are required to have their own insurance. There is a medical board standard that requires them to have insurance. Generally speaking, they have they own independent insurance from a medical indemnity provider. To that point about the large practices, one of the provisions that is of concern is the provision that allows disclosure to protect the public of information to the practices at which the doctor practises prior to any investigation into a complaint or an allegation. That is of concern. That has a huge potential for reputational risk to the doctor in circumstances where an investigation has not taken place and where those allegations have not been tested. That is of great concern to us.

Ms McDonald: The complaints in our space—and, Georgie, it will be exactly the same at Avant—about medical practitioners are on the rise. Many of those anecdotally are ultimately found to have no validity at all. That is part and parcel, in our view, of the public's expectations about what can actually be achieved and an example of the stress that is on the health system generally in terms of availability of medical practitioners, time available and the complexity of some of the presentations. Those corporate organisations bring their own medico-legal challenges in terms of continuity of care et cetera. You do not have the usual doctor-patient relationship that I might have had when I was growing up where you saw the same general practitioner every day. The world has changed and has caused knock-on effects for doctors which bring additional stress for them.

CHAIR: I thank each of you for your contributions today.

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COULSON BARR, Dr Lynne, OAM, Health Ombudsman, Office of the Health Ombudsman

FLETCHER, Mr Martin, Chief Executive Officer, Australian Health Practitioner Regulation Agency (via videoconference)

LORD, Mr Nick, National Director, Engagement and Government Relations, Australian Health Practitioner Regulation Agency (via videoconference)

McLEAN, Mr Scott, Executive Director Legal Services/Director of Proceedings, Office of the Health Ombudsman

ORCHARD, Dr Jamie, General Counsel, Australian Health Practitioner Regulation Agency

CHAIR: I welcome our final group before us—representatives from OHO and Ahpra. They are well known to the health committee. Perhaps Ahpra would like to make an opening statement after which we will move to some questions. We have your submission. There have been some themes of concern with submissions.

Mr Fletcher: I acknowledge the traditional owners of the lands on which we are joining you today. We are on the lands of the Wurundjeri and Bunurong people of the Kulin Nation. I pay our respects to elders past, present and emerging.

Thank you for this opportunity to appear today as part of the committee's inquiry into the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2022. As you know, I am Martin Fletcher, Chief Executive Officer of Ahpra. I am joined here on the videolink by Mr Nick Lord, who is our National Director Government Relations. You have Dr Jamie Orchard, our General Counsel, with you there in Brisbane.

We welcome the introduction of this bill into the Queensland parliament and support the amendments that have been proposed by Australia's health ministers. As the committee is aware, there has been significant work to reach this point, including extensive consultation with practitioners, the public and the broader health sector.

In particular, Ahpra and the national boards welcome enshrining public protection and public confidence in the safety of services provided by registered practitioners as the paramount guiding principle. Protecting patients from harm has always been our No. 1 priority, and this guiding principle rightly places public protection and patient safety at the heart of everything we do. It will mean that all entities exercising powers under the national law, not only Ahpra and national boards but also tribunals, must have public protection and public confidence as paramount considerations in administering the scheme, making regulatory decisions or otherwise exercising functions.

I wanted to briefly comment on three areas of reform. Firstly, we strongly support the new guiding principle and objective that recognises the importance of cultural safety for Aboriginal and Torres Strait Islander peoples. As the regulator for more than 825,000 registered health practitioners nationally and 190,000 registered students, the national scheme has a vital part to play in developing a culturally safe and respectful health workforce that is inclusive and responsive to Aboriginal and Torres Strait Islander peoples and helps eliminate racism. This important addition to the national law not only recognises our role but requires all decision-makers in the scheme to take cultural safety into account to ensure that Aboriginal and Torres Strait Islander peoples receive culturally safe health care that is free from racism.

Secondly, in keeping with the paramount guiding principle, the bill introduces new powers designed to help us to better protect public safety and respond to serious public health risks. There is a new power for Ahpra and the national boards to issue interim prohibition orders to unregistered practitioners, including those whose registration has lapsed, suspended or withdrawn. It also enables a public statement to be issued about registered practitioners and unregistered persons who are the subject of an assessment, investigation or disciplinary proceeding. In short, these new powers clearly align with the proposed paramount guiding principle of public protection and will help us to keep the public safe when the need arises.

We recognise, and have heard indeed today, the opinions expressed by some agencies that these powers, particularly issuing a public statement, are potent and could impact on the reputation and practice of registered health practitioners. We recognise these concerns—and they are valid—

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and are best addressed by ensuring there are strict parameters around the use of these powers. The bar needs to be both high and clear to all. Practitioners rightly expect procedural fairness and natural justice in our regulatory work, and the bill includes significant checks and balances. We will also develop guidance on how we will use these powers in practice and consult widely with the professions and the community to get right. We will publish this guidance to ensure full transparency.

At this early stage I can see a narrow but important role for those powers. In a small number of circumstances it would help us to protect the public if we could publicly explain risk and warn patients. As an example, warning patients of an infection control risk from a practitioner's unsafe practice and urging them to come forward to get health care, or when we have concerns about the spread of communicable diseases from a practitioner's practice to patients, or when better understanding the full scope of harm caused by the practitioner will help inform our regulatory action.

Thirdly, we recognise that there are very spirited arguments on all sides about removing the specific ban on testimonials. In particular, I note the concerns that have been expressed about vulnerable patients being exploited by unscrupulous doctors in cosmetic surgery which has rightly attracted significant media comment and community concern over the past few months. The committee may be aware of the independent review of the regulation of health practitioners in cosmetic surgery, commissioned by Ahpra and the Medical Board of Australia. This review is considering what further guidance specific to cosmetic surgery advertising may be needed to better protect the public. The testimonial amendment will not prevent Ahpra and the Medical Board acting on the recommendations of the independent review.

The proposed amendments would bring the national law into line with wider consumer law. They also highlight the distinction between a perfect world and the world we live in. We live now in a highly visual, digital world. Consumers expect to have access to reviews and testimonials when purchasing any services, including health services, and to be able to share their views about the services they receive and the people they receive them from. This is happening in all walks of life, is at the heart of social media communication and is partly what has given rise to the emergence of social media influencers. It seems to us that on this issue the train has left the station. It would be better for us to focus our regulatory effort where there is greater risk of harm to the public and where expectations of regulatory focus can be realistically met.

We believe the proposed legislative amendments get the balance between the perfect and the good right. Importantly, testimonials will still be regulated and will have to be truthful. The change will enable us to focus our resources and to target proposed new stronger powers where there is the risk of real harm to patients because a practitioner is not being truthful—for example, because they are being false, misleading or deceptive or creating an unreasonable expectation of beneficial treatment. Truth and honesty are at the heart of the relationship between a patient and their health practitioner. The proposed legislation will help uphold this core value.

Offences of this sort—for example, false, misleading or deceptive advertising—are within the scope of our regulation of advertising under section 133 of the national law. We welcome the proposed change which would bring a substantial increase in the maximum penalties for advertising offences. This is an important step. Ahpra will work with the national boards to review published advertising guidelines to ensure they fully align with the changes in the national law. Again, this review will include wide consultation with stakeholders and we will also develop further guidance about good practice in using testimonials in advertising.

In closing, we welcome the introduction of this bill into the Queensland parliament. We consider the bill will strengthen public safety and confidence in the provision of health services, and give Ahpra and the national boards a modernised set of regulatory tools that we need to help us do our job to protect the public. Thank you again for the opportunity to appear today. We are very happy to take questions.

CHAIR: Thank you very much. I will go to our Health Ombudsman, Dr Coulson Barr.

Dr Coulson Barr: I would also like to start by acknowledging the traditional owners of the land where we meet today and pay my respect to all elders past, present and emerging. I would like to echo the comments made by Mr Martin Fletcher in supporting the way in which the proposed amendments aim to strengthen public safety and confidence in the safety of health services and also supporting the inclusion of the new guiding principle and objective that recognises the importance of cultural safety for Aboriginal and Torres Strait Islander peoples in the application of the national law. As you know, the proposed amendments have broader application to the national scheme, which is why we felt it would be helpful for the committee to hear firstly from Ahpra.

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The OHO's submission focused on four key areas which directly impacted on the functions and powers of the Health Ombudsman, so I will just touch on those briefly. In summary, we express support for the amendments which will allow the Health Ombudsman to make a public statement warning the public about a health practitioner. The proposed amendments clearly limit the making of such statements to situations where the Health Ombudsman reasonably believes that practitioners pose a serious risk to patients and it is necessary to issue a public statement to protect public health and safety. In our submission we talked about how the bill contains several safeguards on the issuing of such statements including show cause provisions and the right to seek review at QCAT. We also note that the health commissioners in Victoria, New South Wales and South Australia already have a power to issue public statements.

Given that the OHO frequently receives complaints about very serious conduct, it is prudent for the Health Ombudsman to have the power to warn the public about a practitioner who poses a serious risk to persons and it brings us in line with those other states. We also recognise the importance of procedural fairness and we hear that there have been a number of submissions focusing on that. It is something that the office addresses on a daily basis: getting the right balance of offering procedurally fair processes but also taking prompt, protective actions to address issues of serious risk and public health and safety.

When you look at the proposed amendments on public statements, it is important to note that the OHO is already required to publish practitioner details when immediate registration action is taken or an interim prohibition order is issued. This public register, which is on our website, includes details of the conditions of practice and whether there is a full suspension or a prohibition of practice. However, it does not include an explanation of the nature of risk that has been assessed that is posed by the practitioner.

Being able to make a public statement will provide that additional protective function of providing a public warning on the nature of the risk posed by the practitioner—and Martin Fletcher touched on some of the examples earlier—such as a case where there is evidence that a dentist has not undertaken appropriate infection control measures and previous patients might be at risk of contracting bug borne viruses. I would use this power judiciously for these types of circumstances where the explanation of the nature of risk was assessed as necessary to address the public health and safety. I note the Victorian Health Complaints Commissioner also uses this power judiciously and has issued around only 10 public statements over recent years.

The other areas we covered in our submission included the amendment for Ahpra and the national boards to issue interim prohibition orders in limited circumstances. We believe that these powers will complement the existing powers of the Health Ombudsman to issue interim prohibition orders. It will also allow Ahpra to take swift action to manage a serious risk and protect the public, and that is until a matter is referred to the Health Ombudsman to consider more comprehensive regulatory action. As you are aware, Ahpra and OHO already have a strong working relationship. I am confident we would be able to implement a process where we work effectively on the co-regulation in this area.

Our submission also expressed support for the increased penalty for breaching a prohibition order or an interim prohibition order. We feel that it appropriately reflects the seriousness of an offence of breaching such orders. These are only imposed on persons where the Health Ombudsman has formed a reasonable belief that the person poses a serious risk to persons.

Finally, our submission expressed support for the inclusion of a power for the Health Ombudsman to accept undertakings from a registered practitioner as a form of immediate registration action. It would be useful for the committee to note that practitioners already offer undertakings to us when we are engaging with them about a proposed registration action. This would allow us to be able to accept such undertakings. It will also make the Health Ombudsman Act more consistent with national law.

Accepting undertakings from a practitioner will be a more appropriate form of action in many circumstances where suspension is not necessary and it will remove the more complex and time-consuming process of imposing conditions and trying to articulate what is the most appropriate condition in the circumstances. As such, the Health Ombudsman will be able to take immediate registration action to protect public health and safety more quickly and effectively. Thank you again for the opportunity to appear. We are happy to take questions.

CHAIR: Thank you very much. Of course, the committee is very familiar with how health complaints are managed by both Ahpra and the OHO. I will go to a question to Mr Fletcher first. I draw your attention to the United Workers Union submission. There are some cases—and I am looking at one now—that have been before Ahpra but not in the OHO remit for 152 weeks and it has

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not concluded its investigation. There was some concern raised—I think valid concern—about the lengthy time lines and I want to highlight that. As we heard from medical practitioners, when these things go to lengthy investigations there is a lot of stress on the practitioners. Could you address that first, Mr Fletcher?

Mr Fletcher: We absolutely recognise that being the subject of a notification or a complaint can be extraordinarily stressful for a registered health practitioner and can be a source of distress and sometimes that can be exacerbated by a matter that can take a protracted period of time. We are absolutely focused on wherever we can reducing the time frames for the investigations that we undertake. I think we have previously briefed the committee that one of the challenges is that there are more complaints every year, so we are dealing with more and more demand. We are, in fact, putting additional resources into our complaints teams as we speak, recognising that one of the challenges at times has been that our investigators have very large caseloads and we want to make those caseloads more manageable.

Sometimes the fact that a matter takes a long time also reflects aspects of the complexity of the issues. There might be, for example, interface with police or the coroner that adds to the time frames. It may well be that the practitioner themselves is raising a whole set of concerns along the way—and that is their absolute right in terms of procedural fairness—and all of that has to be addressed carefully and comprehensively. There can be a range of factors why a matter may take a protracted period. In terms of the central focus of your question, we absolutely recognise the importance of doing everything we can to reduce those investigation time frames. It is a very high priority for us.

CHAIR: You are doing a review on cosmetic surgery. When is that review due?

Mr Fletcher: We expect to publish the outcomes of that review in September this year. The review is being conducted by Andrew Brown, former health ombudsman in Queensland, so he is well known to the committee. It is our intention to publish in full the findings of the review, the recommendations that he makes, the submissions to the review unless people have requested that they be kept confidential and our response to those recommendations.

CHAIR: In terms of the national law, will that review form part of what is in front of us now in making sure that we get it right?

Mr Fletcher: Essentially, the review is looking at things like the guidance that is currently published by the Medical Board around cosmetic surgery and ways in which that might need to be strengthened, the approach that we take to risk assessing notifications that we receive about cosmetic surgery, what we might do to try to promote greater and more accurate information for people who might be considering undertaking cosmetic surgery and how we work with other regulators in this space. I do not believe there is any aspect of what is proposed in terms of these amendments that will in any way constrain or fetter our ability to respond to the recommendations of the review.

CHAIR: That is great clarification for a number of submitters this morning.

Mr O'CONNOR: My question is to Ahpra. Regarding the removal of the ban on testimonials being used in medical advertising, we have heard today, and I think in all of the submissions we received, that there was not much support, if any, for this. Can you outline further the basis for this proposal and what risk could there be from removing the prohibition, particularly regarding the cosmetic procedures?

Mr Fletcher: I might ask Dr Jamie Orchard to comment on this. He is in the room with you.

Dr Orchard: I think there are a couple of things to note about the proposed amendment. First of all, as Mr Fletcher said in his opening, it is not a complete removal of the regulation of testimonials. In fact, those testimonials that pose the risk are primarily those that are misleading and deceptive and/or which set an unrealistic expectation of benefit. Those matters will still be the subject of regulation.

We think that the benefit of the change and focusing on those risk aspects mean that regulation does keep up with current society in respect of the general public, and that includes consumers of health services relying on various materials these days, including testimonials. It also brings us more into line with the general law and approach in respect of the regulation of testimonials. Take, for example, the approach of the ACCC. It does not impose blanket bans on testimonials but does regulate the use of testimonials in appropriate circumstances, including in certain health related fields such as in relation to platforms that might provide reviews of medical practitioners. All in all, we think that it is an opportunity for us to really focus our resources not on a blanket ban in respect of testimonials but in respect of those that present the greatest risk to the public.

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Mr O'CONNOR: Going to the second part of the question, has any assessment been undertaken on the risk that this removal could have, particularly for the cosmetic surgery industry?

Dr Orchard: It is difficult to undertake that sort of assessment. As I said, the assessment that we have undertaken—and that is taking into account the broad range of consultation that was undertaken as this bill was developed—was all taken into account, including the risks that have been posed or have been suggested through some of the submissions that have been made to this committee and have previously been made, but also in respect of the positives that we see coming from it, as I have outlined. That assessment has been undertaken along the way.

Mr MOLHOEK: My question is to either OHO or Ahpra. In respect to public statements that have been made, I heard mentioned that in Victoria there have been about a dozen cases. Have there been any occasions when public statements have been made and there has been some recourse or a practitioner has perhaps sued or been successful in prosecuting defamation or some other action in that respect?

Dr Coulson Barr: I am not aware of that, but I might defer to Mr Martin Fletcher. Are you aware of any matters, Martin?

Mr Fletcher: I am not aware. We probably need to take that on notice and come back to you. We could certainly liaise with the Health Complaints Commissioner of Victoria and seek that information.

Mr MOLHOEK: Can we do that?

CHAIR: Anything taken on notice we need back by Friday, 10th.

Mr Fletcher: Subject to whether we can provide that, we will certainly meet that deadline.

Mr MOLHOEK: I ask because we have talked about the issue of natural justice and it is hard to take things back. If there have been a number of public statements made and there has been no recourse, it may well be a storm in a teacup as an issue. I am curious to understand the extent of the potential problem.

Dr Coulson Barr: I would have to say that the majority, from my recollection, of the public statements are made about unregistered practitioners rather than registered practitioners, just as a matter of course. Do you agree that the proportion is the majority?

Dr Orchard: The majority is unregistered.

CHAIR: I think that is what it is aimed at.

Ms KING: We have heard statements from, in particular, the Australian Medical Association and the Queensland division of the Australian Medical Association that there was no or insufficient consultation conducted with them in respect of the proposed changes to the national law. Could you please outline for the committee the consultation processes that were engaged in, to your knowledge?

Mr Fletcher: I might ask Mr Lord to comment on that question.

Mr Lord: The proposals in the legislation bill have been subject to a number of rounds of consultation. I would point to a round of public consultation that was undertaken, I believe, by the then Australian health ministers advisory committee. I think 2019 was the first round of public consultation. I am aware that there was some more targeted consultation on the bill itself, again undertaken by jurisdictions. I believe it was earlier this year, as the bill was being drafted. I would probably point to those two rounds of consultation through the process.

Ms KING: In some of our submissions today, the United Workers Union, in particular, spoke to case studies of their members. In relation to the issue of accepting undertakings versus conditions being imposed, they spoke to concerns around the rigidity required in the imposition of conditions. I wonder how proposed changes to the national law that will allow for the acceptance of undertakings may change that scenario.

Dr Coulson Barr: We have had experience of practitioners, as part of a response to a submission, putting forward conditions that they think would be workable for their practice and also identifying the risks that we have identified. I think the undertakings allow more flexibility for conditions to be tailored to the particular circumstance. I think that would be the major benefit of having undertakings, because it gives the practitioner more scope for putting forward conditions that they think would be workable for their circumstances.

Ms KING: Do you think it is fair to say that it allows for a case-by-case tailoring of appropriate conditions to be achieved more easily?

Dr Coulson Barr: Yes.

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CHAIR: The QNMU spoke about the seriousness of drug mishandling where there are repeated and serious errors with medications. They understand that in the public safety realm that needs to be addressed, but where there are other causes—and it might be a first time—where is the balance in terms of the investigation? That might be a better question for Ahpra, because I think this would be triaged directly to Ahpra. I will try to find the exact quote, but can you speak to their particular issue, Martin?

Mr Fletcher: We are well aware of the fact—and you use the example of medications. Sorry, did you want to—

CHAIR: It was around the reporting of scheduled medicine offences, at page 5 of their submission. They asked for some clarification around misappropriation of medicines where there is significant evidence. They wanted to raise that issue with us. I do not know if you can talk to that at all.

Mr Fletcher: This is about the amendment in relation to the reporting of scheduled medicine offences?

CHAIR: Yes.

Mr Fletcher: I will ask Mr Lord to comment on that.

Mr Lord: Is the question from the QNMU whether or not misappropriation of drugs would be potentially a reportable offence?

CHAIR: From what I took from their opening statement, where there are repeated and serious issues around medication errors they understand that Ahpra has a role to play. However, they brought in the fact that it might be a first-time offence or a mistake, a clinical error, due to staffing workloads, for example. Are these things taken into consideration when investigated?

Mr Fletcher: The short answer is yes. One of the things that we do is risk assess any complaint that we receive. Obviously, as you say, if it is an honest error, if you like, or a one-off mistake that someone has made—and sometimes it is in the context of very busy clinical environments with lots of demands on people—then we obviously would look at that as being likely to be a lower risk matter that does not necessarily require regulatory action, especially when you will often see that the practitioner has insight and has taken steps themselves or, indeed, the health service they work in may have put in additional education or supervision.

I think the wider piece around this particular amendment though is that it can be potentially quite serious offences under drugs and poisons legislation, which is different in different states and territories, that may be dealt with and we may not have visibility of that. What this amendment seeks to do is actually give us greater visibility, because at that serious end that might actually be very important information to have to really properly fully understand the potential risk to the public of a practitioner.

CHAIR: Thank you for that. That is excellent.

Mr ANDREW: To Ahpra, I refer to the criteria that surrounds the bar that is put in place for questioning or for going public with a practitioner. Do you think there should be any safeguards put in place so that cannot be changed by regulation going forward? Will that be locked into a position, do you think? What are your thoughts on that?

Mr Fletcher: I will ask Dr Orchard to comment on that.

Dr Orchard: The answer is that, assuming that the bill passes into law, it is enshrined in the legislation in terms of the test that we and the national boards would be required to meet before we could make a public statement in terms of not only that there has to be a reasonable belief of a breach of a relevant provision or the person is subject to an assessment or investigation but also that there must be a reasonable belief that the person poses a serious risk to persons and also that it is necessary to issue a statement to protect public health. Those are the standards that will be enshrined in the legislation.

How that will work in practice is something, of course, that we will do a lot of work on. You have heard Mr Fletcher say that there will be significant consultation with the professions, the national boards and other stakeholder groups before we formalise and publish information about how we will act on those particular matters. Certainly, the thresholds for using the powers will be enshrined and the natural justice requirements in terms of the show cause process will be enshrined in the legislation. We will be required to satisfy all of those steps before a decision is made to issue a public statement.

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CHAIR: On that point, this morning the federal AMA representative talked about the one-day notice. We actually gave the example of a dental surgery in Cairns that had some issues where a public statement needed to be issued for public safety. They tended to really hang on the idea that one day is not enough. I do not know if anyone has a view on that. They went back to what appeared to be, as they said, trust issues with previous cases. That probably goes to what the deputy chair was saying when he asked if there are any examples of things in other jurisdictions that have gone the other way. I guess we will find out by Friday. Do you have any views around the one-day notice? I think we should raise that as a valid point.

Dr Orchard: I am certainly happy to address that issue from Ahpra's point of view. First of all, I think we should note that there is that threshold that I just mentioned that we need to meet before we use the power. It is likely that it would be rarely used and quite often used in respect of unregistered people as opposed to registered practitioners. Secondly, it is important to note that there is the full show cause process before the decision is made to issue the public statement. The one day actually refers to giving the person who is the subject of the public statement notice that a decision has been made before it is actually published. Thirdly, it is 'at least' one day; it is not a strict one day. Once again, we will be doing some work with the professions to work out what is appropriate in all of the circumstances.

The last thing I would say about it is this: bear in mind that what we are doing in this situation in terms of issuing a public statement is taking steps to address a potential risk—a very real significant risk—to the public and to public health. In circumstances in which either Ahpra or the board has considered the submissions from the person, determined that that risk still exists and it is necessary to issue a statement to address the risk and to protect the public, it would be difficult to have a long period after that before the public is advised. We really need to move very quickly at that stage to let the public know. That is why the reference to 'at least' one day is really quite reasonable, I think, in the circumstances.

CHAIR: And that show cause period would be a number of—

Ms KING: It is a week, isn't it?

Dr Orchard: Again, it talks about a reasonable time but usually you would expect something like seven days to give the practitioner or the person an opportunity to make a submission.

Ms KING: I was going to ask for a comment on what I have derived from what we have heard around the publication of public statements, that it really is the most serious cases of imminent harm. I would like your comments on whether, in some of those cases, the behaviours or conduct that have led to that point mean that the existing regulatory processes may not capture that behaviour, for example, in the case of unregistered practitioners. I would like your comments on that.

Dr Orchard: I think we heard of an example given of an unregistered person providing dental services. We might commence an investigation into that conduct, both in respect of holding out and also performing restricted acts—that is, the dental procedures. That investigation is likely to take some time before we can get it to the court. In that time the person might still be performing procedures. Despite our attempts and our demands that they desist, they might continue on. The public statement would give us the opportunity to go public and to warn the public, firstly, that the person is not registered. It might also be an opportunity to get the message out to previous patients that they might be the subject of some form of infection as a result of being dealt with by a backyard dentist and that they should seek treatment. For those people it is really important that they get treatment at an early stage. We have to get to them quickly so that they have the best possible chance of addressing any harm. I think that is quite a useful example of when we might use it.

Ms KING: In fact, it encapsulates the paramount principle of the community's safety and confidence in healthcare professionals.

Dr Orchard: Absolutely.

CHAIR: That is a great way to summarise. That brings us to a close.

Mr ANDREW: Chair, is that it? Do we have any more time?

CHAIR: We are out of time. We are actually over time. I thank everyone, including the member for Mount Ommaney who stood in today. Mr Fletcher and Mr Lord, thank you for joining us. You have provided really good clarification on some of the issues raised. Thank you, Dr Orchard and the Health Ombudsman, Dr Coulson Barr, for being here today. I now declare this public hearing closed.

The committee adjourned at 1.01 pm.

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