MIGA submission

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

Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2017 inquiry

July 2017

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Executive Summary – MIGA's position

1. MIGA's position on the following proposals in the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2017 **(the Amendment Bill**) is:

- **immediate action powers** (cls 24 and 65 of the Amendment Bill, relating to s 156 of the National Law and s 58 of the *Health Ombudsman Act*):
    - it opposes the proposed changes to immediate action powers (as they would create inconsistent regimes across Australia) to take action based on 'public interest' considerations
    - a proposed immediate action power based on public interest grounds broader than that already in place in New South Wales is neither necessary nor appropriate
- **requesting and disclosing information** (cls 20, 39, 80 and 82 of the Amendment Bill, relating to ss 132 and 206 of the National Law and ss 279 and 282 of the *Health Ombudsman Act*):
    - in general, it supports appropriate collection of practice information from practitioners, and disclosures of disciplinary or enforcement action taken against practitioners to others where necessary, but it is concerned how the proposed amendments may lead to unnecessary information requests from practitioners, or inappropriate disclosures of action taken against a practitioner to other colleagues or bodies
    - it is also concerned that such unnecessary disclosures may impose uncertain obligations on those recipients
    - it sees further work on these issues is required, and that the opinions of both MIGA and other key stakeholders are necessary in the development of foreshadowed guidelines by the National Boards and AHPRA on this issue
- **splitting matters** (cl 64 of the Amendment Bill, relating to a proposed new s43A of the *Health Ombudsman Act*) – it opposes the proposed provision, where it is inappropriate to have both the Health Ombudsman and the Medical Board / AHPRA dealing with the same matter
- it supports a number of other changes proposed in the Amendment Bill, subject to appropriate clarifications or further changes being made to some proposals to ensure the provision of procedural fairness to practitioners

MIGA's interest

2. MIGA is a medical defence organisation and medical indemnity insurer advising, assisting and educating medical practitioners, medical students, health care organisations and privately practising midwives throughout Australia.

3. With over 30,000 members and a national footprint, MIGA has represented the medical profession for over 115 years.

4. MIGA's role includes advising and assisting its members through professional regulatory and disciplinary processes throughout Australia, including those with the Queensland Health Ombudsman, the Australian Health Practitioner Regulation Agency (**AHPRA**) and the Medical Board of Australia (**the Board**).

5. Through its Risk Management Program, MIGA educates the profession about regulatory and disciplinary processes, and focuses on understanding and minimising the causes of patient complaints.

6. By its advocacy and policy work, MIGA has had significant involvement in the development of the medical regulatory and disciplinary system, both in Queensland and the rest of Australia. Its recent work includes written submissions, oral evidence and stakeholder consultations in the context of the:

    - Queensland Parliamentary inquiry into the performance of the Queensland Health Ombudsman's functions

    - Commonwealth Senate inquiries into both the medical complaints process in Australia and the complaints mechanism administered under the *Health Practitioner Regulation National Law*

    - COAG Health Council and Queensland Health Department consultations on proposed changes to the *Health Practitioner Regulation National Law* (**the National Law**) and the *Ombudsman Act 2013* (Qld)

    - independent review of the use of chaperones to protect patients in Australia, commissioned by the Board and AHPRA

    - the Board consultation on revalidation for the medical profession

Proposed public interest test for taking immediate action

7. MIGA opposes the proposed amendments to powers to take immediate action against practitioners, as set out in cls 24 and 65 of the Amendment Bill, relating to s 156 of the National Law and s 58 of the *Health Ombudsman Act*, where the proposed test for taking action on 'public interest' grounds is too broad, and inconsistent with that already in place in New South Wales.

(a) Proposed power is too broad and uncertain

8. The proposed amendments to immediate action powers add an additional basis for action, namely that the Board or the Health Ombudsman may take immediate action if they reasonably believe such actions to be in the 'public interest'.

9. MIGA's opposition is to the proposed threshold for taking immediate action on public interest grounds, not the proposed power to take action on those grounds of itself.

10. The proposed 'reasonable belief' threshold for taking immediate action on public interest grounds is out of step with the existing New South Wales test. This test is consistent with the United Kingdom test. Both the New South Wales and United Kingdom tests are based on a 'satisfaction' threshold.

11. There is no reason why the test should be inconsistent with that already in place in New South Wales. It is in the interests of practitioners, the public and the national regulatory scheme to have consistent regimes wherever possible. There is nothing to suggest the New South Wales test is insufficient.

12. 'Reasonable belief' provides a considerably lower threshold for taking immediate action on public interest grounds than does the requirement to be 'satisfied' action is in the public interest.

13. Decisions on immediate action are normally made at an early stage, on an urgent basis and with limited information. They can have a very serious effect on a practitioner's practice and mental health, particularly if suspended or subject of significant restrictions.

14. Accordingly, the 'reasonable belief' test should be substituted with a 'satisfaction' test for taking action on public interest grounds.

15. Below we provide further information about how the existing test operates elsewhere, why it is appropriate, why the proposed changes are different to the existing test and why it is inappropriate for inclusion in the National Law.

16. MIGA is uncertain about what is meant by the comments in the Amendment Bill Explanatory Notes (**the Explanatory Notes**) (see p32) about the current threshold for immediate action being "*problematic*" given a number of recent cases.

17. The Explanatory Notes indicate that in relation to Djerriwarrh Health Services in Victoria, a Board/s could not take immediate action because evidence presented did not meet the required threshold. From the various reports of investigations and reviews into the Djerriwarrh matter, and AHPRA's public statements on the matter, issues with the immediate action threshold have not been apparent. Notably, AHPRA's press release of 10 March 2017 refers to immediate action having been taken against five practitioners.

18. The broader issues associated with the Djerriwarrh matter should not trigger changes to immediate action powers where there does not appear to have been an issue in that matter about the present scope of those powers.

(b) Existing public interest tests for immediate action

19. The proposed amendments contemplate the immediate action powers already in place in New South Wales as being sufficient to provide what is considered to be the necessary public interest grounds for taking immediate action.

20. MIGA does not agree with the assertions on pages 13 and 43 of the Explanatory Notes, namely that:

    - the National Law as it applies in New South Wales contains a "*similar*" public interest test

    - the proposed changes to immediate action powers align them with the grounds on which immediate action can be taken in New South Wales

21. As set out above, in New South Wales the test for exercise of immediate action powers on public interest grounds is whether a professional council (equivalent to the Board in other jurisdictions) is 'satisfied' an action is in the public interest (s 150 of the *Health Practitioner Regulation National Law (NSW)*).

22. The position in New South Wales is consistent with that in the United Kingdom (s41A of the *Medical Practice Act 1983* (UK)).

23. This is a higher threshold for action than the proposed test in the Amendment Act of 'reasonable belief' of immediate action being in the public interest.

(c) Difference between 'reasonable belief' and 'satisfaction'

24. There are significant differences between what constitutes 'reasonable belief' and 'satisfaction' for a decision-maker in determining whether to take immediate action under the National Law.

25. The term 'belief', in a legal sense, has been defined as "*...an **inclination of the mind towards assenting to, rather than rejecting, a proposition** and the grounds which can reasonably induce that inclination of the mind may, depending on the circumstances, leave something to surmise or conjecture*." Reasonable grounds for a belief "*...requires the existence of facts which are sufficient to induce that state of mind in a reasonable person.*" (*George v Rockett* (1990) 170 CLR 104 at [8] and [14]).

26. By contrast, the term 'satisfied' fits with the '*Briginshaw*' standard, namely that:

> "*reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The **seriousness of the allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations** which must affect the answer to the question whether the issue has been proven to the reasonable satisfaction of the tribunal. In such matters **'reasonable satisfaction' should not be produced by inexact proofs,***

> ***indefinite testimony, or indirect inferences***." (*Briginshaw v Briginshaw* (1938) 60 CLR 336, Dixon CJ at 362)

27. The *Briginshaw* standard applies to the test of whether a professional Council is 'satisfied' as to the need for suspension or imposition of conditions on public interest grounds under s 150 of the *Health Practitioner Regulation National Law (NSW)* (*Crickitt v Medical Council of NSW (No2)* [2015] NSWCATOD 115 (***Crickitt***) at [56]).

28. By contrast, the Western Australian State Administrative Tribunal (**WASAT**) has held that:

> "[u]*nder s 156 of the National Law, the Board, and therefore the Tribunal,* ***needs only to form a reasonable belief that the practitioner poses a serious risk to persons and that it is necessary to take immediate action to protect the public health or safety. We do not consider that the Briginshaw approach is appropriate****."* (*R and the Medical Board of Australia* [2013] WASAT 28 ***(R's* case**) at [106]).

29. The Tribunal in *R's* case distinguished and did not follow the earlier case of *Bernadt and Medical Board of Australia* [2012] WASAT 120, where it had been decided "*...the Tribunal must feel an actual persuasion of the occurrence or existence of the relevant facts, under the* Briginshaw *principle or approach, in order to form a reasonable belief under s 156 of the National Law...*" (at [27]).

30. Although both cases involve exercise of power under s 156 of the National Law, it was suggested in *R's* case that "*...the statement in Bernadt has been taken out of its context. The matter in Bernadt was heard over five days and ... proceeded much as though it was the hearing of an allegation of professional misconduct against the practitioner. It did not proceed as a preliminary matter pending determination of the substantive complaint about the practitioner...*" (at [105]).

31. The approach in *R's* case has been followed in Queensland (*Shahinper v Psychology Board of Australia* [2013] QCAT 593), left undecided in the Northern Territory (*Nitschke v Medical Board of Australia* [2015] NTSC 39) and not yet considered in other National Law jurisdictions.

32. In those circumstances, it cannot be said that the proposed public interest test for immediate action is similar to, or aligns with, that in New South Wales.

(d) Appropriateness of existing New South Wales test

33. There is no evidence to suggest the immediate action power on public interest grounds is not discharged appropriately in New South Wales, or that the test based on a standard of satisfaction is unduly restrictive.

34. The New South Wales model should be implemented first before the proposed broader power is contemplated.

35. As indicated in the Explanatory Notes Prof Ron Paterson, who recently conducted the *Independent review of the use of chaperones to protect patients in Australia*, supports the inclusion in the National Law of public interest grounds for taking immediate action on the basis of the New South Wales model involving a satisfaction threshold, not a different model (p32).

36. In *Crickitt*, the New South Wales Civil & Administrative Tribunal explained why the 'satisfaction' test, based on the Briginshaw standard, is required in immediate action cases. It observed:

> **"[t]*he exercise of a power to suspend will have grave consequences for a medical practitioner*,** *affecting not only the ability to earn a livelihood, but also the continuing ability to use his or her professional skills…* ***The grave consequences are accommodated within the need to ensure that we are satisfied to the Briginshaw standard*** *that we can safely make the conclusions necessary to make a determination that section 150* [of the Health Practitioner Regulation National Law (NSW)] *is enlivened…* ***the "draconian" nature of the power is such that great care needs to be taken to ensure that there is some proper and appropriate basis for making any order****…"* (*Crickitt* at [56(1) and (4)]).

(e) Varying thresholds for immediate action

37. There appears to be some suggestion that the use of the test of 'reasonable belief' is necessary in order to align with the language of s 156 of the National Law and s 58 of the *Health Ombudsman Act* (Explanatory Notes, p43).

38. It is unclear why these sections cannot contain different criteria for taking immediate action..

39. Already s 156 of the National Law provides different threshold tests for taking immediate action. 'Reasonable belief' of serious risk to persons or need to protect public health and safety is the threshold under ss 156(1)(a) and (b) of the National Law. By contrast, the existence of a certain state of affairs, namely improperly obtained registration or cancellation of registration elsewhere, is the threshold under ss 156(1)(c) and (d) of the National Law.

40. There is also already inconsistency between the respective tests under s 156(1)(c) of the National Law on the one hand, and s 58(1)(b) of the *Health Ombudsman Act* on the other, relating to the threshold for taking immediate action based on improperly obtained registration. As set out above, the former provides for action based on the relevant state of affairs being in existence, but the latter based on a "*reasonable belief*" of that state of affairs.

41. Differing thresholds for immediate action already exist under s 150 of the *Health Practitioner Regulation National Law (NSW)*. The threshold for taking immediate action on the grounds of protection of public health and safety is where a decision-maker is "*satisfied that it is appropriate*". By contrast, the threshold for taking action on public interest grounds is that the decision-maker is "*satisfied the action is otherwise in the public interest*".

42. There is no reason why a test for immediate action in the public interest, based on a test of satisfaction as under s 150 of the *Health Practitioner Regulation National Law (NSW)*, cannot be included in s 156 of the National Law, and s 58 of the *Health Ombudsman Act*.

(f) The uncertainty of what constitutes 'public interest' grounds

43. Introduction of a 'public interest' test for immediate action is a new concept for the National Law.

44. The circumstances in which a 'public interest' may arise can be quite distinct from other circumstances which may warrant immediate action, namely serious risk to persons, protection of public health and safety, improperly obtained registration or cancellation of registration elsewhere.

45. It is potentially a very broad power with uncertain boundaries. There is considerable scope for reasonable minds to differ over what constitutes 'public interest'.

46. Even in New South Wales, where both the Medical Council of New South Wales and its predecessor Medical Board of New South Wales have had the power to suspend or impose conditions on practice on public interest grounds for many years, it has been observed that:

> "[t]*here is very little consideration within the provisions of the* [Health Practitioner Regulation National Law (NSW)] *as to the manner in which the Council or its delegates are to conduct themselves in determining whether the necessary preconditions to the use of the available powers under section 150 are satisfied"* (*Crickitt* at [56(7)(h)]).

47. The present AHPRA regulatory principles (referred to on p31 of the Explanatory Notes) are insufficient and too generalised to provide appropriate guidance on taking immediate action on public interest grounds.

48. The development of detailed guidance for immediate action decision-makers, prepared in consultation with key stakeholders such as MIGA, would be the best way of dealing with this relative void. It would reduce the risks of inconsistency and inappropriate exercise of (or failure to exercise) immediate action powers.

49. In *Crickitt* the Court gave some consideration to what should be considered in the context of 'public interest', namely:

> "*the need for patients to have confidence in the competence of medical practitioners and that medical practitioners will exhibit traits consistent with the honourable practice of an honourable profession. Integrity, trustworthiness and high moral and ethical values are an integral part of the practice of medicine, as is compliance with regulatory requirements and codes of practice established by those responsible for the administration of the medical profession. The public must have confidence that medical practitioners who treat them exhibit these traits*." (at [56(7)(f)])

This is a good starting point for development of detailed guidance for immediate action decision-makers, prepared in consultation with key stakeholders such as MIGA. Ultimately what was given in *Crickitt* was broad guidance, and there is considerable scope for various decision-makers to reach different conclusions using the above criteria, without further guidance.

50. In addition, it is uncertain whether the proposed public interest ground for taking immediate action would include issues of public health and safety.

51. In New South Wales, issues of "*health and safety*" are subsumed within 'public interest' (*Crickitt* at [56(7)(c), see also *Reid v Medical Council of NSW* [2014] NSWCATOD 152 at [102]) . This is in the context where s 150 of the *Health Practitioner Regulation National Law (NSW)* is expressed as providing alternative bases for action based on "*protection of the health and safety of any person or persons*" or where it is "*otherwise in the public interest*".

52. In the context where the proposed changes provided for 'public interest' grounds as a distinct basis for immediate action, the extent to which public health and safety concerns would be subsumed within 'public interest', or otherwise operate independently of them, is unclear and would need to be clarified.

(g) Issues with use of an example for immediate action on public interest grounds

53. MIGA also has concerns about the example "*of when action may be taken in the public interest*" included in the proposed changes to s 156 of the National Law and s 58 of the *Health Ombudsman Act*.

54. The example given is of a practitioner being charged with a serious criminal offence, unrelated to their practice, for which immediate action is required to maintain public confidence in the provision of services by health practitioners.

55. Although this can be an appropriate circumstance for immediate action in the public interest, inclusion of this example in legislation is inappropriate, unhelpful and potentially confusing.

56. The phrase "*Example of when action may be taken…*" can be interpreted not just as an example of when action can be taken, but also of circumstances where action is warranted. The term 'may' can be interpreted to mean a justified set of circumstances.

57. Inclusion of but one of a range of possible examples which may warrant immediate action in the public interest could create an impression of this being a circumstances where it is most likely there is a 'reasonable belief' that such action is in the public interest.

58. In *Crickitt,* involving a medical practitioner charged (but not at that point convicted) with the murder of his wife, the NSW Civil & Administrative Tribunal observed:

> "[o]*n one basis, it might be appropriate to quarantine the* [practitioner's] *misconduct to that of his treatment of his wife, and on this basis determine that there are insufficient grounds to conclude that section 150* [of the Health Practitioner Regulation National Law (NSW)] *applies."* (*Crickitt* at [75]).

In that case, the Tribunal upheld the original decision to suspend, but on arguably broader grounds. This of itself shows:

- the scope for uncertainty around what constitutes 'public interest' even where such powers have been in place for some time
- the danger of putting examples in legislation which may be interpreted to be in the imperative, or at least as a prima facie case warranting immediate action

59. Accordingly, there is a need for an appropriate body, in consultation with key stakeholders such as MIGA, to develop guidelines around the exercise of immediate action powers on public interest grounds.

Further immediate action issues

60. More broadly, MIGA is concerned about the discrepancy between the existing scope for exercising immediate action powers in New South Wales, based on a 'satisfaction' standard, and those elsewhere in Australia, based on a 'reasonable belief' standard.

61. Ultimately, the effect is that practitioners outside New South Wales are more likely to be subject of immediate action than a practitioner in New South Wales based on the same facts.

62. There is no evidence to suggest the New South Wales immediate action regime does not protect public health and safety properly, or does otherwise not function appropriate.

63. In addition, and as it raised with the Committee's inquiry into the performance of the Health Ombudsman's functions last year, MIGA remains concerned about both the Board and the Health Ombudsman holding immediate action powers.

64. Other states and territories, including the only other co-regulatory jurisdiction of New South Wales, place such powers in the hands of one body only.

65. For reasons of fairness and consistency, those powers should reside in one body only.

Requesting practice information and disclosure of regulatory action or other matters to a practitioner's colleagues

(a) Requests for practice information

66. Subject to the issues raised below, MIGA supports the proposed amendments to the National Law contained in cl 20 of the Amendment Bill, replacing the existing s 132 of the National Law, relating to the request of practice information from practitioners.

67. In general, the proposed amendments in relation to requiring practice information follow the current practice of regulators requesting a broader range of details to reflect the variety of

situations in which practitioners work, particularly beyond the employment relationship. This includes practitioners working as independent contractors, in hospitals and in group practices.

68. MIGA is concerned to ensure that practice information requested is relevant to the matter at hand. Unnecessary, broad requests for detailed information must be avoided.

69. It is unclear why a Board would require practice information as contemplated under the proposed ss 132(1) and (4)(a) of the National Law, where a practitioner is self-employed, not subject to any control of their practice by others with whom they share premises (such as would generally be the case in a hospital or group practice) and does not see the same patients as the other registered health practitioners with whom they share premises.

70. It is appropriate for a Board to have the power to require practice information where practitioners may interact with each other in the provision of health care, or where a person or body has some form of control over a practitioner's provision of health care, such as through a supervisory or business arrangement. For example, it is appropriate for the Board to have the power to require practice information where practitioners may see the same patients, such as general practitioners each practising in the same location who may share or 'cover' each other's patients, or general practitioners and specialists at the same location where there may be referral and return of care between those practitioners. Similarly, it is appropriate to request information of hospitals and group practices where practitioners work.

71. The mere sharing of costs of premises does not of itself involve control over another practitioner's provision of health care. If a practitioner's practice is unrelated to that of another practitioner or body, the mere fact of those persons or bodies being at the same location should be insufficient to warrant the request of practice information about those unrelated persons or bodies. For example, two practitioners in different specialities or professions may be at the same location, but would never refer patients to each other, nor would they exercise any control over each other's practices. In those circumstances, there is no utility in requesting practice information of the other practitioner.

72. This position would appear to reflect the intention of the proposed changes. The Minister for Health's speech introducing the Amendment Bill indicates that the proposed changes are intended to protect public safety by ensuring that, irrespective of a practitioner's manner of engagement, their employer or equivalent entity is made aware of action taken (Hansard, 13 June 2017, p1544). This contemplates collection of information and disclosures of action taken only where other practitioners have some degree of control over, or effect on, the subject practitioner's practice.

(b) Disclosures of action taken

73. MIGA has concerns about the potentially broad range of circumstances in which practitioners, who are working with self-employed practitioners who are the subject of disciplinary, health, conduct or performance action or matters concerning them, would be informed of such information, and the content of such disclosures (cls 39, 80 and 82 of the Amendment Bill, amending s 206 of the National Law and ss 279 and 282 of the *Health Ombudsman Act* respectively).

74. For a Board or the Queensland Health Ombudsman to have a discretion on whether to make such disclosures is an insufficient control mechanism to deal with the variety of situations in which such disclosures would be contemplated.

75. The criteria of "*risks to the public*", "*circumstances of the case*" and "*the particular arrangements of the practice*" set out on p25 of the Explanatory Notes as bases for disclosure are vague guides to when such disclosures may be appropriate. They are unhelpful.

76. Whether such disclosures may create obligations under the National Law on the part of the recipients, and how any such obligations may operate, are unclear.

77. Further work around these issues is required, including whether factors to be considered in requesting information or disclosing action taken should be provided for in legislation, or whether protocols or policies around these issue should be developed. This work should be done in consultation with key stakeholders such as MIGA.

78. If the proposed amendments to the National Law and the *Health Ombudsman Act* remain in their current form, the contemplated AHPRA / Board guidelines on practice information will need to address these issues. The contribution of key stakeholders such as MIGA will be important during their development.

79. The contemplated guidelines should also be adopted and followed by the Health Ombudsman in the interests of fairness and consistency.

Other proposed amendments

80. MIGA has the following comments about other proposed amendments:

- **review periods for changes of conditions or undertakings** (cls 17 and 18 of the Amendment Bill, relating to ss 125 and 126 of the National Law) – it supports the proposed amendments in the interests of improving certainty for practitioners and avoiding premature applications for review, but endorses the acknowledgment in the Explanatory Notes that it may not be necessary to impose a further review period in every case of change (p17)

- **clarifying powers of co-regulatory jurisdictions** (cl 19 of the Amendment Bill, relating to s 127A of the National Law) – it supports the proposed amendments, in the interests of clarity and allowing matters to be dealt with more easily in where a practitioner resides

- **grounds for no further action** (cl 22 of the Amendment Bill, relating to s 151 of the National Law) – it supports the Board (and the Health Ombudsman) having the powers to take no further action if the complaint or other matter has been referred to another entity for any action, has already been dealt with or resolved by the Board, Health Ombudsman or another entity, or if those bodies believe the practitioner has taken appropriate steps to remedy relevant issues, meaning no further action is required

- **review of immediate action decisions** (cls 23 and 66 of the Amendment Bill, relating to s 155 of the National Law and new ss 58A and 58B of the *Health Ombudsman Act*):

  - it supports the Board having powers to revoke suspension or impose a suspension after different immediate action had been taken, so long as a similar process is followed to that as for an initial immediate action proposal, in order to ensure procedural fairness for the subject practitioner

  - it supports the Health Ombudsman having the power to review their decision to take immediate action on either an affected practitioner's application or their own initiative, which is consistent with the existing position under the National Law throughout Australia

  - the Health Ombudsman's power should be consistent with equivalent National Law provisions, which are based on a test of reasonable belief of material change in a practitioner's circumstances

- **review of health panel decision to suspend** (clauses 30, 32, 33 and 34 of the Amendment Bill, relating to ss 181, 184, 191, 191A and 191B of the National Law) – it supports the proposal to allow a health panel to review / reconsider the decision to suspend a practitioner, having similar powers to what it did initially, subject to:

  - panels proposing to proceed 'on the papers' being required to take into account the views of the affected practitioner on that proposed course when making such a decision

  - removal of the requirement for a practitioner or student to give notice requesting a hearing within 14 days, and to give an undertaking to be available for any hearing within 28 days - this may be impractical and further material may be required which cannot be obtained within that time period - the fact of a suspension being in place ensures there can be no issues of public health and safety if further time in which to convene a hearing is required – a discretion to decide a later reconsideration date does not address these issues properly, as it could well lead to considerably longer delays in dealing with reviews

- **tribunal prohibition powers** (cls 36 and 76 of the Amendment Bill, relating to s 196 of the National Law and s 107 of the *Health Ombudsman Act*) – it supports the proposed amendments to allow the relevant tribunal to make a prohibition order about the provision of any health service, on the basis that this is consistent with the position in New South Wales

- **Health Ombudsman taking action despite referral** (cl 64, relating to a proposed new s43A of the *Health Ombudsman Act*) – it opposes this proposed inclusion, where it is another form of 'splitting' of matters between bodies – it opposed matter 'splitting' in the 2016 parliamentary inquiry, and the Committee shared those concerns

- **continuing existing investigations after immediate action** (cl 68 of the Amendment Bill, relating to s 64 of the *Health Ombudsman Act*) – it supports the Health Ombudsman having the ability to continue an investigation already underway after immediate action is taken without needing to start a new investigation – a new investigation is unnecessary

- **waiver of the right to receive three monthly investigation progress reports by a health service** (clause 74 of the Amendment Bill, relating to s 84 of the *Health Ombudsman Act*) – it supports the proposed amendment, so long as the right to receive such updates is automatically reinstituted on application by the service in question

81. MIGA notes the proposals in the Amendment Bill for improving communication with notifiers.

82. In particular, there is a proposal for AHPRA and the National Boards to develop a common protocol to ensure appropriate information is disclosed to notifiers at appropriate times, taking into account privacy concerns of practitioners and patients (p16, Amendment Bill Explanatory Notes).

83. MIGA is one of the key stakeholders which should be consulted in the development of this protocol.