# *HEALTH, ENVIRONMENT AND INNOVATION COMMITTEE*

**Members present:**
Mr R Molhoek MP—Chair
Ms SL Bolton MP (videoconference)
Ms K-A Dooley MP
Mr JP Kelly MP
Mr DJL Lee MP
Dr BF O'Shea MP

**Staff present:**
Dr J Rutherford—Committee Secretary
Miss A Bonenfant—Assistant Committee Secretary

# PUBLIC HEARING—INQUIRY INTO THE HEALTH PRACTITIONER REGULATION NATIONAL LAW AND OTHER LEGISLATION AMENDMENT BILL 2024

## TRANSCRIPT OF PROCEEDINGS

**Tuesday, 28 January 2025**

**Brisbane**

# TUESDAY, 28 JANUARY 2025

**The committee met at 10.00 am.**

**CHAIR:** Good morning. I declare open this public hearing of the committee's inquiry into the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2024. My name is Robert Molhoek, member for Southport and chair of the committee. I acknowledge the Aboriginal people and Torres Strait Islander people of this state and their elders past, present and emerging. I also acknowledge the former members of this parliament who have participated in and nourished the democratic institutions of this state. Finally, I acknowledge the people of this state, whether they have been born here or have chosen to make this state their home, whom we represent to make laws and conduct other business for the peace, welfare and good government of this state.

With me here today are Mr Joe Kelly MP, member for Greenslopes and deputy chair; Ms Sandy Bolton MP, member for Noosa, who is joining us online today; Mr David Lee MP, member for Hervey Bay; Ms Kerri-Anne Dooley MP, member for Redcliffe; and Dr Barbara O'Shea MP, member for South Brisbane. 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 proceedings. Witnesses are not required to give evidence under oath or affirmation but I remind witnesses that intentionally misleading the committee is a serious offence. I also remind members of the public that they may be excluded from the hearing at the discretion of the committee.

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 and the chair's direction at all times. You may be filmed or photographed during the proceedings and images may also appear on the parliament's website and social media pages. Members and witnesses, please remember to press your microphones on before you start speaking and turn your microphones off when you are finished. You should also turn your mobile phones on to silent mode before we commence.

## McMULLEN, Dr Danielle, President, Australian Medical Association (via videoconference)

**CHAIR:** I now welcome our first witness today from the Australian Medical Association, Dr Danielle McMullen. Good morning. Would you like to make an opening statement before we start our questions?

**Dr McMullen:** Thank you for having me. I will make a brief statement and then, of course, take questions. My name is Dr Danielle McMullen. I am the President of the Australian Medical Association and a GP based in Brisbane. I would like to acknowledge that I join you from the land of the Yagara and Ugarapul people and pay my respects to elders past, present and emerging.

The AMA, as you may know, is a professional association representing doctors of all specialties and stages of career in all settings across Australia. The provision of medical care requires the highest level of trust between patients and medical practitioners. Patients need to know that their practitioners will practice in a way that justifies the trust that they put in them. The AMA does not condone conduct which breaches the trust that the community has in their medical practitioners. As such, we do not oppose the bill; however, we caution that the use of new powers to restrict reinstatement and permanently publish a practitioner's regulatory history really needs to be used sparingly and proportionately with the conduct.

I make this statement because the AMA does remain concerned that the national scheme does not do enough to support the wellbeing of health professionals. We do believe it is entirely possible to have a scheme that ensures the public is protected without derailing the lives and careers of the doctors who have dedicated their lives to patients and communities but we do not currently have that system. This was demonstrated in 2023 when Ahpra released a report that identified 16 deaths by suicide and four instances of attempted suicide or self-harm among practitioners who were subject to regulatory notification. We do acknowledge that Ahpra has taken action since this report but these changes occurred in a structure that really should have been designed to protect these health professionals in the first place. We need a national scheme that supports good practice and patient

safety and patient care without impacting on the doctors who already practice according to appropriate professional standards and, of course, that does not impact unnecessarily on the mental health of any doctor, including those under investigation.

Again, we call on health ministers to mandate that Ahpra has a duty of care to the registrants, particularly a duty to minimise the mental health impacts and financial impacts on health practitioners subject to notification. By mandating the protection of practitioner wellbeing, the AMA continues to advocate that this would support upcoming work on the agenda around vexatious complaints and low-value complaints.

All of that might seem a bit off topic but it is not. I make those points because changes to the national law really do impact our lives every day as practitioners and these powers suggested by the amended bill are well intentioned but must be used judiciously. We also do need real reform to the national law that supports us so that, when these changes are made, we know that doctors doing the right thing have nothing to fear and that those under investigation will have their health protected. The profession must be listened to in consultation on the national law and health ministers cannot be the only people in Australia who drive changes to the national law and determine how Ahpra and the national laws will regulate us—the almost one million health professionals in Australia.

Amendments to the national law must abide by best practice consultation processes, and I would like to raise the concern about the insufficient time to engage with this process. Notwithstanding the time today, the consultation process was a couple of weeks before an election and then over the Christmas holidays, and we were concerned that that may not give the profession long enough to really consider the changes.

In summary, we do not oppose the draft amendments but seek to ensure that the new powers will be used judiciously in proportion to the conduct under notification and with the wellbeing of practitioners front of mind. Happy to take questions.

**Mr J KELLY:** Thanks, Dr McMullen, for that presentation. That is shocking: 16 suicides. Over what period of time did that occur?

**Dr McMullen:** That was over the period from January 2018 to December 2021. Four years.

**Mr J KELLY:** The AMA's submission talks about a threshold of professional misconduct of a sexual nature as it is understood and applied by the medical boards. Could you provide more detail around that professional misconduct of a sexual nature, as it is understood by the boards?

**Dr McMullen:** There is a document linked in our submission called *Sexual boundaries in the doctor-patient relationship,* which was created by the medical board, and it is with reference to that. The point we were trying to make there is that, when we have thresholds, there needs to be a common understanding of what that threshold is, so we would suggest using medical board definitions.

**Mr J KELLY:** Would it be your view that the best way to protect patients from sexual misconduct by a practitioner would be to put information publicly available on a website? Would an average person who is seeking medical help google the practitioner they are going to see, if they even know their name, to check what their history might be?

**Dr McMullen:** I would encourage discussing that with consumer groups as well in terms of what would suit their needs when seeking healthcare information. We do think the public register, as is supplied by Ahpra, is a useful and relevant source of information for consumers and also, of course, for doctors who may be seeking to make referrals. Importantly, it has a significant impact on the life of a doctor if there is information about them published on the register, and that is feedback that we get from our members and from doctors around the country.

From that, I would suggest that people are reading it and it is having an impact on the working lives of these doctors if they have noticed a change in their relationships with referred patients and referrers once that information was made public. Hence, with the real gravity of permanent information on that register, we do think it has a significant impact on the working lives of those doctors and, therefore, is not something to be taken lightly. Of course, sexual misconduct is clearly not behaviour condoned by the AMA or the medical board. It is inappropriate behaviour at a severe threshold and really threatens the trust that patients have in us as doctors, hence we do not oppose the bill but it must be used judiciously because we do think it would have an impact on the register.

**Mr J KELLY:** Do you think there should be greater definitions of what constitutes the nature of sexual misconduct that should be notified publicly?

**Dr McMullen:** We think there needs to be agreement on what those definitions are. Our suggestion is to use the medical board definition. We are a federated structure across the jurisdictions. It is really important that all of the tribunals and national boards also understand what is meant by that definition, so that is why we propose the medical board one there.

**Mr J KELLY:** Ahpra has listed about seven examples in its submission—and I am sorry if you are not familiar with them but I will not go through them all because some of them are quite shocking. If a doctor has been convicted twice of raping somebody, in any way, shape or form it would seem to the average person that that person should not practice ever again as a medical practitioner, let alone be allowed to even apply to practice. It seems to me that we should have systems in place already that prevent people who are committing such serious crimes from practising as any sort of health practitioner.

**Dr McMullen:** I believe the decision is with the regulator but certainly patient safety and that trust that patients have in their doctors is front of mind for the AMA. I think that does tie in to one of the other amendments in this bill around reinstatement of registration, and we do support national consistency there. If my understanding is correct, the recommendation is for that to go through the tribunal which was involved in the original decision before it is put to the national board, which would ensure that the original facts of the case were considered in terms of reinstatement, which may alleviate some of the concerns you have raised there.

**Mr LEE:** Thanks for your presentation, Dr McMullen. Just picking up on the definition of 'sexual misconduct', the bill refers to an ordinary construction of what constitutes sexual misconduct, and I note the mention of the *Sexual boundaries in the doctor-patient relationship*. What are your thoughts on the possibility of a legislated definition of 'sexual misconduct'?

**Dr McMullen:** I can take that question on notice and we can get back to you as to whether we think there should be a stronger definition in there. As our submission states, we were comfortable with an understanding but I will take that on notice and we can provide a quick turnaround on that specific question, if you like.

**Mr LEE:** Thank you. During both your written submission and your presentation, you talked about an issue with suicide and you made mention of unwarranted and vexatious complaints. To what extent has that been a problem in the medical profession?

**Dr McMullen:** We quite consistently get reports from members and doctors more broadly about the negative experiences of being under investigation. Of course, it is never a pleasant experience to have your conduct investigated by a regulator but the fact that Ahpra, by its own account in that report, stated that there were 16 completed suicides and another four known episodes of self-harm or attempted suicide should be shocking to all of us. No person under investigation deserves to have their mental health so severely affected.

Ahpra conducted an internal investigation into vexatious complaints. I am just finding the number in front of me—it found that only 17 vexatious complaints had been identified. That really does not match with the complaints that we hear on the ground. Part of that may be around the definition of 'vexatious complaint' compared to a low-impact, trivial-type complaint. Regardless, we know that doctors under investigation find it extremely stressful and there could be improvements through Ahpra and the national boards to the notifications and investigation process, and we continue to work with both the medical board and Ahpra to improve the experience to minimise the impacts on doctors under investigation.

**Ms DOOLEY:** Good morning. Thank you for your presentation. What observations, if any, can you make about the way the requirement for a reinstatement order is proposed in this bill and how that is working in New South Wales because that is the only jurisdiction presently applying such requirement. Do you talk to your colleagues in New South Wales?

**Dr McMullen:** Yes. I am originally from New South Wales so I have spent most of my practising career in New South Wales. I am a relative newcomer to Queensland. Obviously the regulatory space in New South Wales is slightly different but, from a national perspective, we do see some value in ensuring the people who are reviewing reinstatement requests have an understanding of the facts of the case as it originally stood. Now, of course, that reinstatement does not reprosecute or reinvestigate but having access to the full information is important. The primary thing we want to achieve is national consistency but we are not opposed to following the New South Wales model where the jurisdiction or the tribunal who had coverage over the original case also has a role in the reinstatement process.

**Dr O'SHEA:** Good morning, Dr McMullen. Thank you for your work at the AMA. The AMA's submission supports the permanent publication of regulatory histories regarding all sexual transgressions but it recommends a further clarification of the threshold that would trigger the publication. Does the AMA support the proposal in the bill to permanently publish a regulatory history regarding professional misconduct based on sexual misconduct where the sexual misconduct is not necessarily the sole or main basis for the tribunal's decision of professional misconduct?

**Dr McMullen:** I can take the detail of that question on notice but the summary statement outlined in the submission is that we do not oppose the permanent publication of the regulatory history where there has been a serious sexual misconduct violation but, as outlined in a number of the questions today, I think there is still some lack of clarity around the definitions. It would seem that more consultation or thought needs to be given to what the threshold is. As our submission outlines, the main point we want to raise is that these powers need to be used judiciously. For that to occur, tribunals obviously need clarity around definitions and what would be an appropriate threshold so that tribunals not only understand how they are expected to act but also doctors under investigation have an understanding of what to expect and to help protect their wellbeing under investigation.

**Ms BOLTON:** In regard to the changes within this investigation, what kind of monitoring and evaluation would you expect from Ahpra going forward to not only inform the evaluation of what has been implemented but to also work in that space to address the concerns you have raised?

**Dr McMullen:** We think, at a minimum, it is important that the frequency with which these powers are used and the types of places in which they are used is recorded, collated and reported on and that the experience of the practitioner under investigation is taken into consideration. We think that Ahpra should routinely seek to reflect on the experience of those practitioners.

**Ms BOLTON:** What do you consider to be a sufficient amount of time? You raised that the time is insufficient for this bill; what do you consider would be sufficient going forward?

**Dr McMullen:** The notice of consultation time—my understanding is there was a split with elections in between but there was only approximately two weeks for feedback on this and again, it was over the holiday period. I think it was previously published that guidelines would suggest that best practice would be at least one month.

**CHAIR:** We are out of time. Thank you, Dr McMullen. We have two questions on notice. Your response will be required by 4 pm on Thursday on 30 January so it can be included in further deliberations. Thank you very much for your time this morning.

## WRIGHT, Dr Michael, President, Royal Australian College of General Practitioners (via videoconference)

**CHAIR:** I now welcome the president of the Royal Australian College of General Practitioners, Dr Michael Wright. Thank you for joining us this morning. I invite you to make an opening statement.

**Dr Wright:** I would like to begin by acknowledging the traditional owners of the lands on which we meet today and by paying my respects to elders past, present and emerging. I am here today on behalf of the Royal Australian College of General Practitioners. The RACGP is Australia's largest professional general practice organisation. It represents over 50,000 members working in or towards a career in general practice in both urban and rural areas around the country. I would like to thank the committee for the opportunity to appear before you today.

Doctors work to the highest ethical standards and are one of the most trusted and respected professions. The RACGP believes it is important to strike the right balance between patient and community protection, as well as natural and procedural justice for health professionals. Being able to view a practitioner's regulatory history on the Australian Health Practitioner Regulation Agency, or Ahpra, public register—including when conditions are no longer in force and the circumstances for which publication are met—is key to ensuring patient safety and to providing a choice as to which health professionals the community seeks consultations with.

We do have some concerns about retaining information on the public register permanently, as well as the publication of tribunal outcomes where allegations were disproven, or proven in part. Regarding the other proposed legislative changes, the RACGP supports a nationally consistent requirement for practitioners to seek a reinstatement order if their registration has been cancelled, or they have been disqualified from practicing. We also welcome greater protections for notifiers and those who assist regulators during investigations about health practitioners. Our members do not support non-disclosure agreements in the context of a sexual boundary violation or sexual misconduct. I look forward to answering your questions.

**Mr J KELLY:** Thank you, Dr Wright, for your presentation and submission. Regarding the issue of the permanent recording of information around sexual misconduct; is that something that the RACGP supports?

**Dr Wright:** We support retaining the information on the register when any conditions are no longer in force and/or if the circumstances for publication are met and publishing and retaining that history would ensure prospective employers are notified of the terms of any conditions or restrictions. But despite our members support for accountability and transparency, they have expressed concerns about retaining information on the register permanently. It may be appropriate to publish information for a set period and then remove it from the register once it expires, which would be a similar approach to the Spent Convictions Scheme. The college does not have a firm position on a suitable expiry date for those conditions.

**Mr J KELLY:** I am interested in an issue that might arise because someone is dealing with a mental illness or a condition, for example, and they commit an act which is sexually inappropriate and are pulled up by the appropriate system's checks and balances. That person then seeks treatment and no longer poses a threat to society—or patients most particularly. That information is then on the permanent register forever, with no opportunity for it to be removed; is that your understanding of this legislation?

**Dr Wright:** I think so. It may be appropriate to publish information for a set period, then remove it once it expires. As I have mentioned, it is similar to the Spent Convictions Scheme which may operate in various jurisdictions and generally places a limit of 10 years around an issue before it is considered spent, provided the person in question does not reoffend and potentially, that is another option.

**Mr J KELLY:** Does the RACGP have a view on the requirement for reapplying for registration being handled by two different bodies?

**Dr Wright:** The proposal for nationally consistent processes would be welcome because that would reduce complexity in the system.

**Mr LEE:** Thank you for your submission, Dr Wright. In relation to your written submission, you refer to tribunal decisions in which the allegations are not established being recorded on the register. Forgive my ignorance but has that historically been an issue—where the allegations have been disproved it has been recorded on a register?

**Dr Wright:** I have to take that question on notice to find out the number. I do not have those figures in front of me.

**Mr LEE:** I found it curious that that would be recorded on the register. The written submission then goes on to deal with complex cases being considered on a case by case basis; can you further elaborate on that please?

**Dr Wright:** Yes. Where concerns have been raised, some of the members have talked around the publication of tribunal outcomes for complex cases such as those which resulted in time-limited conditions, or those where allegations were proven in part. We recommend the publication of those tribunal outcomes be considered on a case by case basis but we have not outlined the process.

**CHAIR:** It would be helpful for the committee to understand the process from your perspective in terms of the steps that occur leading up to a practitioner being named on the national register?

**Dr Wright:** There may be a process coming directly through Ahpra, or there may be a complaint made by—it does vary in different states as well—different organisations. The complaints may come to a different regulator. I am currently in New South Wales. I know you have OHO in Queensland so there are different regulators who that may go through from a patient, or there may be other mechanisms that go through Ahpra directly. There are various inconsistencies across the jurisdictions; having a national process would make this more simple.

**CHAIR:** In simple terms, would it be fair to say that before any practitioner actually got to that point they would go through a fairly rigorous process? There are a lot of steps that occur before someone would be so named on a national register; is that correct?

**Dr Wright:** I would expect there would be a number of steps that would be followed before it reached that position, yes.

**CHAIR:** Would it be safe to assume—I am probably asking for an opinion and I cannot do that. I will go to the member for South Brisbane.

**Dr O'SHEA:** Does the RACGP support the bill's proposal to allow tribunals to impose a period during which a disqualified person may not apply for a reinstatement order?

**Dr Wright:** What we do support is the idea that practitioners should be able to apply for a reinstatement order but there needs to be a clear mechanism to outline when that might not be appropriate or to automatically reject that if they continually reapply when their application has been refused.

**Dr O'SHEA:** Can the RACGP clarify whether it supports the proposal in the bill regarding permanent publishing of regulatory history from professional misconduct based on sexual misconduct where the sexual misconduct is not necessarily the sole or main basis for the tribunal's decision of professional misconduct?

**Dr Wright:** Could you clarify that—where sexual misconduct is not the main reason for the exclusion?

**Dr O'SHEA:** That is right. The proposal in the bill is that sexual misconduct does not necessarily need to be the sole or main basis for the tribunal's decision of professional misconduct.

**Dr Wright:** I am trying to picture a situation where that might happen—where that was not the cause for the original complaint but it has come up in the tribunal discussions. I think we would have to take that on notice to understand the relevance of that.

**Dr O'SHEA:** Where there were a number of factors that contributed to the findings of professional misconduct and sexual misconduct was one of those but it was not the sole or main basis for the tribunal's decision of professional misconduct.

**Dr Wright:** That is a difficult one. I might have to take that on notice as well to find out if that is a supplementary component.

**Ms BOLTON:** How would you see counselling being established and managed going forward for re-registered practitioners? Given Dr McMullen previously spoke about the fact that over a four-year period there were 16 suicides, is there counselling available for those who are under notification?

**Dr Wright:** You highlight a really important issue of the impact of those investigations and the importance of bearing that in mind as well as making sure that the public are protected. Potentially

having this nationally consistent requirement for reinstatement I think will create a clearer process rather than having variation across jurisdictions. Having a requirement that re-registered practitioners do attend counselling with a peer and that they report to registration bodies for a stipulated period in cases particularly of sexual misconduct I think would be important.

**Ms BOLTON:** At the moment for those who are not going for re-registration but who have been under notification is there anything available? What occurs in that process?

**Dr Wright:** There are some services that might be available to practitioners potentially through the medical indemnity, and there are some doctors' health advisory services that do provide some support but look at that as ad hoc at this point, whereas with this reinstatement process you would create a clearer pathway that involved counselling for those people seeking reinstatement.

**Ms DOOLEY:** Dr Wright, you may or may not be able to answer this question. Given that you have 50,000 members—that is significant—would you have any data around the number of investigations of your members of a vexatious nature and, of those, the number that were found to be guilty and the number that were cleared? Do you have any of that data?

**Dr Wright:** I can take that on notice, but my sense is that we do not have that data. There is a lot of concern from our members about the impact of vexatious complaints. I know that the medical indemnity organisations are also doing some work looking at this. I think Ahpra itself has also done some classification work to quantify that. I can take that on notice and check if the college does have any specific information. I do not think we have that data.

**Ms DOOLEY:** I think that would be helpful.

**Mr J KELLY:** Dr Wright, I appreciate the point around national consistency for the reapplication process. In light of the data around the 16 suicides by practitioners under investigation and four attempts, does the RACGP have a view on the fact that you may get a clearance from the tribunal to be re-registered and then be knocked back by the relevant board, so effectively you are going through the same process twice with two different outcomes?

**Dr Wright:** I have not thought of that process. That is a concern that you might get two bodies reaching different conclusions about the same issue.

**Mr J KELLY:** The legislation does allow for appeal to a higher court, but it seems to me we are trawling the same ground twice and I cannot see what the particular purpose of that is.

**Dr Wright:** These matters are serious and they need to be dealt with, clearly. As you are suggesting, doing that on a single occasion would seem more appropriate than investigating it multiple times.

**Mr LEE:** I have a question in relation to the non-disclosure agreements. In your written submission you put a proposition forward that the relevant clause simply be voidable rather than issuing financial penalties. Can you elaborate on that proposition?

**Dr Wright:** Our members do not support non-disclosure agreements in the context of sexual boundary violation or sexual misconduct. However, if an NDA is made, the affected person should be informed but they can still make a notification to Ahpra or another regulatory body. What we are suggesting is that, rather than making it an offence not to inform an affected person of their right to make a notification, it would be simpler to make the NDA clauses void if a notification advice is not given. Does that clarify that?

**Mr LEE:** That does clarify it, yes.

**CHAIR:** Three questions have been taken on notice. It is a requirement of the committee that we have responses by 4 pm on Thursday, 30 January so that we can include them in our further deliberations. Thank you, Dr Wright.

## BEAMAN, Ms Sarah, Secretary, Queensland Nurses and Midwives' Union

## PRENTICE, Mr Daniel, Professional Research Officer, Queensland Nurses and Midwives' Union

**CHAIR:** I now welcome representatives from the Queensland Nurses and Midwives' Union: Sarah Beaman, Secretary; and Daniel Prentice, Professional Research Officer. I note that Deborah is not joining us today. It is good to see you again, Sarah. Would you like to make an opening statement?

**Ms Beaman:** I would, thank you. Good morning and thank you for the opportunity to appear at this public hearing today. I would like to acknowledge the traditional owners of the land on which we meet and pay my respects to elders past and present and pay my respects to any First Nations people here today. My name is Sarah Beaman. I am the Secretary of the Queensland Nurses and Midwives' Union. With me today is Dan Prentice.

The QNMU represents the interests of over 74,000 nurses and midwives who provide health services across Queensland in all settings. I want to start by saying that the QNMU has zero tolerance for healthcare practitioners engaging in sexual harassment, abuse or misconduct, and protecting patients from sexual misconduct is paramount.

We note that the proposed changes aim to increase transparency for the public about health practitioners' inappropriate, unacceptable behaviour. It is our view that this should be balanced with the impact on the health practitioner's privacy and reputation and ensuring that the re-registration pathway is not duplicated or onerous. It is from this perspective that the QNMU has raised our concerns around two of the proposed amendments—primarily the requirement that the health practitioner who seeks a reinstatement order to apply firstly to the tribunal and then to the board; and, secondly, the expansion of information on the public register which will see the health practitioner's full regulatory history permanently published.

We believe that the current process for nurses and midwives to gain reinstatement in Queensland is sufficient and ensures that the provision of healthcare services is safe. We believe that the NMBA, the Nursing and Midwifery Board of Australia, is clear in defining its requirements that nurses and midwives must be able to meet to work in Australia. It then follows for us that, if the NMBA deems a nurse or midwife has met their registration requirements and is safe to practise, why then would we disqualify a nurse or midwife who seeks to be re-registered and require them to obtain a tribunal order to then only be required to be eligible for reinstatement from the NMBA? We would argue that it is an unnecessary step. While the department in their response to the submissions has acknowledged there will be overlap in matters considered by the tribunal and board as unavoidable, we continue to have reservations about this aspect of the proposed amendment.

Regarding the expansion of information on the register, we understand the objective for this proposed amendment of national law. However, we caution against health practitioners being punished in perpetuity for offences committed long ago. Undeniably, all sexual misconduct by health practitioners is an egregious abuse of trust, and the QNMU is fully supportive of measures that protect patients from health practitioners who undertake these offences. Yet if a health practitioner is sufficiently remediated to appear on the register then continuing to publish their history will foreseeably greatly impact their privacy and practice. We are supportive of measures that protect the community and believe it important to strike the right balance between public protection and procedural fairness for health practitioners.

We are supportive of the publication of proven allegations of serious sexual misconduct for a period of time and then removed from the register when the disqualification from registration has expired. To permanently publicise disciplinary action taken against a health practitioner who has engaged in sexual misconduct amounting to professional misconduct does not allow for a health practitioner to sufficiently address the sexual misconduct that led to their disqualification.

Finally, as outlined in our submission, the QNMU is supportive of greater protections being afforded to notifiers and prospective notifiers. This will not only ensure that notifiers are sufficiently protected from any detriment but also increase confidence and trust in the health practitioners and the healthcare system as a whole. We believe that notifiers should feel safe in being able to report the conduct that they have been subjected to. That concludes my opening remarks, and we are happy to take any questions.

**CHAIR:** On page 5 of your submission paragraph 2 states—

There are structures and organisational controls already in place to protect patients receiving care from health practitioners, including employed nurses and midwives.

Could you walk us through what some of those structures and organisational controls are?

**Ms Beaman:** For those nurses and midwives who are employed by our hospitals and health services, whether it be private or public, the employer does their due diligence when employing someone—whether that be police checks, registration checks and the ability to check the register for any notations or restrictions. Dan, did you want to add anything?

**Mr Prentice:** Yes, but probably the caveat there is that most nurses are employed. There certainly are a small number who are self-employed, but largely most nurses and midwives are employed and therefore they would be subject to those pre-employment checks that are routinely done, as Sarah indicated, in the public and private sector. As well as that, there are the NMBA registration standards. There is a range of those standards that registrants have to meet to maintain their registration on the register, so we believe that there are a significant number of checks and balances already in place for nurses and midwives who wish to practise in any jurisdiction in Australia.

**CHAIR:** In the current season we are in we are seeing labour force challenges, shortages and a lot of labour hire, if that is the term—temps—being brought in. Do you feel confident that those procedures are robust enough to make sure that people could not slip through the cracks who perhaps have a history?

**Ms Beaman:** I have not heard an example where they have not at this point, but I am very happy to hear of those examples, but I know that the employers do due diligence. Nurses and midwives undertake police checks and where they are working with children there are blue card checks on top of their registration. Where they have committed an offence, they are required to declare it and the board does look at that as well. Provided someone is telling the truth, there are absolutely all of those checks and balances in place. I guess what we are trying to avoid is the duplication of that and we have the utmost trust in the regulatory bodies to undertake that work.

**CHAIR:** Over to the Deputy Chair.

**Mr J KELLY:** Thanks, Chair, and I just note that I have worked previously as a nurse with Mr Prentice, so I will go to him for my first few questions. In an average two- or three-day hospital stay—say someone gets admitted to emergency with some sort of GI problem and they go straight up to the gastro ward and maybe have a bit of surgery and then they are ready for discharge and maybe getting Hospital in the Home and a bit of time in the discharge lounge—how many nurses do you reckon that person would come in contact with?

**Mr Prentice:** A significant number. Again, it would depend a little bit on their acuity, but certainly you are looking at least three shifts a day. If you are looking at a three-day period, that is at least nine people and then there are all of those supplementary people that they might meet coming through the department of emergency medicine. There may be multiple contacts with nurses during that period of time. If there is a wait for a bed, for example, then that is more nurses as they are waiting for a permanent bed.

**Mr J KELLY:** If someone comes and taps you on the shoulder and says, 'This person needs to go to an operating theatre,' you have to escort them up there, so that is another one.

**Mr Prentice:** Absolutely.

**Mr J KELLY:** If you added in doctors, OTs, physios and allied health professionals, it would be significant numbers of people during a short hospital stay.

**Mr Prentice:** Yes.

**Mr J KELLY:** If we go to the non-registered staff such as admin officers, cooks, cleaners and catering staff, all of those people potentially have access to a patient unsupervised.

**Mr Prentice:** Yes.

**Mr J KELLY:** Do any of those people get captured by this legislation?

**Mr Prentice:** This applies to those health practitioners who are registered under the Ahpra framework. There has certainly been some speculation that there should be additional professional groups brought into the Ahpra framework, and we also need to remember aged care, because there are a significant number of currently unregulated workers who work there in that over 70 per cent of the aged-care workforce is unregulated as well. You are right: if we are looking at hospitals, hospital work environments are exceptionally complex work environments. If you were to map out all of the connections that centre around a patient, it is a real spiders web of people coming and going and providing hopefully high-quality safe services.

**Mr J KELLY:** In terms of the process that is being proposed in this legislation for reapplying for registration, which is an application to QCAT followed by another application to the NMBA, what is the sort of timeframe that that might add to a process for somebody who is attempting to get back to work and earn a living?

**Ms Beaman:** That is a great question. I know that we have supported members through quite extensive processes and that can be many months, even to years, and to see that process then duplicated or potentially have, say, an outcome from QCAT which says, 'Yes, we think you're okay,' but then have the board saying no would be incredibly distressing. There is duplication of time and effort at a time when I think there is a lot to concentrate on and having one body do that would be the better outcome, but it is extensive.

**Mr J KELLY:** Is there anything in this bill or any of the regulatory impact statements that talks about the need to or the capacity to increase resources for QCAT to be able to manage these additional processes?

**Ms Beaman:** For me it is not just about the resourcing to QCAT; it is actually the distress associated with the reinstatement. To one of your comments earlier, Joe, as to the idea that someone has committed rape, we would not be expecting them to ever practice again. For someone who has undertaken or committed serious sexual misconduct, we would not be expecting them to seek reinstatement. For the purpose of reinstatement, the idea is that someone has to undertake what are quite distressing processes to do that and then to undertake it twice. Yes, there is the aspect of the QCAT resourcing, but it is also the distress and the financial aspect for someone defending themselves. Should they meet the threshold to be determined to practise again, you would hope that they would only have to do that once or that you would have some level of inter-rater reliability that where you achieve it in one it would be the same for the other. It just seems a duplication of process as currently stated.

**Mr J KELLY:** Just for final clarification because I am not a lawyer: if you get one answer from QCAT and you get a different answer from the board, I assume you are then off to the Supreme Court or the High Court or somewhere like that. What is the length of time for that sort of process?

**Ms Beaman:** I would have to take that on notice to get an example, but I am sure that my team would be able to find that. I know it would be extensive, but it is about balancing—getting the right workforce that is safe.

**Mr J KELLY:** There is no need to take that on notice; I will just take it that it would be extensive.

**CHAIR:** Thanks, Deputy Chair. Before I go to the member for Redcliffe, can you give us some idea of the quantum? How many of your members or how many cases a year would you perhaps be dealing with where you are helping someone work through the process of reinstatement?

**Ms Beaman:** I would absolutely have to take that one on notice. I can think of a number that come to mind straightaway, but I am not across all of the numbers.

**CHAIR:** Are we talking a handful or are we talking dozens?

**Ms Beaman:** I know of at least a small handful.

**CHAIR:** Okay, so it is not like hundreds?

**Ms Beaman:** No. The other thing is that the majority of the nursing and midwifery workforce is female, so 90 per cent of the nursing workforce is female and 98 per cent of the midwifery workforce is female. The majority of offenders that we see or complaints are against males within the profession, so there is that proportionality there, but I am very happy to take that on notice and come back, noting, I guess, the privacy aspect of things too.

**CHAIR:** Yes, I understand. Thank you.

**Ms DOOLEY:** Good morning, Sarah. Thanks for your presentation. I do want to say thank you for starting with the fact that the QNMU has zero tolerance. You are the first one to actually say that and acknowledge that the nursing workforce really does take that stance, so thank you for that. Joe mentioned the unregulated workforce, and I think particularly of NDIS support workers. As Joe alluded to, in hospital settings there are a lot of interactions with nurses and opportunity to commit an act like that. It could be done in the middle of the night when there are fewer staff around, but support workers work independently in clients' homes and I just wondered if you had any comments to make there. We have seen the royal commission into disability and, sadly, there have been some very public cases, so I just wondered if you could comment on that.

**Ms Beaman:** Just broadly, we are on the record stating that we do believe that there should be the regulation of the care workforce at all levels. I am happy for Dan to speak more to that, but we do believe that there is an absolutely vulnerable population. Whether that is residential aged care or people in the community accessing NDIS, there is an absolute vulnerability there. I will hand over to Dan.

**Mr Prentice:** Yes. Right from when the aged-care royal commission started looking at the whole aged-care sector, one of the ANMF's stances was that the unregulated workforce needed to be brought into either the Ahpra framework or something of similar rigour. I do not think that outcome has been achieved as yet and certainly you could make the same statement about the disability workforce as well. We are a very big supporter of the benefits of a regulatory environment to ensure the safety and quality of care delivery. I think that that needs to play out a little bit longer and we would certainly be supportive of any efforts to create that mechanism. It is interesting to note that little bit more robust requirements will come into force later this year, I believe. I cannot remember the number, but certainly the Aged Care Quality and Safety Commission already have a number of care workers, for example, who have banning orders placed on them. There is certainly the need for rigorous processes around that and so I think we will just have to wait and see how that goes.

**Ms DOOLEY:** I appreciate that that is outside of this legislation, so that is just asking for your commentary on that. Thank you.

**CHAIR:** Yes, but we will be raising some of those issues with the OHO this afternoon, too.

**Ms DOOLEY:** Thank you.

**Dr O'SHEA:** Good morning. The QNMU's submission states—

... that the bill provides that to initiate the publication requirements, sexual misconduct does not need to be the principal behaviour for the tribunal's findings of misconduct.

Do you have any concerns about the threshold for initiating the publication requirements?

**Ms Beaman:** Are you specifically referring to the inference aspect?

**Dr O'SHEA:** No, more about the basis of the tribunal finding that there has been professional misconduct but that it is immaterial whether the sexual misconduct is the sole or the main basis for that finding.

**Mr Prentice:** I think we are a little uncomfortable with the whole idea of inferring a finding and it has been brought up with some of the previous speakers this morning that inference by its very nature is a little less chiselled in stone than it should be and one of the themes that I have certainly heard this morning is around standardisation and definitions. We have to remember that we are dealing with a number of lives here, I suppose, from a victim point of view and a practitioner point of view, so I think there is an overwhelming need to make sure that as much as possible we get it right the first time around. If indeed that capacity to infer is brought into the legislation, then I think there needs to be some robust checks and balances around that and, should that happen, we would certainly love to be part of that consultation around that. There is a place for subjectivity, and we know that various tribunals make differing decisions. I would suspect that even from an Ahpra point of view there is some variation in the kinds of decisions that they make around similar complaints, so that is something where we need to be very careful before we go down there in that there is the possibility of a slippery slope there I think.

**Ms Beaman:** Yes, just balancing that statement of fact versus statement of inference in that framework would be critical.

**Mr Prentice:** I hope that answers your question.

**Dr O'SHEA:** Do you think it would be clearer if the tribunal was very clearly explicit in their findings and what they were basing them on so the inference would not need to occur?

**Mr Prentice:** I believe so, yes. I think clarity is definitely the best outcome.

**Dr O'SHEA:** Thank you.

**CHAIR:** Thanks, member for South Brisbane. We might go to the member for Noosa for a quick question.

**Ms BOLTON:** Thank you, Chair. Sarah or Daniel, you said previously that, for example, somebody who had been convicted or charged with a rape would not be seeking re-registration. Can you give a bit of an understanding as to the type of misconduct that could end up on the register that is of much less risk?

**Ms Beaman:** Great question again. In terms of the idea of risk when we are talking around a boundary violation right through to rape, I am very cognisant of the fact that for the person who has been the victim it is serious in nature for them regardless of what the type is. In terms of the idea about how we balance public safety and the ability for someone to practise, I have seen referrals around boundary violations now that are serious in nature. There is a level. I want to tread very carefully here because I am not trying to say that it is not as serious as rape. However, where someone has potentially committed an offence, we trust that if they were to seek reinstatement and the national regulatory authority said that they were safe to practise there would be a level of due diligence that that body would have undertaken to make that statement and I think the trust in the body to have determined that that person is safe to practise should provide a level of threshold satisfaction. I know I have danced around that a little bit and probably not given you the answer you are looking for, so I am happy to try. It is just highly sensitive because, as we said earlier, we have zero tolerance to all matters of sexual misconduct.

**Ms BOLTON:** In layman's terms with regard to boundary violations, what is a boundary violation?

**Ms Beaman:** I am not talking about someone stepping into someone's yard. I think the AMA spoke to it a little bit earlier. It can be around the relationship someone has from a clinician to a patient. It could be a boundary violation in the fact of that threshold from someone within a position of authority to a patient where there is the developing of a relationship potentially that comes out of that work. It is so varied and depends also on the setting, and I am not trying to downplay any of it.

**Mr Prentice:** If I can just add a bit of a plug for the NMBA. They do provide nurses and midwives with considerable resources and those resources also deal with boundary violations and that is one of those things that I would certainly recommend to any nursing or midwifery registrant as essential reading. It is a complex issue and I think the NMBA has really tried to provide practitioners with some degree of understanding and clarity around what that means for their individual practice.

**CHAIR:** We are out of time. However, I note that the member for Hervey Bay is itching to ask a question. Is it quick?

**Mr LEE:** Yes, just a quick question. I will not reagitate the issue, but you spoke about the double handling and duplication between the tribunal and the board. To what extent have you researched the operation of the New South Wales tribunal scheme?

**Mr Prentice:** No, I have not personally and certainly the New South Wales Nurses and Midwives' Association would be much more familiar with dealing with that. We have a slightly different but again a co-regulatory scheme here in Queensland with the Health Ombudsman as well, so it is different. One thing is that it is the only jurisdiction in Australia that has that approach. I must admit that I am looking forward to the Dawson review into Ahpra which is looking at the complexity, because I think some of the issues that we have talked about today hopefully will be dealt with, particularly around the definitions, standardisation and consistency of outcomes.

**CHAIR:** We are out of time. Thank you so much, Ms Beaman and Mr Prentice. I think one question has been taken on notice, so we would ask to have your responses by 4 pm on Thursday, 30 January so that we can include them in our deliberations. Thank you so much for your time today. We are going to take a two-minute break and then the hearing will resume.

**Proceedings suspended from 11.04 am to 11.08 am.**

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

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

**CHAIR:** I welcome representatives from Avant Mutual. Good morning. I invite you to make an opening statement.

**Ms Haysom:** Thank you very much, Chair. I will start and then hand over to Dr Clancy. Thanks for the opportunity to appear here today. I am the general manager of advocacy, education and research at Avant and also a lawyer with 30 years of experience in health law. I am here today with my colleague Patrick Clancy. He is a senior medical adviser at our team at Avant. Avant is a doctors' organisation and Australia's largest medical indemnity insurer with over 90,000 members around Australia, so that is more than half of Australia's doctors. For decades now we have assisted our members in managing complaints made to Ahpra and to the Medical Board and to regulators in the co-regulatory jurisdictions of New South Wales and Queensland. I would like to start by making it really clear that we do not condone sexual misconduct by health practitioners and we also support transparency where it protects the public.

As to the proposed amendments, we do support the protections for notifiers—the protections from threats, reprisals and detriment where notifications are made in good faith and the proposal that voids clauses in non-disclosure agreements that prevent people from making complaints. We do see merit in the proposal that tribunals make reinstatement decisions. However, we do not support permanent and retrospective publication of information on the register as is proposed in this legislation and we have concerns about aspects of the proposals that give powers to national boards that potentially usurp and undermine the decision-making role of tribunals. Our submission is about fairness and proportionality of the regulatory response to boundary violations in light of the wide spectrum of behaviour that falls within the framework outlined in the Medical Board's sexual boundaries guidelines. The submission focuses on the way the legislation is drafted and legal principles about the respective roles and responsibilities of disciplinary tribunals and national boards. I will now hand over Dr Clancy.

**Dr Clancy:** Thanks, Georgie. I am a medical adviser at Avant and a GP from Brisbane. I want to make just a brief disclosure that I have previously been appointed as a practitioner member of the Queensland Board of the Medical Board of Australia. Avant supports protections from notifiers from detriments or reprisals. We see practitioners who have been the subject of detriments or reprisals after making notifications—our colleagues. This has been quite distressing for each practitioner who has done the right thing and made the mandatory notification, particularly where there may be a power imbalance. However, it needs to be clear that the definitions of detriment and reprisal do not inadvertently extend to situations where a practitioner has appropriately ended the doctor-patient relationship after notification has been made by a patient. This relationship fundamentally relies on mutual trust and the fact notification has been made means that mutual trust has often been lost, even if the notification was made in good faith. If a doctor is the subject of notification, they can have a range of reactions including guilt, fear, anger, resentment and questioning their own abilities, so it is often difficult for them to continue to be impartial and providing ongoing care will actually see the doctor second-guessing themselves and impact on the quality of care received by their patients.

Regarding the proposal to permanently and retrospectively publish information on a public register, Avant encourages the committee to consider the purpose of this amendment. Is it aiming to protect the public or is it going beyond that and being present for curiosity value only? If it is determined that sanctions are no longer necessary to protect the public from risk of harm, patients should be able to have full confidence in that decision. It can only be punitive then for that information to remain on the register permanently. We also see that the proposal to publish is retrospective, so a practitioner who made an error in 2010, completed the requirements of the sanctions and has had an unblemished career since then may now be subject to what is tantamount to another sanction. Thanks for the opportunity to talk to you. We will take questions.

**CHAIR:** Thank you. I would like to kick off with a question around patient protections or patient safety. Where a practitioner is reinstated and they are working as, say, a GP in a small practice, or even a larger practice for that matter, what steps are put in place to ensure patient safety and that there is no reoccurrence of an offence?

**Ms Haysom:** I would start by answering that question by saying that the practitioner needs to make an application to be reinstated, under this legislation, to the tribunal. We see merit in that suggestion because it is a measure of independence that has independent oversight over that

decision. In making that decision, the tribunal needs to decide whether the person is a fit and proper person to be reinstated and also needs to consider whether or not the person is safe and competent to practise. Once the tribunal has made that decision and considered all of the evidence that has been put before them, then the public should have confidence that that doctor has rehabilitated. If there is a requirement for ongoing conditions for that practitioner, then the tribunal can make an order for those conditions to be in place at the time and then the practitioner would need to comply with those.

**CHAIR:** Is there any monitoring or ongoing counselling in place? Is the practitioner required to front up to a supervising group of other practitioners? How do you monitor their progress, wellbeing and performance beyond that?

**Dr Clancy:** A lot of that will be in whatever conditions the tribunal sees fit to impose on them when they are reinstated. It could be things like needing supervision, needing mentoring, needing further education or a requirement to have their own treating practitioner. We frequently see those safeguards on conditions that are imposed.

**Mr J KELLY:** Just to be clear, you would prefer a tribunal only decision-making process for people to be able to reapply as opposed to the two-step process that is outlined in this bill; is that correct?

**Ms Haysom:** Yes, that is correct. We do not really like the idea of the duplication that comes with the two processes, the reinstatement application and then the reregistration application. The board is a party to the reinstatement application and it has the opportunity to put evidence before the tribunal about the conditions that might need to be put in place if the application is granted; therefore, they have the opportunity to raise all of those issues at that time. The tribunal is an independent body and there is transparency over the tribunal decision, so yes.

**Mr J KELLY:** In Queensland it is my understanding that the OHO investigates more serious matters than Ahpra where the board sits, so you could have a situation where the OHO handles a matter which might start as a boundary violation and progresses to something that is potentially rape, which is criminal in nature, and is then referred to the Queensland police for investigation. Under the proposed legislation QCAT gets involved in the reapplication process, and then the board which sits at the Ahpra level is again brought into the decision-making process as to whether that practitioner should go back. One of the arguments made around this legislation is that presently you have people who are familiar with the case making decisions. Would that not be the case in Queensland because the OHO has actually done all of the work around investigating the matter and has no role in the decision-making process as to whether the person can return to work?

**Ms Haysom:** I think there are two issues here. The OHO does the investigation for the purpose of disciplinary proceedings in the first instance where there is ultimately, in the circumstances we are talking about, a finding of professional misconduct and the OHO is a party to those proceedings. The tribunal makes its decision—let's say it is for professional misconduct—and they have been struck off for a period of time. The tribunal puts their time limit on the amount of time that must pass before the person can make a reinstatement application. Then when it comes to that tribunal it is the national board. The national board would have the history of the matter before the OHO and they would have the decision of the tribunal. They are the ones who then need to re-register them. We would say those two different processes are sufficient.

**Mr J KELLY:** In terms of this proposed legislation and the information that is going to be permanently and publicly available, has your organisation been made aware of what the nature of that information will be? Some of the seven examples given in the Ahpra submission are clear-cut and as a consumer you would never want to go to that practitioner. Others are quite grey. What information is going to be out there? If I read some of those my instinct would be not to go to that practitioner, but that may not be a fair assessment if I had access to all of the information. Are you aware of what information is going to be shared?

**Ms Haysom:** Based on the proposed legislation we are not entirely aware of what information is going to be shared. The bill says that once the tribunal makes a finding of professional misconduct based on sexual misconduct—sexual misconduct may be a basis, not the sole basis—or the national board infers that from the tribunal decision—and I am sure your questions will get to that—then what must be put on the register is that there has been a finding of professional misconduct involving sexual misconduct. There will be also a link to the tribunal decision, which is currently the case as well. Beyond that, it is not clear as to what is going to be on there.

**Dr Clancy:** I cannot speak on behalf of consumer groups, but I would argue that the majority of patients will not go and look at the public register before they go to see their practitioner; therefore, those patients, whether they know it or not, need to rely on the regulators to do their job and ensure that the public is being kept safe rather than having something written on a website.

**Mr J KELLY:** Just on that point, it seems we are trying to push the responsibility back onto consumers to be informed and it is buyer beware rather than there being a system to protect the consumer.

**Ms Haysom:** We do not have any objection to publication whilst the sanctions are in place. The issue for us is permanent publication and retrospective publication of that information.

**Mr LEE:** Dr Clancy, clause 22 of the bill would make it an offence for a person to 'subject another person to other detriment or reprisal' in the context of a practitioner-patient relationship. I presume you are looking for more clarity in the bill?

**Dr Clancy:** Yes.

**Mr LEE:** What do you think that might look like within the bill?

**Dr Clancy:** We will leave it up to the parliament and legislators, of course. Something in the bill that specifically says the practitioner-patient relationship being ended—provided it has been done appropriately, of course—is not a detriment or reprisal. Alternatively, something in the explanatory notes to that effect could be relied on as well.

**Mr LEE:** Something which contemplates that if a patient-practitioner relationship was terminated it would not constitute a detriment, or something to that effect. Is that how I understand it?

**Dr Clancy:** Yes. I am happy for the word 'appropriately' to be put in there, of course.

**Mr LEE:** The bill also provides for an ordinary construction of sexual misconduct. Your submission raises concerns about that. Do you want to elaborate?

**Ms Haysom:** In the absence of a definition in the legislation, the best guide as to what amounts to sexual misconduct for the medical profession is in the medical board's sexual boundary guidelines. In those guidelines, as pointed out in the explanatory notes, there are a range of boundary violations listed there and a spectrum of behaviour. As it says in a couple of places in the explanatory notes, the threshold for the issue would be high. There are a range of behaviours. It is difficult, because for all patients who have been subject to boundary violations of inappropriate sexual conduct it is serious. We are not trying to in any way belittle the experience of patients in raising these issues. That is why at the beginning I mentioned the legal principles and definitions. The challenge is that, in the absence of a definition in the legislation which makes it clear that the threshold is high, the best place to look is the guidelines. The guidelines outline a range of behaviours.

**Mr LEE:** I want to go to the question about drawing a necessary inference, which is also touched on in your submission. It confers the board with a discretionary power to draw an inference from a tribunal's decision but also in circumstances where the tribunal may not expressly state sexual misconduct as a basis. Do you want to elaborate on your concerns?

**Ms Haysom:** This allows the board the discretion to have a look at the decision and then make their own decision about whether or not there was sexual misconduct involved. Our view is that the board should be bound by the decision of the tribunal, which has considered all of the evidence before it and made a finding as to the basis of the professional misconduct. I do not think it is right—and it is unfair—for the national board to then say, 'We do not agree with the decision of the tribunal. We are going to infer from the facts that it was sexual misconduct.' It is compounded by what happens later on, which is that the legislation requires there be a note or a statement on the register that the tribunal has made a finding of professional misconduct involving sexual misconduct when that may not in fact be the case. It gives a discretion to the board to go beyond what is in the tribunal decision. We say the tribunal decision should be clear. The parties to the proceedings in the tribunal have the opportunity to make the submission that the finding should be professional misconduct for sexual misconduct. It should not be a matter for the board's inference.

**Mr LEE:** That opens the door to further discussion about where sexual misconduct was found as the basis for the decision, because sometimes there can be quite a complex factual matrix.

**Ms Haysom:** Absolutely. We put some commentary around this in our submission and gave an example of a scenario. Yes, there are often cases where it is quite clear that the conduct is sexual misconduct, sexual assault, really inappropriate sexual relations and sexual boundary violations, but

in our experience often it comes up in the context of other things. We provided an example in our submission of a doctor who might have been involved in some prescribing matters or the inappropriate treatment of patients. There could also be within that factual matrix some sexual boundary violation. We say it is disproportionate and unfair if the tribunal has not made a finding of professional misconduct based on sexual misconduct.

**Mr LEE:** Would you support a legislated definition of sexual misconduct?

**Ms Haysom:** Yes, as long as the threshold was high.

**CHAIR:** Thank you Dr Clancy and Ms Haysom. We need to move on as we are out of time. Thank you very much. There were no questions taken on notice.

## MONTEVERDI, Ms Lidia, Senior Member, Medical Law Special Interest Group, Australian Lawyers Alliance (via videoconference)

**CHAIR:** We will now move on to our next witness that we have with us online. We have a representative from the Australian Lawyers Alliance, Lidia Monteverdi. Please remember to press your microphone on when you start speaking and off when you finish. Would you like to make an opening statement?

**Ms Monteverdi:** I thank the members of the committee for inviting the Australian Lawyers Alliance to appear at today's public hearing regarding this bill. I am a senior member of the ALA's medical law special interest group. I am also a medical negligence solicitor. I would like to begin by acknowledging the traditional owners of the lands on which this public hearing is taking place and the traditional owners of the lands where I am today, the Awabakal people. I pay my respects to their elders past and present and to any Aboriginal and Torres Strait Islander peoples taking part in today's hearing.

The ALA is a national association whose members are dedicated to protecting and promoting access to justice, human rights and equality before the law and for all individuals. The ALA is represented in every state and territory across Australia. We estimate that our some 1,500 members represent up to 200,000 people nationally each year.

Broadly, the ALA supports legislative responses to what has been identified as a concerning increase in notifications made against registered health practitioners for sexual misconduct. Without adequate information on the public record about the misconduct of registered health practitioners, patients and prospective patients are being placed in potentially unsafe situations. The ALA is of the view that patient safety and the ability of patients to make their own decisions about respective healthcare practitioners is paramount, particularly in circumstances where that practitioner has been found to engage in sexual misconduct. It is for this reason that our submission includes that behaviour which constitutes unsatisfactory professional misconduct should be included in this bill in order to ensure that a broad range of harmful and potentially unsafe conduct which compromises public safety is recorded on the national register.

The ALA notes the departmental response which was sent around last week to our submission in relation to the definition of non-disclosure agreements, and we are grateful for that clarification. Finally, and importantly, in our submission we have identified the need for a national public education campaign. This recommendation is based on our experience acting for injured people who had no idea about the existence of their ability to look up their practitioner on the Ahpra website. These reforms, in our view, must be supported by a public education campaign in order to educate the general public about the existence of the national and specialist registers and how to navigate them. Again, the ALA notes the departmental response to our submission sent last week, and we welcome Ahpra's indication that they support community education to assist the implementation of these reforms.

Finally, I wish to thank the committee for considering our submissions and thank you for the opportunity to appear today before you all.

**CHAIR:** Thank you for your submission. In reading through your submission I got an overwhelming sense that you wanted stronger, not easier, conditions placed on reinstatement. Would that be a fair comment?

**Ms Monteverdi:** Yes, I think so.

**CHAIR:** For the sake of our general knowledge and education, could you explain to the committee the difference between 'unsatisfactory professional conduct' and 'professional misconduct'? Could you go into the definition of those two terms?

**Ms Monteverdi:** Professional misconduct is broadly seen as conduct which is more serious. If we are talking about sexual misconduct claims, it is typically seen as boundary violations or sexual intercourse with patients. Unsatisfactory professional conduct is seen as the lower threshold, if I could put it that way. It is typically seen as conduct which is serious but not so serious to amount to professional misconduct.

I am going to go rogue and answer the second part of the question that was not really put. You have asked a very important question in that the general public have no idea about the distinction between professional misconduct and unsatisfactory professional conduct. That is why in our submission our view and our experience dealing with injured people is that they would attach importance to either professional misconduct or unsatisfactory professional conduct, particularly if we are talking about sexual misconduct. That is why our submission calls for unsatisfactory professional conduct to be included in the bill.

**Dr O'SHEA:** Going back to the definitions of professional misconduct and unsatisfactory professional conduct, professional misconduct amounts to conduct that is substantially below the standard reasonably expected from a registered health practitioner, whereas unsatisfactory professional conduct is below the standard reasonably expected. There is quite a difference there. In terms of the fact that this would be the trigger for permanent publication of regulatory history related to misconduct, based on sexual misconduct, why does the ALA think that it should be expanded?

**Ms Monteverdi:** The ALA's view, as I touched on, is based on our experience dealing with injured people. My own experience as a medical negligence solicitor is that I have had countless discussions with patients who then become my clients who have said to me, 'I didn't know about this particular practitioner's history and had I known about it I would have placed importance on it and I would have found somebody else.' That is my own experience. I know that that is the experience as well of many other ALA members.

Our position in addition to our experience is that any member of the general public might place a different amount of importance or significance on past findings if they are to do with sexual misconduct, and that is particularly if that prospective patient or member of the public has their own trauma or sexual abuse history. It is quite important that they are aware of that so they can make their own informed decisions.

**Mr LEE:** I have a question in relation to the unsatisfactory professional conduct—that lower threshold. What sort of conduct would you comprehend being picked up under that category?

**Ms Monteverdi:** I think it depends. I was looking through New South Wales case law to see if I could find some decisions in relation to unsatisfactory professional conduct. I do not want to give the committee an incorrect answer. Perhaps if I could take that on notice and we could provide you with some examples just so that you are better informed.

**Mr LEE:** That would be great. On the face of it, I would be concerned about that lower threshold picking up all sorts of conduct within the definition.

**Ms Monteverdi:** Yes, understood.

**Ms BOLTON:** I have a question on the non-disclosure agreements. You had concerns about that. Is the concern that it could be a clause in another contract?

**Ms Monteverdi:** No. The concern was that perhaps the way the legislation was drafted meant that the bill was talking about a standalone non-disclosure agreement as opposed to it forming part of an employment clause, for instance. I think the departmental response makes that issue clear, and we are happy to accept that, as I understand, it is a contract or other agreement. It is up to the committee obviously, but our suggestion I think from memory was something along the lines of contract or clause in a contract just to make that abundantly clear.

**Ms BOLTON:** That is in their employment contract?

**Ms Monteverdi:** Yes, that is right.

**Mr J KELLY:** In relation to the expansion that you are seeking, is that related only to matters that involve some sort of a sexual nature to the issue or are you anticipating the permanent publication of all professional misconduct or unsatisfactory professional conduct matters?

**Ms Monteverdi:** Our submission focuses on sexual misconduct because that is what we understand these amendments to be focused on. In terms of unsatisfactory professional conduct or professional misconduct as it relates to conduct of a sexual nature, we do believe, and our submission is, that that conduct should be on the register. In terms of unsatisfactory professional conduct generally, it is perhaps not something that we considered. As one of the other members put, it might be that unsatisfactory professional conduct forms a whole ambit of different types of conduct that might not necessarily be appropriate to be on the public register.

**Mr J KELLY:** These sorts of registers that you are talking about are obviously based on giving consumers better information which is fundamental to a properly functioning market in an economic sense. The reality is though that in a healthcare setting the vast majority of people who are seeking and receiving health care are not sitting around assessing the relative merits of their practitioners in advance of receiving the care. I am a registered nurse by profession. I have qualifications in health economics. The patients that I have seen in many years of nursing have never chosen to come to me personally. How does this register that is being proposed in this legislation add to patient protection in terms of what we have now?

**Ms Monteverdi:** We think it needs to go hand in hand with a public education campaign. You have touched on the issue perfectly. Most people do not proactively look up who their health practitioner is going to be. Frankly, that is because we do not believe that most of the general public know that they can even do that. A simple response to that might be that most people tend to Google who a practitioner might be. If there is funding released to Ahpra to ensure that the practitioner's registration from Ahpra appears at the top of the Google page then that will increase public awareness that they can look up who their practitioner is going to be and educate themselves on that.

**Mr J KELLY:** You mentioned in your practice you have dealt with people who said—I think you used words to the effect that if they had known that in advance they might have made different choices in relation to that. What are those scenarios and what are those situations? Obviously you cannot breach clients' confidentiality. I would be interested to know where a patient is making a decision that could be changed and altered by that sort of information being available.

**Ms Monteverdi:** Frankly, my experience is that it does relate to practitioners who have had a finding in relation to sexual misconduct.

**Mr J KELLY:** I am thinking about the practicality of this. Again, this is a hospital-based scenario. A short-stay patient of one to two or three days could deal with upwards of 100 practitioners in that time. How does a person practically check the register for hundreds of people that they might deal with during a hospital stay?

**Ms Monteverdi:** I think practically they will not. It is very difficult in a hospital setting because often you only know the practitioners by their first name. You do not know their last name. You cannot look for them. I think there is work to do. I think these amendments are important in terms of assisting the public in finding out information about specialists or practitioners who they choose to see as opposed to who they come across in, for instance, a hospital stay.

**Mr J KELLY:** Would it be more effective to have systems in place to allow for people who are making actual decisions about the practitioners they are going to see to operate in a manner like this and different safeguards in place for other scenarios where you simply will not have any choice in the people who you will come into contact with who will provide you with care? In effect, you have to rely on systems in a hospital to protect you. You cannot rely on this sort of mechanism to protect you in a hospital setting.

**Ms Monteverdi:** Yes, that is right. I agree with that.

**Ms DOOLEY:** Thank you for your presentation. I am curious about your focus on public education. No-one else has mentioned that this morning. Can you tell me what that might look like? What do you think would be the key elements needed in that—obviously from Ahpra registration? Could you elaborate on that?

**Ms Monteverdi:** The public education could be something as simple as Ahpra have run public education campaigns around plastic surgery and cosmetic surgery. I think the committee or Ahpra could have a look at those education campaigns as a mud map. In touching on the previous exchange, that education campaign could include, for instance, flyers in hospitals. In New South Wales we have REACH. If you have an issue and you want to seek a second opinion in hospital, there are flyers beside each bedside about REACH. It could be that next to the REACH call is something about Ahpra and being able to look up your practitioner. Social media campaigns are really helpful as well, whether it be through Facebook, Instagram or TikTok, to reach the younger generation. I suppose what I am getting at is that it does not particularly need to be a massive campaign but quite a targeted campaign to reach as many of the general public as possible.

**Ms DOOLEY:** Have we have time for one more question?

**CHAIR:** It has to be super quick.

**Ms DOOLEY:** You may not be able to answer this but, in broad terms, just moving on from what Joe mentioned about hospitals versus private GPs and specialists, could you comment on the cases that you have represented—I assume the majority would have been more one on one with the GP or a specialist rather than in a hospital context? Could you comment on that broadly?

**Ms Monteverdi:** I think that is right, generally. If we are talking about sexual misconduct specifically—

**Ms DOOLEY:** Yes, specifically.

**Ms Monteverdi:—**generally that conduct of a sexual nature has been by specialists or allied health—for instance, psychologists and psychiatrists. I am sorry to pinpoint that specialty. In New South Wales, however, there have certainly been a number of examples of sexual misconduct by particular practitioners in a hospital setting. For that reason, I think the previous member is right in that systems need to be in place to assist and to protect the public in hospital.

**CHAIR:** Thank you for appearing today. I think we have one question on notice. Your response will be required by 4 pm on Thursday, 30 January so that we can include that in our deliberations. Thank you very much.

**Ms Monteverdi:** Pleasure. Thanks very much to all of you.

## BASSINGTHWAIGHTE, Ms Claire, Deputy Chair, Health and Disability Law Committee and Member, Occupational Discipline Law Committee, Queensland Law Society

## BRODNIK, Ms Kate, Principal Policy Solicitor, Queensland Law Society

## DEE, Ms Genevieve, President, Queensland Law Society

**CHAIR:** I now welcome representatives from the Queensland Law Society. Please remember to press your microphone on before you speak—I keep reminding everyone and then forgetting myself—and off when you have finished. Would you like to make an opening statement?

**Ms Dee:** Thank you for inviting the Queensland Law Society to appear today. In opening, I would like to respectfully acknowledge the traditional owners and custodians of the land on which we meet. As the committee may be aware, the Queensland Law Society is the peak professional body for the state's legal practitioners. It is an independent, apolitical representative body. The society supports the bill's objectives to improve public protection and public confidence in the safety of services provided by registered health practitioners. However, it holds concerns with some of the proposed reforms and the way in which they will be progressed. Those concerns are outlined in its written submission.

In addition to those issues, I would like to discuss the impact that publishing historical information on a public register may have on an individual in circumstances where they have already proceeded through a disciplinary process, where a finding has been made and where sanctions have been issued. At that time, entry on the register was not permanent and had the practitioner been aware of that requirement they may have taken a different approach in their matter. This is why the retrospective application of laws is of great concern to the society and our members.

An affected person has no opportunity to respond to the change in circumstances now imposed on them. In a similar vein, the regulators and the tribunal involved in the original finding and sanction based their decisions on the law at the time, which included balancing community safety and protection. Changing the outcome now does not support that work. We urge the government to consider the very real impact that publishing historical data may have on the individual's reputation, livelihood and wellbeing as well as on the community and circumstances where salient details and nuance can be lost over time. This is even more important considering the other concerns we have identified in our written submission. We ask the committee to recommend the bill be amended to address our concerns before it is further considered by parliament, including an amendment to proposed new section 225A so that it apply only to tribunal decisions made after the commencement of this law.

I am joined today by Claire Bassingthwaighte, Deputy Chair of the QLS Health and Disability Law Committee and member of the QLS Occupational Discipline Law Committee, and our Principal Policy Solicitor, Kate Brodnik. We welcome any questions from the committee.

**Mr J KELLY:** Thanks for your submission. I think we all start at the same starting point: we do not want to see any patients impacted by sexual misconduct of any sort. In relation to the retrospective aspects of this bill and the other statements that you have made, are you indicating that, if the people who had gone through the various processes that will be captured by this bill had known that this would be the consequence, they may have elected to try to defend themselves more vigorously or taken a different course and tried to prove their innocence so to speak?

**Ms Bassingthwaighte:** Thank you for the question. It certainly would be a potential strategy for consideration by the legal advisers and by the respondent in those disciplinary proceedings. It is a different ultimate outcome having something on a public register for perpetuity. It has a much more significant impact on that practitioner's registration, should the board allow them to go back to registration or full registration in due course. So, yes.

**Mr J KELLY:** Looking forward rather than backwards, we are talking about a spectrum of potential conduct here. There may be a certain degree of it where a person may choose to go down a path of acknowledging that they are wrong and seeking to correct their behaviour through education or other means and accepting that as an outcome, whereas if they feel that they will be put on a permanent register even if they do that they will simply elect to fight it to the ultimate degree to try to prove their innocence. Would that result in more time, resources, angst, et cetera, for all involved?

**Ms Bassingthwaighte:** It certainly is a very real possibility. I could not sit here and say that in any practitioner's situation they would definitely proceed down that path but I think it would very much be something for consideration as well—and this is the area in which I personally practice.

**Mr J KELLY:** You also mentioned in the submission concerns around the appropriate termination of care. I forget the terminology that was used in a couple of submissions but there could be detriment to a patient or action. As a nurse or a doctor, if someone is accusing you of something, your natural reaction would be to say, 'Perhaps the best thing is to not engage with this person anymore.' What you are saying in your submission, I think, is that, if you refuse care, even under appropriate circumstances, that could be considered as having taken adverse action against that patient.

**Ms Bassingthwaighte:** Absolutely. That is the clarity that we are seeking within that piece of legislation. There is no issue with the concept and there is no issue with the legislation in itself on that point but for seeking clarity around that.

**Mr J KELLY:** Finally, this information seems not very clear yet as to what will be shared with the general public in relation to this. It could be foreseeable that people could share that information on social media, misconstruing the basis of that information and damaging practitioners quite significantly beyond the scope of what was ever intended by this legislation. What protections are there for a practitioner if that starts to happen? How complex is the process of trying to clear your name and clear the public record? Is it even possible in a day of social media?

**Ms Bassingthwaighte:** The reality is that it is not really, in our experience of dealing with social media. The previous submissions were reflecting things like reaching out to TikTok or Instagram. Once things are in social media, it is like a beast essentially that has been unleashed and it is very difficult to rein it back in, if ever. That is absolutely a consequence or a potential consequence of this. There are Facebook groups, Instagram groups and things like that that exist out there where things are discussed and the nuances and the legal reality is many times lost, so that is an absolute concern.

**CHAIR:** You would think that that would probably act as a greater deterrent in this day and age for health practitioners.

**Mr LEE:** Clause 21 of the bill, which sets out new section 225A and B, talks about conferring a discretionary power on the board to make necessary inferences. You raised concerns about that in your submission. Do you want to expand on that for us, please?

**Ms Bassingthwaighte:** The concern is that the board is able to draw its own inference from a tribunal decision. If a tribunal finds that there is sexual misconduct as a component and that sexual misconduct has gone on to be classified as professional misconduct, that is one scenario but there are other scenarios, which are arguably just as common, where the totality of the conduct involved in a particular disciplinary proceeding may not be sexual misconduct. It could be prescribing. It could be any other element of the practitioner's conduct but the definition of 'sexual misconduct' is very, very broad under the board's guidelines.

If you look at the board's guidelines, it incorporates anything from making an inappropriate comment with sexual innuendo to taking a sexual history from a patient where it is subsequently deemed that that was not necessary. That is sexual misconduct under the current guidelines that are published by the board. There could be an allegation of that and it could be the case that the totality of the conduct in the disciplinary proceedings is largely about something else, which perhaps warrants a finding of professional misconduct. If the tribunal is not actually saying, 'We think that the sexual misconduct issue warrants a finding of professional misconduct,' the society's position is that the board should not be able to draw that inference of its own wishes based on the legislation.

Very importantly, it then goes on to say that the statement must include that the professional misconduct included sexual misconduct. It might not necessarily be clear from the tribunal decision—it might not be the tribunal's decision that that was indeed the case, particularly if we are talking about things applying retrospectively. That is very grey and they are potentially damaging greywaters to be entering into as opposed to something where the tribunal has said, 'The sexual misconduct amounts in and of itself to professional misconduct.' I think that is a separate category that we are not concerned about.

**Mr LEE:** I take your point about the broad definition of sexual misconduct. So would you support a legislative definition of sexual misconduct with the appropriate thresholds?

**Ms Bassingthwaighte:** Thank you for that. We would probably need to have a look at the definition but certainly something that perhaps narrows what is captured. As I said, the definition currently is very broad and my understanding is that this aspect of the legislation is best directed to those more significant ends of the sexual misconduct scale—that is really what is intended to be captured there. I think, subject to having a look at the definition, that would be supported.

**CHAIR:** We have had a few groups refer to the medical board's guidelines. Would you consider them to be an adequate definition?

**Ms Bassingthwaighte:** The medical board's guidelines are the guidelines that I was talking about that include things like making a comment that has sexual innuendo or taking a history from a patient that includes a sexual history where it is not clinically relevant or is later deemed not clinically relevant. It needs to be narrower than that to be truly reflective of what I think the legislation is intending to do.

**Mr J KELLY:** Just picking up on those last two points—if the more serious end of the spectrum is what we are trying to capture, is that not already captured by various criminal proceedings? If you are raping somebody and you are caught, you will be convicted and your chances of being re-registered are extremely low. What are we missing that we need to capture here?

**Ms Bassingthwaighte:** Many matters in the tribunal relating to sexual misconduct could involve a consensual sexual relationship with a patient. It does not have to be rape. There is a very broad spectrum within that—even at the upper end of the scale where it is not a criminal matter, it is a breach of the board's code of conduct.

**CHAIR:** I am a little curious about the other end of the scale. We have not heard much discussion around tolerances. Where is the line drawn that gets someone into a lot of hot water for banter?

**Ms Bassingthwaighte:** The importance of clarity and defining what it means for this piece of legislation is really important. The current definition under the board's code of conduct and the guidelines is intentionally broad. It is a matter for the committee. Is it a consensual sexual relationship with another adult? Does it have to be a current patient? You could engage in a sexual relationship with a former patient that goes on to include marriage and children. That would be a matter that would be in breach of the board's sexual misconduct guidelines and therefore can be—and has been on many occasions—prosecuted in the tribunal. That would not necessarily perhaps be appropriate for this. Where the patient is particularly vulnerable et cetera, even if it was consensual—and obviously those matters where there is no consent are quite serious—those are the matters that ought to be captured by some type of legislation as a variant of this.

**CHAIR:** I have been reflecting on the number of cases that the OHO manages. How many cases would we be dealing with in Queensland annually of reinstatement? How many applications for reinstatement would QCAT potentially be dealing with or the board on an annual basis? Do you have any stats around that?

**Ms Bassingthwaighte:** I am sorry, I do not. There would be a few. I probably could not give you any clear statistics. That information might best come from either the OHO or the medical board, as they are both the prosecuting authorities. Between the two of them they would have the totality of that data. Ahpra would have that data available to them quite readily.

**CHAIR:** They are coming in this afternoon so I might ask them that. It would be helpful to understand the severity or lack of severity around these issues in terms of how many cases we are actually dealing with.

**Mr LEE:** The bill provides for a judicial review. Your submission talks about a merits review. Do you want to take us through that? It talks about resource applications.

**Ms Bassingthwaighte:** It is the society's position that there ought to be a process for a merits review. It is generally less expensive to seek a merits review than to go through a judicial review, which is a more longwinded process and takes up a higher court's time. That would always be an option. Given the avenue this circumstance would have come to arise in, in our view it would have been appropriate for there to be a merits review in the tribunal.

**CHAIR:** Some of the previous groups suggested there was some unnecessary duplication with QCAT and then going to a further board. Do you have a view around whether we need a two-step process? If QCAT said it was okay to re-register and then the board deemed it was not, what is the process beyond that?

**Ms Bassingthwaighte:** Based on our interpretation of the legislation as opposed to the concept behind it, the society's position is that the two-step process is not warranted. Transparency around deciding to re-register a practitioner after they have been deregistered can easily be achieved by publishing the board's decision to re-register. Sending a practitioner to the tribunal to take up the tribunal's time and resources, bearing in mind the board will also include clinicians from appropriate professions when making decisions, takes up valuable resources for a fairly overworked and underfunded tribunal. The tribunal may well come to the conclusion that the practitioner can be

re-registered. They might impose certain conditions. It is common for there to be something like mentoring conditions. If the practitioner then goes back to his national board and they say, 'No, we don't agree,' the practitioner has gone through the time and expense and ultimately been told no and no-one gets that decision published. It has not really made the process easier. It does not necessarily add protection. It moves the apparent responsibility to the tribunal but not the actual responsibility. A simpler process for increasing transparency, if that was the aim of the legislation, is for the board's decision to be published.

**CHAIR:** We are almost out of time. Did you have a question, member for Noosa?

**Ms BOLTON:** Chair, you asked the question I was going to ask so it is all good.

**CHAIR:** We are going to adjourn now for 30 minutes. There were no questions taken on notice. Thank you for appearing today.

**Proceedings suspended from 12.06 pm to 12.37 pm.**

**AYSCOUGH, Ms Kym, Acting Chief Executive Officer, Australian Health Practitioner Regulation Agency**

**BEASLEY, Ms Prue, Director, Office of the Health Ombudsman**

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

**LORD, Mr Nick, National Director, Engagement and Government Relations, Australian Health Practitioner Regulation Agency**

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

**CHAIR:** I now welcome representatives from the Office of the Health Ombudsman and the Australian Health Practitioner Regulation Agency, Ahpra. Would anyone like to make an opening statement?

**Ms Ayscough:** Yes. Thank you for the opportunity to appear today before the committee for your inquiry into the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2024. I am Kym Ayscough. I am the Acting Chief Executive Officer of Ahpra. I am joined by Dr Jamie Orchard, General Counsel, and Nick Lord, National Director, Engagement and Government Relations. We would like to acknowledge the traditional owners of the lands on which we meet today and pay our respects to elders past and present. We welcome the introduction of this bill into the Queensland parliament and support the amendments that have been proposed by Australia's health ministers. We recognise the leadership of health ministers in addressing sexual misconduct by health practitioners. There are four areas that I would like to briefly comment on.

First, the bill proposes that additional information be published permanently on the national public registers about disciplinary action taken against health practitioners who have been found by a tribunal to have engaged in serious sexual misconduct. This will support the public to make better informed choices about accessing the health services of registered practitioners and it will better address community expectations about having access to information on sexual misconduct by health practitioners. Employers of health practitioners will also be able to access the information on the public register. We believe there are appropriate safeguards built into the bill.

We have reported on the year-on-year rise in complaints about boundary violations which include sexual misconduct. Our 2024 annual report data shows that 1,156 complaints were made, which is 37.5 per cent higher than the previous year; 174 were about practitioners in Queensland. The complaints mostly involved medical practitioners and nurses. Ahpra and the national boards are clear: there is no place for sex in the practitioner-patient relationship. We condemn sexual misconduct in all of its forms. Any sexual exploitation is a gross abuse of trust and can lead to long-lasting and profound damage. These changes align with the range of reforms that Ahpra and the national boards are progressing to improve public safety involving sexual misconduct in health care.

Second, we support a nationally consistent approach for reinstatement orders where practitioners have had their registration cancelled or disqualified by a tribunal. This change will give greater transparency in the process to the public. Importantly, these provisions in the bill recognise that the tribunals in each state and territory are constituted under local legislation and rules governing proceedings are specific to each tribunal. The approach taken in the bill will support national implementation while ensuring the changes are workable for tribunals in each state and territory.

Third, the bill includes important notifier and public protections. It is essential that patients and others are free to contact the regulator when they have concerns about the care provided, or the conduct of practitioners. We welcome the creation of new offences that make it clear that it is unacceptable to interfere with the right of patients to make these notifications by threatening or otherwise intimidating a person, or by trying to exclude that right to make a notification via the non-disclosure agreements. The proposed penalties for these offences are appropriate. They recognise the seriousness of the conduct and should be a deterrent.

Finally, if the bill is passed, Ahpra will be tasked with implementation of the changes nationally. Tribunals will also need time to establish the reinstatement order procedures. We expect 12 months will be needed for these activities. For Ahpra and the national boards, the changes to support permanent publication of additional information on the public register will require dedicated resources to carefully consider professional misconduct findings that date back to the start of the national

scheme in July 2010. There have been 1,265 findings of professional misconduct that involved sexual misconduct and/or sexual boundary violations, so our legal team will need to carefully review those matters to identify those that are in scope and the information that is to be published. Internal protocols will need to be agreed with national boards, procedures and policies will need to be updated and system changes will need to be made.

Practitioners rightly expect procedural fairness and natural justice in our regulatory work. We recognise the concerns expressed by some stakeholders about information being published permanently on the national register. These concerns are best addressed through the safeguards in the bill and by Ahpra ensuring we have clear protocols and parameters in place. We will engage with key stakeholders on our implementation activities and publish guidance to ensure full transparency. Thank you again for the opportunity to appear today. We welcome any questions that you may have.

**CHAIR:** Thank you, Ms Ayscough. I invite Dr Coulson Barr to make an opening statement on behalf of the Office of the Health Ombudsman.

**Dr Coulson Barr:** Thank you for the opportunity to appear today before the committee for your inquiry into the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2024. This bill contains amendments to the Health Ombudsman Act 2013 and modifications to the Health Practitioner Regulation National Law (Queensland) to support the national law to be applied in Queensland as the co-regulatory jurisdiction. I am Lynne Coulson Barr, the Health Ombudsman in Queensland. I am joined by Prue Beasley, the director from the Office of the Health Ombudsman that we refer to as the 'OHO'. We also start by acknowledging the traditional owners on the lands where we meet today and paying our deep respects to elders past, present and emerging.

I would like to echo the statements and comments by Ms Kim Ayscough, the acting CEO of Ahpra, in welcoming the introduction of this bill. It proposes changes which clearly align to the paramount principles of protecting the public health and safety of the national law and of the Health Ombudsman Act 2013. The proposed amendments will not only support the objectives of maintaining public confidence in registered health practitioners and the safety of health services but also the confidence in our service complaints system. The OHO provided a submission in support of the proposed amendments which I will briefly summarise. Some of the points will echo those outlined by Ms Ayscough.

Firstly, I support the proposed amendments to publish disciplinary action taken against health practitioners who have been found by a tribunal to have engaged in serious sexual misconduct. Publication of these findings on the public register will assist the public to make informed choices when accessing the health services provided by registered health practitioners. This provides greater transparency and will better meet community expectations, as Ms Ayscough outlined.

Any sexual exploitation by a registered health practitioner is an egregious abuse of trust. It can result in profound and long-lasting impacts on victims. Sexual misconduct by registered health practitioners can erode public confidence in these professionals and erodes confidence in the safety of health services more broadly. The publication of these disciplinary findings against practitioners should also have a deterrent effect on other practitioners from engaging in sexual misconduct. I am of the view that there are appropriate safeguards built into the bill pertaining to publication, including that the boards retain their discretion not to publish regulatory history information for health and safety reasons. Ms Ayscough has just commented on those safeguards.

A secondary reform in the bill which we support is the introduction of a new requirement for cancelled or disqualified practitioners to apply for and obtain a reinstatement order from the responsible tribunal before applying for re-registration. I understand that the respondent to the application by the practitioner will be whichever regulator brought the disciplinary proceedings originally, and therefore in Queensland it will either be the Health Ombudsman or the national board. My view is that this amendment will provide a nationally consistent approach to reinstatement orders and provide the public with greater transparency.

Further, I note and support the proposed amendment to section 107 of the Health Ombudsman Act. This amendment will remove the wording of indefinitely disqualifying a practitioner. Instead, it will stipulate clearly that the tribunal may impose a sanction that either permanently disqualifies a practitioner or disqualifies or cancels their registration for a specified period.

Thirdly, and lastly, we support increased protections from reprisals, threats and intimidation for notifiers who make a notification in good faith. I note that the national law currently does not contain an offence for reprisal. This is in contrast to the Health Ombudsman Act, which has existing

protections from reprisals. Those are in sections 261 to 263 of our act. I am supportive of this amendment to the national law and the corresponding amendment to section 261 of our act because it will extend the protections by prohibiting threats and intimidation as well as reprisals. It is critical that people who make complaints and notifications about their concerns about health practitioners feel safe from reprisals, threats and intimidation.

I also support the amendments to the Health Ombudsman Act and the national law to void non-disclosure agreements which prevent or restrict a person from making a health service complaint or notification under the national law. These amendments also serve to increase the protections for people who seek to raise their concerns about registered practitioners. Thank you again for the opportunity to speak to our submission. We welcome any questions you may have.

**Mr J KELLY:** In relation to retrospectivity, why is that thought to be necessary?

**Ms Ayscough:** The intention of these amendments really is largely around improving public protection. It is about better improving the information available to the public so they can make choices about their healthcare provider. The amendments emanated from concerns raised by members of the public that there were practitioners on the national register of practitioners who have a history of sexual misconduct which is invisible to the patient when they are seeking to make decisions about their health care. Members of the public are obviously continuing to make decisions about practitioners where a sexual misconduct finding has occurred since the commencement of the national scheme. If you take account of that intention to ensure the public has access to information to inform their healthcare choices, then the retrospective nature of the amendments makes sense.

**Mr J KELLY:** In terms of the proposal to effectively have two different bodies handling decisions around reinstatement, what was the genesis of that? What was the reasoning? Why do we need to go down that path? What caused the ministers of various governments to make that decision? What problem are you trying to solve?

**Ms Ayscough:** I think once again it was questions from members of the public about how it was that practitioners who had a significant history were able to be re-registered and practising. The decisions that are made currently in all jurisdictions apart from New South Wales are decisions made by national boards, which means they are decisions that are very carefully considered. Reasons are articulated, but the hearings are not public and the decisions are not published. The intention of the reinstatement order, which already applies in New South Wales, is to give to tribunals the ability to test the suitability of the person seeking to return to registration after a cancellation or a period of disqualification and to improve transparency to that decision-making process.

**Mr J KELLY:** If we accept that, why do that twice? You are saying you have a board that has clearly shown it was incapable of operating on judicial principles. To remedy that situation you are introducing a judicial process. Why replicate that? Why not just do that once with a proper judicial system?

**Ms Ayscough:** I did not make any comments about the capability of the boards making the decisions. My comments were around transparency and the publication of reasons, which is not part of the process.

**Mr J KELLY:** With respect, you said there were people slipping through the net. If there are people slipping through the net, how does taking a second body and putting that underneath that stop that? You do that by having a judicial system. Why would you have two systems instead of just one judicial system if that is in fact the problem that is occurring?

**Ms Ayscough:** I do not want to be argumentative but I do want to be clear: I did not say there were people slipping through the net. I said there was a misunderstanding by the public about how it could be that practitioners who had previously been found guilty of misconduct—and in this case, sexual misconduct—could be re-registered. The public did not understand the process by which the decisions were made to return those practitioners to the register. I do not call into question the capability of national boards to make that decision.

In response to that lack of understanding, these amendments intend to make the process more transparent so it is more open for the public to understand the basis on which the decisions are made. The primary reason for a two-stage process is that the tribunal will consider all of the evidence that relates to the suitability for registration, but there are other requirements that national boards need to take into account when deciding whether to register a practitioner; for example, questions of recency of practice. The intention is that the tribunal will consider that suitability in the reinstatement order. The board will then take into account all of the other registration requirements and ensure that the person is suitable and meets those requirements before registration.

**Mr J KELLY:** From the perspective of dealing with matters that may relate to sexual misconduct, are you in effect saying that if a tribunal makes a recommendation to a board that the person is suitable to practice again then the only elements for the board to consider are things like recency of practice and all of those other things that boards consider: whether they have professional indemnity insurance, whether they have continuing professional development and those sorts of things?

**Ms Ayscough:** The board would consider the reinstatement order made by the tribunal plus the additional requirements that are set out in those registration standards.

**Mr J KELLY:** Would the board reach a different decision on the reinstatement order?

**Ms Ayscough:** The only history we have is to look at the way reinstatement orders have applied in New South Wales. In the history of the national scheme, whilst New South Wales has had this requirement for a reinstatement order via the tribunal, there have been 28 matters where a person who obtained a reinstatement order has applied for registration. In 27 of those cases the practitioner was registered and in the 28th case the practitioner withdrew their application for registration because there were concerns raised by the Medical Council of New South Wales. That is the history of how reinstatements orders have worked. Even in New South Wales the reinstatement order is made by the jurisdictional tribunal. The registration decision is still made by the national board. That demonstrates the board's history in dealing with reinstatement orders.

**Mr J KELLY:** Submitter after submitter has said to this committee via their submissions that people will effectively be going through the exact same process twice. How do you respond to that?

**Ms Ayscough:** As I have said, there are different elements of the requirements for registration to be considered by each body. The tribunal will consider the original decision around the misconduct and the suitability of the person applying for the reinstatement order at that point in time. The board needs to take account of the reinstatement order plus the additional requirements for registration which are not considered by the tribunal.

**Mr J KELLY:** So if in 27 out of 27 cases in New South Wales—let's put aside the one person who did not bother to proceed because they probably knew they would not get through for whatever reason—the board has clearly accepted the recommendation of the tribunal, why do we even have this discussion? If the tribunal says they are fit to go back to work, then barring failure of recency of practice, CPD, indemnity insurance and all of those other tests, why do we need this second level of consideration of that particular matter?

**Ms Ayscough:** I think the answer is actually in the question: because issues of recency of practice, CPD, indemnity insurance et cetera are issues for consideration by the national board but they are not issues for consideration by the tribunal.

**Mr J KELLY:** If someone was not accepted would the board publish decisions as to why they were not accepted?

**Ms Ayscough:** Do you mean if an application for registration was refused by a board?

**Mr J KELLY:** Yes.

**Ms Ayscough:** No, they do not publish those decisions. They provide the decision and the reasons to the—

**Mr J KELLY:** How would I know why I was being knocked back?

**Ms Ayscough:** They provide the decision and reasons to the applicant but they do not publish those reasons.

**CHAIR:** If I can just expand on that line of questioning. Essentially, what you are saying is that QCAT is really looking at the broader moral issues around reinstatement and suitability and whether they are a recidivist or not. What you are suggesting—what I think I am hearing—is that the medical board actually looks at their ability to do the job, not so much the morality of how they have behaved in the past. Is it spelled out in the legislation that there are two very distinct roles or levels of assessment required by the two different bodies, or does it just happen by inference?

**Dr Orchard:** It is not set out expressly, is the simple answer. As has been indicated earlier, there is still that two-step process: to make an application for the reinstatement order; then for the secondary application back to the board for the board to consider. That is when the board will consider those additional factors Ms Ayscough referred to earlier. We should also note that there may well be

cases in which there is a break in time between the reinstatement order being made and the application for registration being made. The fact that the practitioner seeks and obtains a reinstatement order means they are entitled to apply for registration. It does not mean they are going to do that immediately. It might be that they take some time in which to make that application. Other aspects might arise in that timeframe that the board will need to consider in making the final decision about the application.

**Ms DOOLEY:** Thank you for being here. We appreciate your submissions and your presentations. My question relates to public education. Ms Ayscough, in your presentation you indicated that by looking at retrospectivity the public then has an opportunity to look at a health practitioner they may or may not want to see. The Australian Lawyers Alliance presentation this morning did highlight that. I note that they are the only ones—plus yourselves—who have indicated that. Do you want to speak to that as well and what that might look like? The ALA did give some indication of what public education might look like.

**Ms Ayscough:** We do not have a specific plan around public education at this point in time, but I would refer to the comment I made in my opening remarks about the requirement for 12 months to prepare for the implementation of these changes. First of all, that is because of the very careful work that is going to be required to determine which matters are in scope and which information should be published about those practitioners. We will also need to develop and would intend to publish protocols, for example, so there is clarity for everybody about how these amendments are being operationalised. We publish a regulatory guide which provides more detail about our regulatory processes, particularly as they relate to if I can use the summary language of complaints and discipline processes. We publish a regulatory guide that sets out in some detail how those processes work. We would certainly need to look at what kind of education both for the public and for practitioners would be appropriate in implementing those changes.

**Ms BOLTON:** I am loath to go back to this but I still need some clarification. The Queensland Law Society proposed that if the tribunal were to publish its decisions that would be just as effective as having the board review. It would achieve the same outcomes. From what I understand you are saying, the board looks at other things besides that. For clarity, what the QLS put forward would not address the full intent of the legislative changes and what they aim to achieve?

**Ms Ayscough:** Can I check that we are talking about the reinstatement orders because there are two different things?

**Ms BOLTON:** Yes.

**Ms Ayscough:** In terms of reinstatement orders, yes. The proposal that those matters are considered by a tribunal means that the tribunal will consider the evidence and, generally speaking, tribunals' decisions and their reasons are published. When a national board considers an application for registration, that is essentially a personal application by a practitioner seeking a decision of the board. The board's decision is communicated in detail to the practitioner including the reasons for their decisions and only the outcome of the decision is published on the national register at the moment. If a person has had a history of misconduct and is re-registered by a national board, the reasons for that decision will be communicated to the practitioner, but the public online register of practitioners, where a member of the public might go to read the details about their qualifications and any limitations on the registration of the practitioner, will simply record the fact of their registration and only any current restrictions that might apply to their registration. At the moment there is no indication that there have previously been limitations on a person's right to practise. The register only includes the information that applies as at the day of the search.

**Ms BOLTON:** If that process changed, would that then avoid the duplication that appears to be occurring?

**Ms Ayscough:** In this amendment bill we do have the changes that deal with both of those things. First of all, there is an amendment that proposes to publish in perpetuity the relevant history of a practitioner who has been found guilty of professional misconduct relating to sexual misconduct so that that information will always be available on the public register to inform a member of the public who is making a decision about their health care. The second amendment that we are talking about here in terms of reinstatement orders tackles a slightly different question which is the question of how is it that a person who has previously been found to have sexual misconduct as professional misconduct is now able to be a registered practitioner? It is a slightly different question. One is about the restrictions on registration; the other is about suitability for registration at all. They are the two different questions that the public were asking which caused ministers to consider these amendments in this bill.

**Ms BOLTON:** The QLS had concerns around the capacity of QCAT to expedite reinstatement orders. Do you have similar concerns?

**Ms Ayscough:** Once again, in my opening remarks I referred to the requirement for 12 months for Ahpra, the national boards and the tribunals to be ready to implement these changes. When we look at the data, I have shared already the number in New South Wales where this reinstatement order already applies. We anticipate that probably fewer than 10 practitioners per year across the whole of the country might seek a reinstatement order. Think about the numbers I just shared around New South Wales. That is 28 practitioners over 15 years. If we extrapolate that across the country—we know how many practitioners have their registration cancelled and disqualified relating to sexual misconduct—we anticipate, as I said, probably no more than 10 practitioners across the whole of the country. QCAT as a large jurisdiction might get a reasonable share of those, but we are not anticipating significant numbers of practitioners who will be needing to seek reinstatement orders.

**CHAIR:** We are over time, but both of you are appearing at a public briefing on other matters, so I will allow a quick question from the member for Hervey Bay.

**Mr LEE:** The bill proposes discretionary power to make a decision by necessary implication or by necessary inference. I am interested to know what matters you would take into consideration when exercising that discretion.

**Dr Orchard:** I think you are referring to the decision to publish information on the register. It is a mandatory requirement under the proposed bill that in circumstances where the board does form that view—that it is a finding of professional misconduct on the basis of sexual misconduct—the certain information will be published on the register. At the moment, and in the past, the concept of sexual misconduct in tribunals has not been one that tribunals have found necessary to determine—that is, when they are looking at conduct and they are determining whether there is professional misconduct they do not specifically refer to the conduct as being sexual misconduct or otherwise. What that means is that there is currently a large number of findings of professional misconduct which might fall within the description of the bill as being sexual misconduct but the tribunals have not used that expression. That will fall upon the board to determine whether that professional misconduct is in fact sexual misconduct such that it gives rise to it. It will be necessary for the board to make that decision. That is why it is unavoidable that the board will have to make an inference as to whether the tribunal was finding professional misconduct on the basis of sexual misconduct.

**Mr LEE:** Presumably that is based on case law.

**Dr Orchard:** Yes. You will find in the vast majority, if not all, of those findings of professional misconduct where there has been some form of sexual misconduct that the tribunal simply has not referred to sexual misconduct. They simply refer to professional misconduct.

**Dr O'SHEA:** Thank you for coming in and for your submissions. I know it all takes a lot of time. At the start of Ahpra's submission they mentioned that the Australian health ministers brought in these amendments that the patient should be aware of previous serious sexual misconduct. It is all very well intentioned. When you look at the bill, it talks about professional misconduct where sexual misconduct may not be the sole or the main basis for the finding of professional misconduct. Do you have any concerns about that and the wording of the bill?

**Dr Orchard:** As Ms Ayscough said earlier, it will be necessary to publish some guidelines to make it very clear how that expression will be interpreted and applied. That will need to be done in the context of the particular matter. It may be that some aspects that might not normally be regarded as sexual misconduct in the context of all of the facts do give rise to a finding of sexual misconduct. For example, a sexual inappropriate remark or a sexual innuendo on its own may not be professional misconduct and, in fact, probably would not find its way to the tribunal, but if you put that in the context of a practitioner undertaking some form of intimate examination and making a sexualised comment or a sexual innuendo in the course of doing so then it is quite likely that that would be seen as sexual misconduct. In the circumstances, the ministers had intended that sexual misconduct be a broad concept, not a narrow concept. Nonetheless, it will be necessary to provide that guideline to make sure it is clear to everyone how that will be interpreted and applied.

**Dr O'SHEA:** Rather than the board having to make a necessary inference, if this bill is adopted nationally, would it not be more sensible for tribunals to be asked to make very clear statements about their decision in terms of professional misconduct and sexual misconduct rather than the boards then having to infer from the findings?

**Dr Orchard:** I expect going forward that is quite likely—that in tribunal proceedings you will see either the representatives of the board or representatives of the practitioner making submissions about whether this is sexual misconduct or not and maybe seeking a positive finding from the tribunal in that regard. That may well be how it occurs, and I suspect it will be. Looking backwards, we have

that batch of 1,265 matters that need to be considered. In those matters it is unlikely that the tribunal would have made a finding about sexual misconduct.

If we only focused on looking forward and we are only looking at the new cases that flow, then the public would end up with a distorted view. They would end up with a view of those practitioners in the future who were found to have engaged in sexual misconduct but those from last year who might have engaged in equally or more serious sexual misconduct would not have that material on the register. That would create a distorted view for the public. That is why it is necessary to take a look back and to continue it into the future.

**Dr O'SHEA:** With those 1,200 cases, I see it is the Ahpra legal team who would be reviewing those. Would those tribunal decisions go to the board then?

**Dr Orchard:** Yes. The board is the decision-maker in this process. The board is empowered to delegate. They might delegate that power to a committee. Nonetheless, the initial assessment would be undertaken by lawyers in accordance with the guidelines that will be developed by the board, but the board would be the ultimate decision-maker in deciding whether to publish.

**CHAIR:** We are out of time. Thank you, Dr Orchard. That concludes this hearing. Thank you to everyone who has participated today. Thank you to our Hansard reporters. A transcript of proceedings will be available on the committee's webpage in due course. We had no questions taken on notice. I declare this public hearing closed.

**The committee adjourned at 1.12 pm.**