HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE

Members present:

Mr AD Harper MP (Chair)
Mr MC Berkman MP
Mr MA Hunt MP
Mr MF McArdle MP
Mr BL O'Rourke MP
Ms JE Pease MP

Staff present:

Mr R Hansen (Committee Secretary)
Mr R Bogaards (Inquiry Secretary)

PUBLIC HEARING—INQUIRY INTO THE HEALTH PRACTITIONER REGULATION NATIONAL LAW AND OTHER LEGISLATION AMENDMENT BILL 2018

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 5 DECEMBER 2018

Brisbane

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The committee met at 9.00 am.

CHAIR: Good morning and welcome. Before we start, can I request that mobile phones are switched off or to silent. I now declare this public hearing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee open. I would like to start by acknowledging the traditional owners of the land on which we are meeting today. I am Aaron Harper, the chair of the committee and member for Thuringowa. The other members of the committee with me are Mr Mark McArdle, member for Caloundra and our deputy chair; Mr Michael Berkman, member for Maiwar; Mr Marty Hunt, member for Nicklin; Mr Barry O'Rourke, member for Rockhampton; and Ms Joan Pease, member for Lytton. Today's hearing is part of the committee's inquiry into the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2018. The bill was referred to the committee on 31 October 2018, and we are required to report to the Legislative Assembly by 4 February 2019.

There are a couple of procedural matters before we start. This committee is a statutory committee of the Queensland parliament and, as such, represents the parliament. It is an all-party committee which takes a nonpartisan approach to inquiries. This hearing is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. The committee will not require evidence to be given under oath, but I remind you that intentionally misleading the committee is a serious offence. Witnesses have been provided with a copy of the guidelines so we will take those as read. Hansard will record the proceedings and you will be provided with a copy of the transcript in due course. This hearing will also be broadcast live on the parliament's website.

For any media present, I ask that you adhere to my directions as chair at all times. The media rules endorsed by the committee are available from committee staff if required. I remind those in attendance today that these proceedings are similar to parliament to the extent that the public cannot participate. I remind members of the public that they may be admitted to, or excluded from, the hearing at the committee's discretion. Please note that this is a public hearing and you may be filmed or photographed.

DALGLIESH, Mr Elliott, Hall Payne Lawyers

PYRA, Ms Kalina, Hall Payne Lawyers

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

CHAIR: Welcome. This is a significant piece of legislation and Queensland is leading the way in strengthening the health practitioner law. Thank you for your submission. I note that you did make a comprehensive submission to the COAG consultation on proposed reforms to mandatory reporting, that you are restating your position today and that you are asking the committee to accept the recommendations to amend the bill as stated. I see that you have made those recommendations, but would you like to start with an opening statement and we will move to some questions from there?

Mr McARDLE: Could I ask that you keep it very short? The committee has very limited time with you.

Mr Shepherd: The QNMU thanks the committee for giving us this opportunity to present views on the national law amendment bill. We also thank the Department of Health for considering our comments during the consultation period. Beth Mohle, the state secretary of the QNMU, is unable to attend today and passes on her apologies.

This bill amends the mandatory reporting requirements for treating health practitioners and increases the maximum penalties for persons who falsely hold themselves out as a registered health practitioner or who use titles restricted under the act. While the QNMU agrees with the holding-out provisions in the bill, the amendments around mandatory reporting are of most concern to us. It has been a longstanding position of the QNMU that it is not necessary for treating practitioners to make mandatory notifications when the health practitioner is engaged in and compliant with treatment. International and Australian research indicates mandatory reporting carries a punitive quality rather

than compassion towards rehabilitation. The focus on sanctions is weighted against the practitioner, particularly when they are aware of the need for help but fear retribution, loss of standing and loss of income.

We recognise that the existing provisions are there to ensure safe, quality health care is provided by regulated and confident health practitioners. We do not disagree with this premise. Indeed, it is at the core of everything that nurses and midwives do. However, regulatory mechanisms should also ensure that health practitioners who are, or might be, suffering from a health impairment are encouraged to seek referral and treatment without fear of a breach of trust and confidentiality by the treating practitioner. Any delay or failure to seek timely referral and treatment can have adverse consequences for the health practitioner and for the public.

When a nurse or midwife presents for treatment, the treating practitioner will invariably provide a period of time off work whilst that treatment takes place. When this occurs, the impaired practitioner is not presenting a risk of harm to the public because they are not practising their profession. An important concept is that when practitioners recognise the need for treatment you do not want them to hesitate in seeking it. A nurse or midwife who has insight and professionalism to seek referral to a specialist and initiate treatment of an impairment should be supported in that treatment and rehabilitation rather than be subjected to further humiliation and hardship imposed by the regulatory body.

The national law preserves the principle of legal privilege for the legal profession and also preserves the principle of client confidentiality when making admissions to insurance providers, but the long-accepted principle of patient confidentiality is not supported for health practitioners. Providing a complete exemption for health practitioners will be consistent with this long-held principle.

We have numerous examples which my colleagues can share with the committee where mandatory reporting requirements have effectively ended the professional career of some of our members who were seeking treatment. Such reporting has also destroyed the therapeutic rapport and relationship that was built up over the period of treatment, often resulting in relapse.

Our submission to this committee reiterates the position we made to the Council of Australian Governments' consultation on proposed reforms to mandatory reporting. We therefore ask the committee to recommend the bill reflect the provisions of the Western Australian legislation that does not require mandatory reporting by treating practitioners.

CHAIR: Thank you very much, Mr Shepherd. You talked a little about the Western Australian model. What evidence do you have that the WA model is superior in terms of health outcomes for registered health practitioners and the general community?

Mr Shepherd: We do not have the evidence here ourselves, but we have spoken with the legislative policy division of Queensland Health. The data that they told us—they did not share with us—indicates that there is not a significant difference between the two jurisdictions.

CHAIR: I see a key recommendation is that the bill mirror the provisions contained in the WA act 2010, but in the event the committee does not accept the recommendation the QNMU recommends that the committee recommends that AHPRA provide a comprehensive implementation, communication and education program to raise awareness and compliance with the new regime. Did you want to talk to that point about educating health practitioners? You have some 59,000 registered, I think.

Mr Shepherd: Yes. I can speak to the information that has been provided by the Nursing and Midwifery Board of Australia, because nurses and midwives often become treating practitioners as well. It is not just GPs and doctors. Whenever a health practitioner is admitted to hospital, they are going to be cared for by nurses and midwives as their treating practitioners. The information that the NMBA provides to nurses and midwives on their website is very passive in nature. The nurse or midwife has to actively go and seek that information from the website. It would be more beneficial if these provisions come in as written in the bill that nurses and midwives receive active education from AHRPA and the NMBA about the issues that are being put into the bill as to what defines a substantial risk to the public and when it is appropriate and when it is not appropriate to make a notification, or in our jurisdiction to make a complaint to the Health Ombudsman.

CHAIR: I note that there are a number of criteria for the treating practitioner to consider including the nature, extent and severity of the impairment; the steps the practitioner or student is taking or willing to take to manage the impairment; and the extent to which the impairment can be managed with appropriate treatment. I think overall, though, listening to your opening statement, you agree that health consumers in Queensland should have complete faith in the people they are being treated by—

Mr Shepherd: Yes.

CHAIR:—and that it needs some rigour around monitoring or compliance in that regard.

Mr McARDLE: Thank you for your time, Mr Shepherd, and the lawyers as well—wonderful human beings. You have raised some serious concerns in your documentation. Have you spoken about your concerns to Queensland's chief nurse—the government employed chief nurse—whom I thought would have been a natural fit for you to talk to?

Mr Shepherd: I do not recall any specific meetings with the chief nurse about the mandatory reporting requirements.

Mr McARDLE: Okay. Do you say that the bill should be amended in regard to including the WA provisions? Do you find that strikes a better balance between the outcome for patients and the outcome for a nurse or midwife? Is that a better balance than what we are proposing in this bill?

Mr Shepherd: We believe it is a better balance because it encourages nurses or midwives to seek treatment rather than hesitate. They recognise that they have a condition or an impairment which they need to seek treatment for, and it might not necessarily already be at the threshold of creating a substantial risk that would warrant any cessation of practice. We want them to go to their treating practitioner, their GP or their treating psychiatrist and get the treatment that they need. If they are off work and they are not practising their profession, they are not presenting any risk to the safety of the public.

Mr McARDLE: You would argue that if a nurse or midwife is getting help from a medical practitioner and they are complying with that medical practitioner then that is a twofold bonus—to the nurse or midwife and to the patient?

Mr Shepherd: Yes, it provides a balance—

Mr McARDLE: It provides certainty for both.

Mr Shepherd: It provides certainty for both because the practitioner is not at work providing care.

Mr McARDLE: We know that the backlog in OHO in this state is quite significant in regard to complaints. The longer a complaint takes to get resolved by OHO or QCAT, the more damage can be done to the reputation of a nurse or midwife. It allows that to be streamlined, if need be, but also provides protection for the patients whom that nurse or midwife may treat; would that be right?

Mr Shepherd: I have not seen the data about the backlog for the Health Ombudsman, but what you are saying is correct in that it enables the nurse or midwife to get the treatment they need, and while they are off work they are not presenting any risk to the patients because they are not treating any patients.

Mr McARDLE: You mentioned earlier that you had spoken to a unit within Queensland Health about data and they said the data in WA and Queensland was very similar in relation to, I suppose, outcomes. Who did you talk to?

Mr Shepherd: It would be in my notes back at work. I can take that on notice and give you the name and position. He was the director of the Queensland Health Legislation, Policy and Strategy Unit, I believe.

Mr McARDLE: If you could take that on notice to confirm exactly the title of the person and who the person was for the committee.

Mr Shepherd: What they told us—and Kalina and Elliot were at the meeting—from my recollection is that there were no significant differences in the data.

Mrs O'ROURKE: You spoke about medical practitioners seeking assistance and the mandatory reporting and that actually destroying some practitioners' careers. Do you have anything to support that? Is there any documentation around that we could look at or consider?

Mr Shepherd: My colleagues would have that information, but I know from my own experience when AHPRA first started in 2010—I used to work for AHPRA as a senior health and performance officer; I was occasionally appointed as an investigator and I had the carriage of some matters to QCAT—I had two or three health practitioners who had been undergoing treatment from their treating psychiatrist and when that mandatory notification was made under the new national law the rapport between those two parties was just destroyed—that had been built up over some years in one case—and they had to go and seek another practitioner and then build that up again and it hindered that practitioner's recovery.

Mr BERKMAN: Intuitively it makes sense to all of us that punitive consequences for health practitioners will act as a barrier to seeking assistance. Can you provide us any additional data or anecdotal information to help us understand the extent to which punitive outcomes for health practitioners act as a barrier?

Mr Shepherd: Certainly. I will pass that on to my colleagues.

Ms Pyra: The difficulty we find is with health practitioners where there is a mandatory report by the treating practitioner. Often we have had cases where—and I am talking about cases where the nurse is insightful, is absent from work, has notified their employer and has taken sick leave—nurses who have been certified unfit for work for a period of time, let us say six months, are a period of time into their sick leave and have a mandatory report made because their treating practitioner believes that under the legislation, because the person has an impairment, irrespective of their insight, a report should be made to AHPRA. That may well be a misunderstanding of the mandatory reporting conditions. We have found that the Nursing and Midwifery Board oftentimes, seeing a remainder of time that the nurse has to remain away from work, will seek to take immediate action, suspending the practitioner's registration or taking immediate action to prevent them from returning to work. This is in circumstances where the person has already been off work for a significant period of time and where the evidence from them is that they are not going to return to work until certified fit to do so, but in my discussions with AHPRA I have been informed that often the Nursing and Midwifery Board takes quite a risk-averse approach to health practitioners who are seen to have some form of impairment.

If your registration is suspended, if you are prevented from working, then pursuant to your employment contract your employer can terminate your employment. Sometimes that does not happen; sometimes it does. We find that the health assessment process with AHPRA can take six to 12 or 18 months to be completed. This is in circumstances where you have a compliant health practitioner, and invariably a report like that to AHPRA impacts upon their mental state because they will say to us, 'I am doing everything right. Why am I being punished?' It hinders their return to work until the health assessment process is over, and in certain circumstances those people can lose their employment. It can have a really significant impact.

We have all at this table seen practitioners who lack insight, and as the QNMU's lawyers we counsel those people on how to appropriately manage their practice and what they should do, including going non-practising for a period of time, but our main concern is in relation to those practitioners who are seeking treatment. I have personally had nurses say to me, 'I don't want to talk to my doctor about this. I don't want to go and see a psychiatrist,' or saying, 'I am now going to change my treating practitioner because of the report.' They are the sorts of matters we are talking about, which do seem punitive because of the risk-averse approach that is taken.

CHAIR: We are out of time. Thank you very much for that response and I thank the QNMU for being here today.

CLEMENTS, Dr Michael, Deputy Chair, Royal Australian College of General Practitioners Queensland Council

WILLETT, Dr Rod, Member, Royal Australian College of General Practitioners Queensland Council

CHAIR: Welcome. Thank you very much for you submission. In the interests of time can we move to an opening statement.

Dr Clements: Thank you for providing the Royal Australian College of General Practitioners with the opportunity to appear before you. I want to state from the outset very strongly that our members do not believe this bill goes far enough. We do not believe it actually achieves the desired outcome and we believe it is going to increase patient risk from practitioners who are not seeking mental health care. You need to be fearful of the doctor who is not seeking medical care, not fearful of the doctor who has a treating relationship with a practitioner that may or may not need to be notified under the voluntary system.

This bill does not achieve the COAG Health Council's stated intent to ensure that a health practitioner feels able to seek care for a health or mental health condition without fear of being reported. We put forward feedback to COAG in August outlining our concerns and we have re-outlined those in our submission. The amendments put forward in the bill remain unchanged from those put forward to the medical profession during the targeted consultation earlier this year. The RACGP is deeply concerned that the feedback from the medical profession has been dismissed. Just like all other people in Australia, health practitioners should be entitled to discuss their health with their doctor in a strictly confidential environment. Doctors should be treated like pilots, bus drivers, taxidrivers, politicians and judges—everybody in the community—who all have the right to see their practitioners without the threat of mandatory notification. Doctors should be treated in that same way.

Treating doctors in Western Australia are exempt from reporting practitioners who are under their professional care. Under this model, the practitioners are able to seek help when needed without fear of repercussions. Western Australia, as you know, will be retaining those arrangements. The model in Western Australia works. The rates of reports regarding practitioner medical conditions or impairments are within the range of other states and territories. You have AHPRA speaking to you later today and I am sure they can back that up. It is important to note that under the WA model people around the practitioner—that might be employers, colleagues or other people who work with them—are still subject to the mandatory reporting requirements so that a practitioner who may be impaired is still going to be reported under the mandatory regulations if they are observed to be acting in an inappropriate manner.

We have serious concerns and evidence that doctors are avoiding seeking help due to fears of being reported. When doctors avoid getting the medical help they need, patient safety is actually at greater risk. Therefore, the current mandatory reporting laws are likely to have the opposite of the intended effect. In a recent poll conducted by the *Medical Journal of Australia*, 59 per cent of respondents told the report that they either disagreed or strongly disagreed that doctors can disclose their mental illness without fear for their career.

Between 2011 and December 2014 there were 153 health professionals who died as a result of suicide. I was director at Ingham Hospital for a short while. I had an intern who worked for me and shortly after I was told that he suicided. I have permission from the wife to talk to the committee about this young gentleman. He was a highly performing, highly skilled, very dedicated doctor whose goals were to go and work in rural and remote areas. He suicided without any contact with any health professionals. We do not know what his individual barriers were because he did not talk to us, but you can be sure that every practitioner who is suffering considers, 'What is going to be the impact on my job?', 'What will the treating practitioner have to say about me to the authorities if I tell them that I am not coping?' I was very saddened. He left behind four children, including a newborn, and it still saddens me to this day that I did not know that he was suffering.

The RACGP believes that adopting legislation that aligns more closely with the WA model would better ensure health practitioners can seek that help when needed. Chair, as a former paramedic working on the front line you know how important it is for health workers to be able to seek help and see a GP when they are concerned. You are in a high-risk profession where you see many things, just like the police force. If a policeman comes and sees me and I am near a police station, I am under no mandatory obligation to report that they are suffering. Just remember: practitioners still have the opportunity for voluntary notifications, and that is a professional standard. It is set by AHPRA and the codes of conduct that if any of our patients are putting public safety at risk we make a

voluntary notification and we do so. It has been safe so far. But police at the moment are certainly not required to follow this rule. Thanks again for providing the opportunity and I look forward to some questions.

CHAIR: Thank you for your opening statement.

Mr BERKMAN: Thank you for your statement. It was really interesting. You have raised a couple of points that I would like to flesh out a bit, if I can. You mentioned that doctors are avoiding seeking help. Can you elaborate on that?

Dr Clements: Rod has some data. We have the membership telling us that they are actually travelling to and seeking telephone consults with WA practitioners to avoid the legislation in the other states. This is not published because they do not want it to be known about, but we certainly have it. The MJA survey is very clear that doctors are avoiding it and beyondblue did a survey which we either have tabled or can table which showed that fear of reporting is a major factor in practitioners deciding whether or not to engage in health care.

Dr Willett: Just to talk to that, one in three practitioners are concerned about the adverse effect on their right to practise. One in two raised a lack of confidentiality as a barrier. That is pretty significant. We are talking about 50 per cent of potentially impaired and unwell practitioners not willing to seek help.

CHAIR: When we have issues with health practitioners—it is a broad area, from paramedics through to medical officers—when there are drugs, alcohol, intoxication or other abuses of medication, do you think it might be in the best interests of the community to have full faith that their treating practitioner is being looked after in the right way but that health consumers should come first? I know you are defending absolutely with passion the medical profession. Everyone should have a right to treatment, but health consumers should have complete faith that there is no abuse. There is a lot of case law that has been presented where things have gone wrong for years. Can you talk to that a little bit?

Dr Clements: Public safety is best maintained through health practitioners being the healthiest they can be and getting that care. When you and I hop on the plane back to Townsville today, the pilots who are flying us are not subject to mandatory notification by their treating health practitioners. Any concerns the public has about a pilot's safety are dealt with or concerns a practitioner has regarding their safety are dealt with under the voluntary notification legislation. I make numerous—I would not say daily—notifications to authorities regarding patients under my care who are not health practitioners under the voluntary notification legislation and protections.

CHAIR: Oranges and apples. CASA has tight regulations.

Dr Clements: The DAME is legally obligated to notify CASA but a GP or a psychiatrist treating them is not mandated under legislation to report that pilot.

CHAIR: Fair point.

Mr BERKMAN: As the chair has pointed out, we often frame discussion on this proposed regulation around drug and alcohol addiction and intoxication. Can you discuss in any more detail how it applies to health practitioners seeking assistance around their mental health more broadly, as a separate need for treatment from anything that involves substance abuse?

Dr Clements: Once they come and see us then we can do great work. We will talk to them about taking time away from the workplace. We will talk to them about making their own voluntary notification if that is required. We can make a voluntary notification to AHPRA if we feel that would assist the patient. The issue is getting them in the door in the first place. I think there is a mistaken assumption in what I have read in the submissions so far that patients will be safer if practitioners are afraid of going to their GP. That is not a safer outcome. It is safer that everybody is free to go and see their practitioner.

Remember you already have submissions talking about defensive notifications. That is where somebody comes and sees me, they may or may not be a risk, my MDO when I call them says, 'Listen, you as a practitioner may be at risk if you don't notify AHPRA' so I should make a notification to protect me, but that is not in the best interests of either the patient or the public. That is not a public interest test; that is a defensive test on me.

If you put in place these mandatory notification rules, all of a sudden my consultation with a patient is, 'What do I need to do to protect my own skin and income?' and it is not about what is best for the patient. Under the existing legislation and under the WA model, the effort is on treating the practitioners. The evidence is very clear. People are going to WA to get their treatment because of this rule.

Mr BERKMAN: We just heard from the QNMU about a risk-averse approach that is taken within AHPRA, but what you are suggesting is that that risk aversion comes a step further back into the consultation, ultimately; is that correct?

Dr Clements: Correct. AHPRA has its issues and there are delays. We have certainly made submissions to AHPRA about the way it deals with complaints once it receives them. I guess what we are talking about is that precognitive step. People suffering mental illness are not in the best place to decide whether or not they will subject themselves to mandatory notification.

This idea of an education campaign is not going to cut it. If you are impaired, you are not going to make an accurate assessment of whether or not you are at risk of being notified. You are just going to assume that you are going to be notified to the health regulator. You might just have a down couple of weeks. You might be bereaving. If you are afraid that your GP might need to notify about you because you just do not understand that you are impaired then you are just not going to seek help. They are the ones we have to worry about.

Ms PEASE: In your opening statement you said that this piece of legislation will increase the risk to patients. Can you elaborate on what you meant by that statement?

Dr Clements: We have to be fearful of the doctors who are not seeking care. It is a challenging job. Paramedics, police—we all suffer from fear of harming our patients or doing the wrong thing. We deal with death on a daily basis so we can be impaired. If I am afraid of seeking mental health treatment for my own impairment when I am struggling because I am worried that I will have my job taken away from me then I will not seek treatment. Remember, if a mandatory notification is made about private GPs like me, it is likely that they are going to take me away from practising. I have no other income. I am not salaried and mine is a single-income family.

When I make a decision about my own mental health and whether I seek care, I am going to be weighing up what the risk is of the practitioner I seek care from having to notify about me and AHPRA taking immediate steps to put me to the side for the moment versus not seeking care and continuing to practise while impaired. The risk comes from practitioners continuing to practise while impaired and not seeking help. We had eight mandatory notifications in Queensland for practitioners in 2017-18. We are talking about really small numbers of people who actually meet that threshold. That is not the issue. The issue is the 30 per cent of practitioners afraid to seek care while they are feeling unwell.

Ms PEASE: Does your membership base contact you seeking advice about a way forward if they have a substance abuse issue or mental health issues? Do you provide advice and recommendations?

Dr Clements: There are a number of doctors advisory services and telephone hotlines. You will hear from the AMA later today. They talk about their doctors support service. We are constantly receiving phone calls from our membership in a confidential and anonymous manner asking about what they can do next. We do provide that advice willingly and freely. As you will have noticed from the departmental brief you have received, there is a concern that these doctors health advisory lines will be subject to mandatory reporting and that you will have the practitioners on the other end of that line defensively notifying to AHPRA because they are worried for their own jobs.

Dr Willett: Further to that, there has been a 50 per cent decrease in calls to the doctors support lines in the last 12 months.

CHAIR: Do you have evidence of that?

Ms PEASE: What do you believe that is based on? I am just interested as to why you would raise that.

Dr Willett: The fear of report.

Ms PEASE: Currently?

Dr Willett: Yes. People are concerned that if they contact these agencies it is the same process and they may be subject to mandatory reporting.

Ms PEASE: Are you able to provide any evidence around that?

Dr Willett: Sure. We will do so on notice. I will get the official figures.

Mr HUNT: I was interested in your comments around sexual misconduct and how you see a difference there. If somebody is seeking treatment around their sexual behaviour, why do you see that as a different risk or a more serious risk or a more serious issue and therefore there should be mandatory reporting as opposed to a situation where they might put a patient's health or life at risk?

Dr Clements: I think you have to be specific about the impairment risks. An impairment risk is that people may not be concentrating hard enough with their patient or may be making inaccurate decisions or not using due care. The risk with sexual misconduct is deliberate acts by the practitioner to cause harm to others. They are an entirely different category to the concept of an impaired practitioner. We are still very supportive of voluntary notifications for impairment, but sexual misconduct is particularly heinous. It normally implies deliberate intent, in which case there should be mandatory notification.

Mr HUNT: I agree; however, you are drawing an example that is a minor example in terms of impairment. A mental impairment may cause somebody to have thoughts of intentionally physically harming people, for example. Would that be an instance where mandatory reporting should be required?

Dr Clements: We do not need mandatory reporting. If we have a patient in front of us who we genuinely believe is a risk to the public, we already notify under the voluntary rules. It is under our professional ethics. We are not aware of any practitioners who have been held to account for this. We are not aware of any evidence of harm in WA or elsewhere from practitioners not notifying under voluntary rules.

We do notify. We cancel drug licences all the time. A practitioner whom we think has intent to harm patients through negligent or deliberate act we will notify about because professionally we are obligated to do that. I will be held to account professionally by AHPRA if I do not notify voluntarily. We do not need the mandatory legislation; we are going to notify anyway. The reason we are against mandatory notification is that you are actually putting a block between the practitioner seeing us in the first place. Once they see us, our job is actually pretty straightforward.

CHAIR: Previous submitters recognise that clause 19 of the bill includes provisions to enable a treating practitioner to use their professional judgement and expertise in deciding whether a mandatory report about a practitioner is required. There is a list of factors which I spoke to, such as the nature, extent and severity of the impairment. There is a clause within the draft bill that provides that avenue. Can you speak to that? Do you support that clause being in the bill?

Dr Clements: The thing is that we are already practising that way. We are already making those assessments and making voluntary notification decisions based on that holistic evidence. What we are concerned about is not the decision-making a practitioner makes once the patient is in front of them. We are good at that. We are skilled at that. We are examined on that. We are held to account under professional standards for that. The issue is the patient coming to us in the first place. The mandatory rules are stopping them from getting into our room in the first place.

Mr McARDLE: Do you have a copy of the beyondblue report with you?

Dr Willett: Not with us, no.

Dr Clements: We will be happy to provide that on notice.

Mr McARDLE: Thank you very much. Do you also support the AMA's proposal that the doctors helpline be exempt in relation to this bill?

Dr Clements: It is our second best option, yes.

Mr McARDLE: I accept that.

Dr Clements: That is correct.

Mr McARDLE: The AMA supports that principle. You would endorse that as a B outcome?

Dr Clements: Correct.

Mr McARDLE: Your argument is that the WA model is working effectively and there is no difference in relation to outcomes. Data, which you will table, exists to substantiate that. You would also argue, I would expect, that you get a better balanced result by having a WA model in place in that the patient or patients are protected, the doctors are getting the treatment they need—and your obligation is ethically to report a doctor in any event—and, more importantly, the doctor is able to practise for many years to come. Let us be truthful about this: if an issue breaks in the newspapers that doctor's reputation, whether it be cleared down the track or not, is over. You would also argue, I suspect, that it is not just the doctor, per se, but his family as well who suffers. You would see the balance being in a win-win scenario: we protect the patient at all times but we make certain a doctor who needs help knocks on your front door and says, 'I need help,' and you will then take the steps to ensure he gets that help. The model in WA achieves that outcome; is that right?

Dr Clements: Correct. He or she, I should add.

Mr McARDLE: I apologise.

Dr Clements: That is right. We are entrusted to make those decisions for every other profession in Australia—for politicians, police, judges, lawyers, bus drivers, taxidrivers, train drivers, plumbers. We are entrusted to make those voluntary notification decisions in all those cases. I do not think health practitioners are of any greater risk. Do not forget that we are seeing suicides. The rate of suicide amongst health practitioners is at the highest edge of the white-collar worker suicide rates in Australia. If we continue with this bill we are not going to see that change; we are actually causing harm to them.

Mr McARDLE: Will the MJA and beyondblue studies you referred to make that quite clear to the committee?

Dr Clements: You have to remember that we are talking about a voluntary response to surveys. We have thousands of responses showing that there is a real disincentive to seeking help. From that you have to draw the conclusion that there are people who are following through and not seeking help.

CHAIR: It is an interesting comparison, because I know that beyondblue has just published its emergency services Answering the Call report. It is the largest study in Australia, with 21,000 people contributing. It addresses significant issues in that space. I look forward to receiving the data that quantifies the extent of the problem around health practitioners avoiding appropriate health care. I think that would be beneficial for us.

BOWEN, Mr Timothy, Senior Solicitor, Advocacy, Claims and Education, MIGA Medical Defence Organisation (via teleconference)

CHAIR: We appreciate your time on the phone this morning. We ask you to make a brief opening statement before we move to questions.

Mr Bowen: Thank you for the opportunity for MIGA to appear today. I apologise for not being able to be there in person. We welcome the shared desire to reduce barriers to doctors and other professionals seeking medical care, but we are concerned that the proposed reforms do not go far enough and may lead to further confusion. We do support substantial risks of harm of intoxication and current and future risks of sexual misconduct being reportable, but we do need further work around these thresholds for reporting. We do not believe that impairment or significant departures from expected standards should be grounds for mandatory reporting by treating practitioners.

The impairment issue is a difficult one to judge for a treating practitioner. It requires consideration of a variety of issues and how they may interact. A mandatory obligation cannot deal with the range of situations this involves. We think the better approach is to build on and develop existing ethical and professional reporting obligations to provide the necessary public protection around this.

In terms of significant departures from expected standards, we do not see how a treating practitioner is necessarily better placed than a colleague, supervisor or employer to determine whether there is a substantial risk. If these two grounds for mandatory reporting by treating practitioners are to remain, again we think further work is required to clarify the reporting thresholds. Most importantly, we think that guidelines and education specifically dealing with these issues must be available before the reforms take effect.

We do not believe that reforms to reducing barriers to doctors seeking help are achieved by reforms alone in mandatory reporting. We would like to see a nationally consistent approach for regulators in dealing with health issues and ongoing efforts into mandatory reporting research and monitoring. We would also like to see the introduction of a reasonable excuse defence for practitioners in not making a report which would give some comfort that decisions they make in good faith will not be unfairly scrutinised later on. Finally, while we agree with the need to deter non-registered persons from holding themselves out as registered health practitioners, there are risks that doctors and other professionals who make certain representations about their experience or expertise with the best of intentions could be unfairly caught up in these proposals for increased penalties.

CHAIR: Thank you very much, Mr Bowen. I note point 29 and that you have just articulated that you have some misunderstandings as to what constitutes impairment or warrants a mandatory report. Point 29 further states—

This has been incorrectly interpreted as requiring notification of mental health conditions, such as depression or anxiety ...

In regard to impairment, where do you think it should be clarified or defined within the bill? What is your advice to the committee on that?

Mr Bowen: The word 'impairment' is not just talking about a health condition; it is talking about when it detrimentally affects or is likely to affect a person practising and putting the patient at risk. That explanation somehow needs to be put within that clause in the legislation, because unfortunately we have seen situations where doctors have been looking at this clause and interpreting impairment in a normal way, in a general way, to say that impairment is a health issue alone and not going to the next step of whether it is posing a risk to the public. If we can somehow define that and explain what is already elsewhere in the national law in that section of the reformed mandatory reporting obligation, we think that would be very helpful.

CHAIR: The member for Nicklin asked a question of the previous submitters on impairment and also sexual misconduct, which you say should stay in there as a mandatory notification. I think you mentioned intoxication too.

Mr Bowen: Yes, we did. Again, there is no question that intoxication is certainly a serious issue. It is a narrower ground, as we see it, for making a report—either there is an intoxication or there is not—whereas when we are talking about something like impairment there can be a wide range of judgements as to whether an impairment exists or not. We think intoxication is fundamentally an easier issue to judge in some ways and potentially presents a more significant risk in many situations.

Ms PEASE: I am not sure whether you heard the previous submitters. Were you listening to the previous submitters here today?

Mr Bowen: I did hear some of it. I might have lost the last couple of minutes because I am on a delay with the video.

Ms PEASE: The submitters from the Royal Australian College of General Practitioners mentioned that they believe that this piece of legislation will increase the risk to patients and the public. Do you have a position on that?

Mr Bowen: I cannot actually suggest that there would be an increased risk. There is already an underlying risk to the public by practitioners who are not seeking assistance from the medical profession. As we look at these reforms we do not see them answering that fundamental question. We would think that risk remains.

Ms PEASE: There was also discussion around the fact that there has been a significant drop in medical practitioners contacting helplines and other telephone services. Have you experienced that in South Australia?

Mr Bowen: No. I do not have any evidence of that.

Ms PEASE: I can imagine that it would be quite difficult as a medical practitioner to undertake to report a professional colleague. Would the consequences of reporting a professional colleague and the outcome potentially play on a practitioner's mind? What would be most important: the safety of your patient or the safety of the public?

Mr Bowen: We do believe it plays on the mind and we have experiences in counselling practitioners around that—the treating practitioner who is calling us saying, 'We are uncertain about whether to make a report. We are conscious of our professional obligations and we realise the absolute need to protect the public, but we are unsure whether making the mandatory report is actually required and whether it is the best judgement in this situation. We also do not want to get it wrong because of the risk to the public if we do not report but also, at the same time, the risk to the practitioner if we do report and it was unnecessary.' That has also informed why we think it is not just about making reforms to whether we report or not but also about how we handle these matters afterwards, bringing a consistent collegiate approach that might provide some more comfort to those practitioners who have reported, whether under mandatory obligations or professional or ethical reporting obligations.

Mr McARDLE: If this bill passes this parliament and is then taken up by other jurisdictions, we are going to have a WA model that is distinct from most other models in the Commonwealth. That is not nationally consistent, is it?

Mr Bowen: No.

Mr McARDLE: I think you made the point earlier that consistency is most important. If I can draw from that, I think you mean that it is consistent so that all concerned know what the law is and know that it is uniform across the Commonwealth.

Mr Bowen: We would support consistency where warranted and appropriate. We are aware of the data or the experience in WA which suggests that there has been no increase to risks posed to patients by their mandatory reporting regime. We would not support making changes to that distinct separate regime without compelling evidence supporting it. Whilst that would lead to the inconsistency that you recognise, we do acknowledge that in certain situations we need to live with some inconsistency in the national law. Our position is that we prefer to have consistency but only where appropriate and warranted.

Mr McARDLE: You also made the comment that the core issue here is a practitioner—he or she—not seeking help. That is the core issue, I think you said.

Mr Bowen: The core issue is that and also treating practitioners struggling on whether to make a report.

Mr McARDLE: Wouldn't the WA model overcome that to an extent in that the treating practitioner by way of their ethical requirements would make a voluntary report but would not be required to make a report on a mandatory basis, provided the practitioner they are treating is doing the right thing? Doesn't that in some sense overcome the concern you have?

Mr Bowen: What we support for impairment would be the adoption of the WA model for impairment, so the practitioner who is ill and seeks medical care knows that their treating practitioner may have a professional or ethical obligation but their obligation is much more nuanced, much more able to deal with the particularities of their situation, so they can say, 'I'm approaching someone who will be able to think very carefully about this, consult with other people and then make a considered judgement about whether report is warranted for me.' That would be the WA approach for impairment.

Mr McARDLE: Doesn't impairment, if it is a mental health issue, normally include alcohol and/or illegal substances as part of the problem?

Mr Bowen: I certainly acknowledge that it can include it. It can also be separate.

Mr McARDLE: It can but it can also be part of the same. I would say that it is probably more likely than not to be part of the problem that leads to the mental impairment. Would that be right?

Mr Bowen: Quite possibly. That is one of the reasons why when we looked at these proposals where it talks about holistic assessment of risks posed by impairment and intoxication we saw a need to work a bit around that to say, 'We need to consider the context of both impairment and intoxication before making any mandatory report on those grounds.' At the moment, as we read this legislation, despite the intent, you could suffer from an impairment problem causing an intoxication problem, but arguably it would still need to be reported. Even if you do not think it should be reported on impairment grounds, you would need to report on intoxication grounds.

Mr McARDLE: Would you feel more at ease with this bill if it did incorporate the WA model?

Mr Bowen: We would feel more at ease if the bill incorporated the WA model around impairment and departures from widely accepted professional standards.

Mr McARDLE: You made the comment about the defence of reasonable excuse. I understand why you say that, given a doctor may determine not to make a report and some time later it comes out that they should have done so and all hell breaks loose. Do you have a model in mind?

Mr Bowen: It would probably be based around the existing provision—I think it is section 256 of the national law—that provides good-faith protections around making voluntary reports, so perhaps a development of that kind of model. We certainly welcome the opportunity to engage with whoever would be considering that and drafting that to work on something appropriate.

CHAIR: Mr Bowen, do you have any evidence that the WA model is superior in terms of health outcomes for registered health practitioners and the general community?

Mr Bowen: We do not put forward any evidence about the WA model which would exclude essentially any mandatory reporting by treating practitioners. We only seek the exclusion for treating practitioners relating to impairment and departures from accepted professional standards.

CHAIR: I do not know if you can answer this, but do you have any data that quantifies the extent of the problem of health practitioners avoiding appropriate health care?

Mr Bowen: No, I do not. We can only speak to our anecdotal experience in advising members.

CHAIR: The proposed reforms have a stepped process. As I said before, for sexual misconduct when there is practitioner-patient risk a mandatory report is required. In terms of the treating practitioner who reasonably believes there is a substantial risk of harm due to intoxication, impairment or departure from professional standards, there is a caveat within there where that treating practitioner may consider a range of things that I spoke about with the previous submitters. They include the nature, extent and severity of impairment, the steps a patient is taking to manage the impairment, the effectiveness of the treatment and any other matter relevant to the risk of harm. The next step in the process is for the treating practitioner to assess the risk of harm: is there substantial risk of harm or not a substantial risk of harm to the public? For anyone observing this hearing, that is a pretty reasonable process, in my mind, of the treating practitioner going through a considered approach before a mandatory report is required. What is your view on that?

Mr Bowen: If we are to leave impairment as a ground for mandatory reporting, we do think that is quite a considered approach. I think we only suggested one further ground of a discretionary consideration around whether to report impairment. Our concern is that, when we are talking about these issues of mixed impairment with intoxication or mixed impairment with departure from standards, we have a range of criteria around impairment but not a range of criteria around those other thresholds for reporting. It creates two problems. One is: how do we judge that, particularly around departure from widely accepted professional standards or what constitutes a substantial risk of harm posed by intoxication? Where are the discretionary factors for that? If we reach a judgement that someone might be potentially impaired but under the discretionary factors it does not meet the criteria but there is still a departure from accepted standards, we would still be compelled to report that on the accepted standards ground even though not the impairment ground. We see that the solution is to introduce discretionary criteria tailored to those other grounds so that all three grounds have discretionary criteria to them and we can make this holistic assessment which the drafters of the legislation have envisaged.

CHAIR: There being no further questions, thank you very much.

Mr Bowen: Thank you, members of the committee.

FOX, Ms Melissa, Chief Executive Officer, Health Consumers Queensland

CHAIR: Welcome. You are a regular contributor to the health committee's public hearings representing Health Consumers Queensland, and we welcome your presence here today to discuss what is another considerable piece of legislation. Queensland will be the first state to look at the proposed reforms to back up the health practitioner national law. Would you like to make an opening statement before we move to questions?

Ms Fox: I would like to start by acknowledging the traditional owners of the land on which we are gathered and pay my respects to elders past, present and emerging.

It has been quite difficult for us as a consumer organisation to come to a position on this piece of legislation due to it being hard for us to find robust evidence and large datasets that are not just anecdotal and qualitative, and I imagine that is the same challenge for you. For instance, how many health professionals do not seek care because of uncertainty about the impact on their careers of doing so? Has the care of their patients been compromised because of this? Where is the evidence about an increase in access to health care by health professionals without an adverse impact on public safety from other jurisdictions that have changed their threshold to report as per this proposal?

It is our understanding that in 2014 in Queensland we changed our legislation to be quite similar to what is being proposed in this bill with the introduction of the OHO. This shows that there is the need for an education campaign, given that we have heard from RACGP that Queensland health professionals are travelling to Western Australia for their health care despite this legislation existing in Queensland.

Health professionals are regulated for a reason and we need to remember that—to ensure safe practice and to protect the public. Therefore, if there are any changes made to the threshold through this legislation, we need to make sure that it aligns to this overall purpose, and hence this inquiry. Consumers want a safer system; so do clinicians and so do you. It seems to make sense to us that if there is a treating clinician who has a concern about another health professional they be obligated to report if it is going to compromise patient safety in any way.

On the other hand, if a policy position stops a clinician seeking treatment for a condition that other members of the public can be treated for, that is also not good for public safety if that clinician goes underground; nor is it right or appropriate for doctors, who deserve the same right to treatment and confidentiality as everyone else in society. We agree with the RACGP that a health professional who is not seeking care is the one to fear, and this needs a change in culture.

We are very conscious of the need to get this right to serve all of those interests. Health consumers need to be assured that the system is robust and that it is transparent and effective. 'Trust us' is not good enough, good intentions are not good enough, professional guidelines are not good enough, and voluntary reporting is not good enough, as we have seen with the terrible experiences of women due to voluntary reporting of the complications of transvaginal mesh to the TGA. Health professionals are a greater risk to the public. We place our trust in our bodies in their hands every day.

We will be keeping a close watch on how this plays out for consumers. As the only organisation here today talking solely from the position of consumers, if this legislation is passed, we would want to know that safeguards are co-designed with consumers which would be respected and followed to ensure the intention of these changes would be met without causing any public harm, and that there are mechanisms for collecting data which provide the ability for ongoing monitoring, evaluation and transparency that gives public oversight and confidence in the system. That is, how many people come through and seek care who would not under the current legislation in other states? Did the treating practitioners feel that they had the information and supports they needed to make the right decision to report? Has the impact on public safety been measured? If we cannot assess that, how do we know if the system is working or not?

CHAIR: Thank you. You draw a bit of a balanced view on this. Yes, there is patient safety and public safety first with any health professional, but you are also mindful of treating practitioners needing to access health care for any issues they have. Have you seen the proposed reforms, the guideline?

Ms Fox: I have not seen that flow chart, no.

CHAIR: You were in the room a few minutes ago when I asked Mr Bowen if he thought it was a considered approach. The main part for me is in the middle, where we talk about intoxication, impairment and departure from professional standards for a health practitioner, where substantial risk of harm to the public is considered, but the treating practitioner has a stepped approach. I think that

is the caveat that I look at to go, before they make a decision to mandatorily report, they consider the nature, extent and severity of the impairment and take steps in managing the effectiveness of that treatment and any other relevant matters. At the end of the day, the treating practitioner assesses the risk of harm to the public. Do you think that is a reasonably balanced approach that this proposed reform is trying to achieve to protect the public and the health practitioner?

Ms Fox: On the surface it does, but we also think there is the risk of confusion in the language for health professionals: 'risk of substantial harm' versus 'substantial risk of harm'. It is very nuanced. We think it could also be difficult for treating practitioners who are not in that specialty to be able to make that call around that risk. We think whatever changes happen—and even if changes do not happen—we have seen that there is the greater need for education to provide clarity for that.

CHAIR: I took that as part of your opening statement—more education to the health profession of how they can access this with some confidence and that the proposed reform is necessary. Thank you very much for that.

Mr HUNT: Thank you for coming. It is important to hear from someone who is representing both sides. It is finding that balance between patient safety and the safety of medical practitioners. I noticed one of your recommendations in your submission. As there can be so much confusion or a wide scope of interpretation in this legislation, one of your recommendations was to include confidential access to an independent third party with expertise in the area, and I am wondering what that might look like.

Ms Fox: That would be the support for the treating practitioner to be able to speak to somebody with knowledge in this area to provide them with guidance as to whether or not they needed to mandatorily report.

Mr HUNT: Someone within AHPRA maybe—

Ms Fox: Or within the health departments.

Mr HUNT: They could confidentially outline the circumstances and seek advice from them.

Ms Fox: Yes.

Ms PEASE: Thank you very much for coming in. You were here when the previous witnesses were speaking today and I am going to ask a question that I asked earlier around your clients and your membership. Do you have many doctors, medical practitioners, nurses or treating practitioners who are members of your organisation?

Ms Fox: Our statewide network consists of consumers and carers as well as health professionals who receive our emails and are engaged with our organisation.

Ms PEASE: Would any of those professionals get in touch with you for advice with regard to current reporting or positions that they find themselves in where they have to—

Ms Fox: No, that is not our experience. That is outside of our scope.

Ms PEASE: With regard to your submission, did you contact your membership base?

Ms Fox: We did some targeted consultations to some consumers who we are aware have this as an area of interest. We also had several conversations with the policy branch because it is such a challenging area and there is such a lack of evidence in this space.

Ms PEASE: You commented in your opening statement that you understand that a number of practitioners are actually seeking medical advice in Western Australia. What evidence do you have for that?

Ms Fox: I was referring to the evidence given by the RACGP.

Ms PEASE: You were just referring to the statements they made in their commentary. You have not seen this flow chart then currently?

Ms Fox: No.

Mr BERKMAN: We are always chasing evidence of what the consequences of this regulation will be. Obviously, having sat through the earlier statements, you will know that we are waiting on some further evidence from the RACGP about the chilling effect on medical practitioners seeking assistance when they need it and their statements that the real risk to health consumers is in those circumstances where a treating practitioner does not seek the help they need. Obviously depending on what evidence we are provided on notice to support those positions, do you support the view that, if we can see that that risk to the general public and to health consumers is actually as a consequence of mandatory reporting—well, I do not know what I am hoping you might be able to tell us here from

the consumer perspective, but it strikes me that the balance you have already described is a really hard one to find and we run the risk of further entrenching the really extensive mental health concerns within the medical profession and transferring that risk on to health consumers.

Ms Fox: It is really challenging, and I sympathise with the committee in making this tough decision. I would be curious to see the data in Queensland since 2014. Has there been an increase in health professionals accessing care who otherwise would not have? Has there been a change in the rate of mandatory reporting? What similar statistics can we look at from Western Australia? How can we learn from where this has happened? If you do make the decision, how can we monitor the impact moving forward with consumers being involved in that oversight?

Mr BERKMAN: I recall you saying that voluntary reporting is not good enough and there should be some requirement for mandatory reporting. If that is the position of HCQ, how do you feel about the availability of a reasonable excuse defence, as was discussed by the previous witness? If the treating practitioner does not report, they can rely on their judgement in circumstances as a defence against any ramifications.

Ms Fox: I think this comes back to the education campaign and to those supports that can be in place—that if there is a greyness they can speak to an independent third party and then have evidence for that if it comes to that.

Mr McARDLE: Would you agree to a defence being included in the bill, though?

Ms Fox: It would need to include having referred to a third party and sought external advice.

Mr McARDLE: Generally speaking, you would agree there should be some sort of defence in the bill about reasonable excuse? What the terms are may be up for debate, but you would agree with the general principle?

Ms Fox: I think we remain committed to the intention of the various thresholds and the substantial risk of harm. I think it would be hard for us to see a reasonable excuse. If a treating practitioner had worked through the circumstances of the person that they are treating and then sought external advice, it would be hard to see grounds for that.

Mr O'ROURKE: From a consumer perspective, have there been reports back through your organisation around intoxication or impairment or failure to provide suitable outcomes for patients? Is there any documentation or similar?

Ms Fox: We are not a complaints body. We do receive frequent calls from individuals who have had challenging experiences through the system and would like our assistance to help walk them through the complaints process. We do not have the ability to do that. Those calls assist us in understanding the pressure points on the system and in particular how the complaints processes can improve but, no, we do not have that level of information. It has not been our experience in at least recent times that we have heard those examples through those calls.

Ms PEASE: If you do receive calls like that, what do you do? Do you refer them?

Ms Fox: We would walk them through the complaints process about making reports at the service level. If they are unhappy with that response, it is directing it to the Office of the Health Ombudsman and also AHPRA.

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

Proceedings suspended from 10.14 am to 10.30 am.

BARTONE, Dr Tony, National President, Australian Medical Association

DHUPELIA, Dr Dilip, Queensland President, Australian Medical Association

CHAIR: Thank you both for being here to discuss the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2018. You have been in attendance this morning and you heard some of the previous submissions. Would you like to begin with an opening statement before we move to questions?

Dr Bartone: Thank you for your time this morning. Today is an opportunity to talk to you about doctors' health—a chance to talk about how we can work together to provide doctors with at least the same level of care they provide others on a daily basis. Being a doctor, helping people heal, is an incredible joy. Helping people is at the centre of what we do. It is at the core of who we are, but there is no denying that it is stressful. Whether we are working in a chaotic, overcrowded emergency department, saving a mum and bub at a complicated birth at three o'clock in the morning, or a busy GP overseeing everything from deeply distressed mental health patients to patients living with cancer, the work often takes its toll. For our younger doctors it is no less stressful. The pressure of training, studying and securing a position is immense. Without adequate access to health care and support these stressors can kill. It is shown in the numbers.

A review of the literature by beyondblue highlighted this. Our profession is at a considerably higher risk of suicide, higher rates of psychological distress and suicidal thinking. I am here to tell you that we are hurting. Outside of Western Australia, doctors do not have the same level of access to health services as the patients they treat. When they feel stressed—and they do, as is human—they feel they have no-one to turn to. The same beyondblue report revealed that one of the most common barriers to doctors seeking treatment for a mental health condition is their concern about the impact on their medical registration. The fear of being reported is just too high. Some suffer in silence. I have even heard that some fly to WA just to see a GP like me. The fear that treating doctors face is similarly high.

To say that the new framework is comprehensive is an understatement. When it comes to ensuring that doctors act professionally and appropriately we have strong national safeguards in place. The current interpretation of the law means they feel that they have to try and guess the risk a doctor may pose to patients in the future. It is an unreasonable request. It results in reporting where in reality it is not necessary. The stigma spreads, the doctor avoids treatment, the problem worsens, the worst happens. It happens to doctors we know. The deputy chair of our own Council of Doctors in Training sadly took her own life last year. Tragically, there have been other suicides since then. I want to highlight that, when considering a change to a new nationally consistent model of mandatory reporting, we have vastly increased the regulatory compliance and professional conduct apparatus in place that governs the medical sector. It is right that we do.

The AMA supports the increased work of AHPRA, the medical board and the new professional performance framework. The AMA, colleges and societies will always work with government to further improve the safeguards where we need to, but change is needed in this one area. I want to see the law changed to one where we talk about impairment to be ideally the same as the WA model. I know there are concerns about the risks of introducing a change to this aspect of the law. All those health practitioners who work with doctors will not be exempt from reporting any concerns. That will remain as it does in the current WA model. Poor practice is most likely to be witnessed in the workplace, and this proposed change will not impact that being reported. There will still be mandatory reporting occurring. The WA experience shows this.

The Australian Health Practitioners Regulatory Agency, AHPRA, annual report figures show that mandatory notifications have risen in WA since the exemption came into effect. Let me be very clear: mandatory notifications in WA have risen from 12 in 2011-12 to 38 in 2017-18. A change in the law will not mean that our professional and ethical responsibilities will disappear; they will remain. We take them seriously—we always will; it just means an exemption for the treating practitioner for treating the health issues of another practitioner.

The figures and personal stories compel us to act now. I also recognise that what we are pushing for is a big change. I recognise that, for all health ministers who have referred this law to you, there is an immense responsibility to ensure the safety of your citizens—our patients. I acknowledge that you have pressures from a wide range of stakeholders. I think the model being proposed by the AMA—which is the WA model—is the most ideal this committee could ask for. It is the right one.

Failing that, our submission makes it very clear that if you are contemplating the current draft then we have important edits that can be made to give the proposed bill the best chance of success. If you propose to send a message to the ministers that the WA law is what we should have, we stand ready. But in our opinion—and let me be very clear about this—the current draft without any of the suggested amendments will not achieve what the ministers intend.

CHAIR: We appreciate your opening statement. I put on record my thanks to all health practitioners within the AMA for the work they do across Queensland. Obviously, this has national implications. This is an important piece of legislation. I did note a couple of things in your submission. You heard me talk about the framework. You do acknowledge that the explanatory notes and the proposed guidance material go a considerable way towards creating an appropriate treatment framework for doctors. You were talking about the explanatory notes?

Dr Bartone: Yes.

CHAIR: What evidence do you have that the Western Australian model is superior in terms of health outcomes for registered health professionals and the general community? You mentioned two numbers: 12 in 2011 and 38 in 2017, some years apart.

Dr Bartone: Correct.

CHAIR: What is the breakdown of those cases in terms of mandatory reporting? Can you provide evidence of those particular cases? Were they around sexual misconduct or something else? I would like to know the breakdown of that increase in terms of what WA has experienced. Can you talk about what other evidence you may have as to why the WA model is superior in terms of the proposed reforms before us?

Dr Bartone: Those figures are AHPRA data, so they are on public record and they are mandatory reports. I cannot provide the breakdown but I am sure we can supply that to you. We should look at the WA situation as a live, in vitro test—a test tube in an experiment. We have evidence of a policy in place and we have the rest of the country where there has been a change in the law, so we can compare the status quo with the change. In fact, in the status quo situation we have had a threefold increase in the number of mandatory reports—more so than in any other jurisdiction around the country where mandatory reporting laws changed. That is a pretty good live example. When you are introducing new law into the community, rarely do you get the opportunity to live-test it in real time. That has to be part of the evidence. My WA colleagues will continue to confirm the fact that nothing has changed on their watch and that doctors feel free to access. Doctors' mental health remains one of the most critically important issues confronting our profession at the moment.

CHAIR: I acknowledge what you are saying. You quoted the beyondblue report, and we will have a look at that. We have asked if that can be tabled. That report *Answering the call* had 21,000 people from emergency services—one in three—at a higher risk than the general population for mental health and suicide risks, which is equivalent to what you are saying. I do not know the numbers in terms of treating practitioners and I look forward to reading that report. Do you have any data that quantifies the extent of the problem of health practitioners avoiding appropriate health care?

Dr Bartone: That goes to the essence of the issue. How can you determine the number of practitioners not presenting for care? We are talking about people perceiving a barrier to accessing care and not presenting. We are talking about situations which continue to skirt under the radar. If they do present, they present with not a full history or not a full state of concerns, so it is like treating a patient with only half a history, half an examination, half of a set of investigations. To have the full data we need to have the freedom of those practitioners presenting, and that is the barrier that we are alluding to. That is the real-time issue in terms of practitioners accessing care and in terms of keeping the public safe by removing practitioners at an early stage to treatment and having that appropriate treatment before it becomes an issue with catastrophic consequences.

CHAIR: If the Queensland parliament does pass the bill as currently drafted, there is obviously a critical need for an extensive education and communication campaign—we heard that raised previously with the profession—and the need to communicate that the law is intended to allow practitioners to seek treatment. Can you speak to that particular aspect of the bill?

Dr Dhupelia: It is going to be a very big responsibility for AHPRA to come up with educational material, resources and guidelines about what the actual law says and to ensure that what they are saying is what the legislation says. We need clarity. We know from the past that it takes a very long time to educate practitioners and there will always be confusion in regard to the interpretation of laws. We know that doctors catastrophise and self-diagnose quite a bit and they always look at the worst side of things. They look at this legislation, they look at the communication and resources that AHPRA

has, they interpret them differently and that stops them from fully disclosing when they go to a doctor. I am a GP. I have members who come to me in relation to their health, and I can sense when they are not telling me what they have come for. As experienced GPs we can all sense that, and that stops me from giving this patient a comprehensive treatment plan. Quite often we hear about the dire consequences that occur to these patients, and you well know that they did not disclose this to you when they came. That makes it difficult for us as treating practitioners.

What we are talking about here, as Tony has said, is a very small percentage of people who this law applies to of treating practitioners. The bulk of them who are working in large institutions, working side by side with nurses, allied health and doctors, will mandatorily report anybody who comes in intoxicated and their performance has gone off. This law is for those GPs who are looking after a few of the people who will come after-hours to them seeking their help, seeking their guidance. The WA model allows that. This model does not allow it.

CHAIR: This proposed reform relates to the treating practitioner who believes that there is a substantial risk of harm. You have heard me talk about this point before. That treating practitioner has to assess intoxication, impairment and departure from professional standards, consider the nature, extent and severity of that impairment and take steps to manage the impairment, measure the effectiveness of the impairment or any other relevant matters. That gives me some comfort that the treating health practitioner can put in place steps to consider mandatory reporting if there a high degree of substantial risk versus none. I look at that framework and think, 'That gives the health profession some confidence that the treating health practitioner can take all steps necessary to assess whether there is substantial risk before mandatory reporting.' What are your observations of that?

Dr Dhupelia: I would argue against that to a certain extent. The decision to treat applies only to impairment, as I see it. It does not, as the consultation document suggests, apply to drugs and alcohol nor a departure from professional standards. The AMA's concern is that, again, this creates confusion as it means that two or three sets of rules may apply to the same condition. For example, if an impairment involves alcohol, under the current draft legislation both the treating practitioner and the practitioner-patient will be unclear as to whether clause 141B(5) can be applied in determining risk or harm. Given the profession's tendency to adopt a risk-averse stance, they are both likely to interpret the section as requiring mandatory reporting. It is confusing. The decision tree is not clear. I think what AHPRA has to do as far as education will be unclear as well. This is a difficult situation for us.

CHAIR: Thank you very much for your comments.

Mr HUNT: I agree with you that having the Western Australian model to compare with is advantageous in our process. When we talked about high suicide rates among doctors you also talked about not knowing what we do not know in terms of who is not seeking help. Tragically, those suicide rates would be indicative of those not seeking help. Do you have any data or statistics in relation to the Western Australian medical profession suicide rate, as opposed to that in other jurisdictions, which might indicate a better model?

Dr Dhupelia: I do not have data specific to Western Australia but, as you have seen in the weekend papers and *Australian Doctor*, they have stated figures from the National Coronial Information System that shows that between 1 January 2011 and 21 December 2014—a period of just four years—there were 153 suicides in the health profession. By my mathematics, which I did fairly early this morning before I came here, that equates to one suicide every 9.5 days in the health profession. Granted, they are not all doctors. The lawmakers and the committee seem oblivious to this and are prepared to let it go under the radar, as this bill presently does. Here is a chance to change these laws to save the lives of the people of the profession who should be afforded the same care and opportunities as any other Australian patient.

The other data that is Queensland specific, in that Queensland is carrying this, is from the Queensland Doctors' Health Advisory Service, which currently receives up to six calls per week from doctors, or from members of their families as those doctors are too scared to make the phone call. At least four doctors in Queensland have committed suicide in 2017-18 and approximately one suicidal doctor in Queensland calls this doctors' health line every two months. Three-quarters of the calls to the program include concerns about mandatory reporting. They are frightening facts.

CHAIR: I do not at all play down the rates of suicide. It is a national conversation. As I have just articulated, from my career in the ambulance, 21,000 people from 33 agencies have provided evidence. I would like to see the breakdown of those numbers in Western Australia. You said that not

all of those suicides were medical health practitioners. Could you provide a breakdown of those suicides to see if they related to nursing, paramedicine or any other health professions besides the medical profession?

Dr Dhupelia: We will certainly try to get the data from the National Coronial Information System.

CHAIR: Thank you very much.

Mr HUNT: In relation to the Western Australian model and reporting, Western Australia relies on *Good medical practice: a code of conduct for doctors in Australia,* which states that doctors have a responsibility to notify the Medical Board of Australia if they are treating a doctor whose ability to practise may be impaired and may thereby be placing patients at risk. Is that not mandatory reporting, too? Would that requirement under the model that Western Australia works under still deter doctors from seeking help?

Dr Bartone: The wording there is 'mandatory'. There is no mandatory requirement, which then creates the barrier to the practitioners accessing the care in the first place. It is up to the judgement, the experience and the lifelong patient examples that underpin the quality of care provided by the treating doctor that he or she brings to each and every consultation in an independent and unbiased way. That is what that good medical guide is referring to. The minute you make it a mandatory reporting, it certainly creates the expectation and the perception in the mind of the patient doctor that there is the likelihood of potentially having a report and having a career-ending decision being made.

Ms PEASE: Dr Dhupelia, you have mentioned that you have practitioners who might come in and talk to you about other medical issues and you sense that there is something else going on. Further to that, and reading your current requirements—the ethical standards—would that not be a requirement for you to investigate further to try to get further information as to what is going on and how best to treat your patient?

Dr Dhupelia: Sure, absolutely. As skilled as we are as experienced GPs, we try to tease this out. We try to develop an element of trust—the doctor-patient relationship. The fact that a doctor is sitting in front of me means that they trust me, but they are still sounding out certain things to see whether they are at risk. It does not allow me as a GP to provide effective treatment when they are holding back. I want doctors to be able to come into my room and not think that they are coming into a courtroom. I do not want them to come thinking that there is a judge and a jury and that I am going to be reporting to AHPRA and, therefore, they are holding back. This is about treating and protecting the patients who just happen to be doctors.

Ms PEASE: I understand that. The circumstances are not particularly different, say, if you were a pilot and going for your licence with CASA and you are a DAME providing that. How do those investigations and assessment of the person who is getting their licence differ?

Dr Dhupelia: It differs in the sense that most of those examinations are mainly a physical type of an examination. Doctors are much more perceptive about their internal health issues and their mental health issues and what they wish to disclose and not disclose. The problem we are having here is that we are seeing the aftermath, not what they are not disclosing to us. That is where the difficulty is. We are seeing the aftermath of what happens to the families, or to the patients who do not get the appropriate treatment, or who self-treat. That is when we have to pick up the pieces. The law allows that at the present time.

Ms PEASE: I acknowledge the great work that all of our medical practitioners provide to our communities, but I am not just necessarily talking about mental health. There is also drug and alcohol addiction and substance abuse. If you are a pilot and you had to get your CASA licence, you would be doing blood tests to assess that. If you had a suspicion that there was a doctor who you were treating, what is your obligation to undertake some assessment of them in terms of their substance abuse?

Dr Dhupelia: Absolutely. It would be part of our questioning. Let me be clear up-front. The AMA does not support doctors using drugs or alcohol when conducting their clinical duties. This is unsafe and we recognise that. As doctors, we have to do everything to try to determine if this is the underlying cause. Changing this law is not about removing patient protection and safety. It is not about being intoxicated at work, because they will be found out and they will be reported. It is about letting them speak freely—the small minority of people—in general practices. This is about the small minority of patients who present to treating doctors. This law is about those treating GPs. We have to give them the freedom to look after those people who come to us after-hours in a distressed state to seek the help that they require.

Ms PEASE: I understand that. I am just trying to tease out that whole issue around patient care, because you have an obligation not only to the patient you are treating but also to do no harm to the general public. With the mandatory reporting, it is substantial risk of harm. If a medical practitioner comes to you and you suspect that they have some sort of substance abuse issue, do you not as a medical practitioner have an obligation to undertake an investigation into that?

Dr Dhupelia: And we will, absolutely. As the consultation unfolds, we will assess what is probably the underlying issue and, depending on that, we will investigate. I have lived and worked in Queensland for 40 years and we have had this legislation for several years. We know that it has not worked. To change the words on a document from 'risk of substantial harm' to 'substantial risk of harm' is not going to create any certainty to the way that is interpreted by those treating general practitioner doctors who are treating patient doctors. In coming back to your earlier point, the earlier we treat these doctors, who just happen to be patients, would ensure that the public are safe.

Ms PEASE: I agree.

Mr BERKMAN: Your evidence about other parallel mandatory reporting obligations is very interesting. If I understand your evidence correctly, under the WA model there is still a mandatory reporting obligation around any workplace awareness of colleagues who are, for example, suffering from a real impairment or intoxication or are otherwise straying from standard practice; is that correct?

Dr Bartone: Yes.

Mr BERKMAN: The upshot of that is that you say this distinction between the WA model and what is proposed here applies to a very narrow group of practitioners, for example GPs. Can you describe any other areas of practice where this is clearly going to make a difference?

Dr Bartone: The treating relationship between a doctor and another doctor patient typically would be a GP in the first instance but could be any other member of the profession in terms of any specialty or any other condition that confronts them. You clearly make the point: we are talking about a really small minority of doctors treating other doctors and not about the mandatory reporting that still exists in the workplace every day in every workplace around the country. That is not at stake here.

There are an increasing number of regulatory processes and frameworks being brought to bear by AHPRA, the Medical Board, our colleagues, our CPD and our training requirements that will ensure we continue to fine-tune and improve the processes by which we deliver safe and appropriate care to the Australian public. That is not what we are debating here today. We are talking about a really small minority of cases where we are talking about removing the barrier to early action, early intervention, early treatment and the resolution of the problem, especially at an early stage—affording that doctor the same level of care as any other member of the Australian public receives.

Mr BERKMAN: We are all aware of the chair's former life as an ambulance officer. To drill down into that further, if there were any circumstances in which a paramedic became aware of another treating practitioner who was potentially intoxicated or impaired in another way, there is no doubt whatsoever that that would be covered by mandatory reporting requirements in the workplace and that it is not going to slip through the cracks?

Dr Bartone: Absolutely.

Mr BERKMAN: Perhaps you were here for the discussion previously about the potential for a defence of reasonable excuse. Do you see that as any kind of a useful compromise? What are the potential benefits or flaws of that as an add-on to what is proposed in the bill?

Dr Bartone: I was not here for that discussion, but that would presuppose that we were happy and content with the law as it stood, and we obviously are not.

Mr BERKMAN: I take your position as essentially that is not really a useful compromise in any—

Dr Bartone: Absolutely not.

Mr McARDLE: Time is short, so I will not go back over the old ground. If you do not mind, Doctors, I will take on board the comments you have made in the submission and orally here today. I want to touch upon the consultation process. In a letter from Mr Luke Toy, at page 2, he talks about consultation as is explained in the explanatory notes for the proposed legislation but not the actual bill. Are you saying that you did not see the actual bill by way of consultation? You saw the COAG amendments but not the actual bill? Is that the case?

Dr Dhupelia: No, that is not what we are saying. We have seen the bill and looked at it. What we decided to do collectively as nine AMAs—as the federal and eight state and territory AMAs—is look at the legislation in front of us, the legislation that has taken 18 months of health ministers'

consideration before it came to us. We looked at the principles of the WA legislation and we looked at what has been presented to us in the legislation itself. We recommended collectively some sensible changes that, if this legislation is to go through, would be minimalistic changes that will make it clearer and give us clarity. We made those five recommendations, which are in our submission and in our appendices attached to our submission. It seems that they have listened that these are sensible changes, but they have put it in the explanatory notes. If you think it is important enough to put it in the explanatory notes, put it in the legislation and make it clearer. That is the whole point.

Mr McARDLE: One of the things that worries me is that all of us in this room are human beings and, therefore, subject to the vagaries of human nature. If I am a medical practitioner and I think I have a problem but I also am aware that if I see either of you gentlemen I could have a report done on me very quickly, I might delay seeing you—and my condition might exacerbate over time. As you know, as practitioners, early treatment and early diagnosis are critical. I am concerned that this bill now continues that theme—that is, I have a condition but I will not see either of you because you might put in a report on me, and my condition actually gets worse and worse. That continues to put patients at greater risk—substantial risk—as opposed to coming to you knowing there is the umbrella of not being reported on mandatorily using the WA model. Would that be an assessment?

Dr Dhupelia: Absolutely; you have hit it right on the head. I absolutely agree with you. I would refer you to today's *Courier-Mail* article and to Ms Susan Bryant's statement in the *Courier-Mail*. She lost her husband, Andrew Bryant, a famous gastroenterologist in Brisbane. I refer you to her emotive email that is in a link in the paper today. What she talked about very clearly was the culture that this legislation is actually creating. The article states—

> It's not just about the privacy issue of your boss finding out about private medical issues but they risk being told they can't work and that they may never be able to work again," she said. "A change in the mandatory reporting requirements would do a lot to create a culture where it is a lot more acceptable to seek help."

That is the aftermath that we have to pick up as doctors.

Dr Bartone: As trained medical practitioners, one of the things we do in the consulting room is create a safe environment for the exchange and the freedom to have a two-way conversation with our patients, to be able to pick up on cues. The minute you introduce anxiety or attempt to mask the situation, it is like putting a blindfold over one eye at least or one hand behind your back. You are not seeing the full story. That is what is at the heart here. It is not only that cultural change but also creating a safe and effective consultation environment for the doctor to seek the appropriate care at the appropriate time in advance, as you eloquently summarised our presentation.

Mr McARDLE: You would balance that outcome with protecting the patient as well?

Dr Dhupelia: Healthy doctors will have healthy patients.

CHAIR: Thank you both for your contribution today.

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

HARDY, Mr Matthew, National Director, Notifications, Australian Health Practitioner Regulation Agency (via teleconference)

ORCHARD, Dr Jamie, National Director, Legal Services, Australian Health Practitioner Regulation Agency (via teleconference)

CHAIR: We welcome your contribution this morning by phone. I am not sure if you have been following the public hearing to date. We ask if you could start please with an opening statement before we move to questions.

Mr Fletcher: Thank you for the opportunity to participate in the hearing today. My apologies that we cannot be with you in person. I think the committee is familiar with the work of AHPRA and the national boards in the national registration and accreditation scheme. We work together so the community has access to safe, quality health practitioners. As you particularly note, Chair, this week we welcomed more than 17,000 paramedics to the national scheme who are now nationally registered for the first time. They join more than 700,000 registered practitioners in 16 health professions across Australia. Public and patient safety is always our top priority. As the committee knows, we work closely with the Health Ombudsman in Queensland.

As you have heard from a number of other people who have appeared before you today, being a registered health practitioner can be very stressful. The Medical Board of Australia and the Nursing and Midwifery Board of Australia recognise this and provide more than $3.5 million of funding for independent health and wellbeing programs to support doctors, nurses and midwives.

Mandatory reporting is a very important part of our regulatory toolkit. It gives us information so we can act quickly to manage potentially serious risks to patient safety. We treat mandatory notifications in the same way we treat every other notification. It does not matter who makes the complaint or what part of the law they use to make it; we assess the risk to the public, gather information fairly, give practitioners the option to have their say and respond proportionately to keep patients safe.

My comments today will focus on mandatory reporting requirements as they relate to impairment. We are not aware of any current debate about the mandatory reporting requirements related to sexual boundaries, intoxication or unprofessional conduct. Mandatory reporting requirements must not stop doctors and other health practitioners seeking care. We want registered health practitioners to feel safe to seek the help they need. This is good for practitioners and good for patient safety.

There is misunderstanding about what mandatory reporting means and what it requires practitioners to do. There are crippling fears about what regulators will do when they get a mandatory report and there are distressing stories of doctors and other health practitioners being afraid to seek the care they need because of fear of losing their registration. This is despite the fact that no registered health practitioner in the jurisdictions in which we administer the national law has had their registration cancelled by a tribunal as a result of a mandatory report about an impairment. These fears are the unintended consequences of mandatory reporting and are the biggest challenges we face.

Clearly, the reporting threshold in the national law is important. However, changing words in the national law on its own will not solve the problem of fear and misunderstanding that we are told is driving practitioners away from seeking the care they need. There is an important difference between a health issue and an impairment. Health issues can be actively managed and do not affect practitioners' ability to provide safe care. An impairment significantly affects practitioners' ability to provide safe care. Mandatory reporting aims to make sure regulators know about practitioners with impairment so we can act to keep patients safe and get practitioners the care they need. There is no role for regulators in the practice of practitioners with health issues that are well managed when there is no risk to patients.

We know that treating practitioners are busy clinicians who make judgements about the risk that a practitioner-patient may pose to the public. We support the proposed new provisions in the bill that provide guidance to treating practitioners on impairment. These will help practitioners make informed decisions and know when they need to make a report and when they do not. We support

the intention of ministers to ensure health practitioners have confidence to seek treatment for health conditions while protecting the public from harm. Increasing the national consistency of mandatory reporting requirements for treating practitioners is also a step in the right direction.

We are pleased that health ministers have recognised the importance of an awareness campaign to clear up the misunderstanding that may be stopping practitioners seeking help. This will need the active support of government, employers, professional bodies and other regulators. It is a big and important task that cannot be done by one agency acting alone. As regulators, we will amend the mandatory reporting guidelines to help practitioners understand their mandatory reporting rights and obligations as agreed by ministers and legislated by the parliament.

In closing, I would also note that we support the decision of health ministers to increase penalties for offences under the national law. When someone falsely claims to be registered, they violate the trust of patients and seriously threaten patient safety. We support the increases in fines and the introduction of a custodial sentencing option for the most serious matters. The national law is the cornerstone of all of the work of AHPRA and the national board and we will play our part fully to implement the decision of ministers and parliament in relation to these amendments.

CHAIR: I am reading the submission. I wonder if you have heard from previous submitters. We just had the AMA, who were concerned that this proposed reform will increase the rate of things like suicide and other issues for fear of reporting by their members and they asked us to consider the WA model. What are your views on that? Have you heard any of the previous submissions this morning?

Mr Fletcher: We did hear the presentation of Dr Bartone and his colleague from the AMA whom you have just spoken with. I have not personally heard some of the earlier submissions. I would like to make a couple of points in relation to that.

As I said in my opening comments, we recognise that there is both misunderstanding and fear about what mandatory reporting means. We are hearing from a number of stakeholders that that is stopping people getting the help they need. We think any approach around legislative reform also needs to address that issue of fear and misunderstanding. That is why we welcome the fact that ministers have identified the importance of an awareness and education campaign. We also recognise that a number of people are calling for the WA exemptions to be rolled out nationally. I would note that if that was to be the case then those exemptions would apply across all of the grounds for mandatory notification because that is the way exemptions work currently in WA.

At the end of the day, the legislation under which we work is a matter for ministers to decide, not AHPRA. Our focus would be on continuing to work closely with all jurisdictions to administer the requirements for mandatory reporting in the national law, as we do now, and we have different arrangements in different jurisdictions now. We do strongly support as much as possible national consistency in approach because obviously that is going to help us communicate to registered health practitioners what they need to report and what they do not need to report.

CHAIR: In your opening statement you also said that no registrations had been cancelled as a result of mandatory reporting. Can you clarify that?

Mr Fletcher: What I said was that no registered health practitioner in the jurisdictions in which we, AHPRA, administer the national law with national board has had their registration cancelled by a tribunal as a result of a mandatory report about an impairment.

CHAIR: In your second last paragraph you talk about establishing an exemption for a first contact advisory service with regard to supporting the desire of health ministers for practitioners who are unwell to seek treatment. Can you unpack that a little bit for us?

Mr Fletcher: In my opening statement I referenced the fact that both the Medical Board of Australia and the Nursing and Midwifery Board of Australia provide funding for independent health and wellbeing programs. Essentially, the way these work is that they operate at arm's length from the board and from AHPRA. They are a point of first contact, advice and referral for health practitioners who are seeking support or help in relation to a health concern.

Mr BERKMAN: I am very interested in the statistic that no registered health practitioner has had their registration cancelled as a result of the mandatory reporting of impairment. I am interested in your take on this. It strikes me that that suggests that the mandatory reporting of impairment under our current experience in essence is all downside in terms of the cultural implications and the risk it creates for medical practitioners not seeking the help they need, and it does not actually offer any additional protections for consumers in terms of the need for that kind of consequence for the practitioners who have been reported. Do you think that is a fair observation?

Mr Fletcher: The point I was trying to make is that one of the things we are hearing is that the concern of many health practitioners which sometimes stops them seeking care is that if they are reported they will lose their registration. I am really making the point that in our experience there has not been a single registered health practitioner who has had their registration cancelled by a tribunal associated with a mandatory report about impairment. The wider point I would also make is that if I look across all of our regulatory action it is actually under one per cent—when you look at all of the grounds, in both mandatory and voluntary notifications—of matters that result in a practitioner going to a tribunal and potentially having their registration cancelled. From a percentage point of view, it is actually a very small percentage of the regulatory outcome that is achieved across-the-board for any concern that is raised with us.

The other point I would make is that there are a number of other outcomes that are open to us in relation to dealing with concerns about impaired practitioners. If I just look, for example, at some of the data we have provided to you where the notifier identifies as a treating practitioner—and this is not complete national data because we do not have all of the Queensland data in there—essentially about 45 per cent of the matters we see result in no further action; around 32 per cent result in an undertaking, which means that the practitioner voluntarily agrees to take steps to address whatever the concern might be; 20 per cent involve conditions, which might be a requirement that the board puts on that practitioner for certain additional steps they need to take to address whatever the issue of concern is; one per cent are cautioned; and two per cent go through a panel or tribunal. I think what we are really seeing is the fact that, as I say, I think there is a perception of an outcome that is not the reality when we look at the statistics. These reports are still important because there are a range of other regulatory outcomes that can be implemented which are focused on ensuring patient safety.

Mr BERKMAN: I am interested in your take on whether an education campaign can properly overcome this misapprehension and deal with the consequences of medical practitioners not seeking the treatment they need.

Mr Fletcher: I think it has a very important role to play, because the primary issue we are addressing here is an issue of fear and misunderstanding. But, as I said in my opening statement, I do not think we can do this alone. Obviously we can play a key role in it, but it is going to need professional bodies, employers, governments and others to play their part in this because I think it is going to be challenging to get this message out to people. There is no doubt about that.

Mr O'ROURKE: Thank you, Mr Fletcher, for your submission and comments today. You said there have been no registrations cancelled, but where a complaint has been received what is the threshold for someone to be suspended while there is an investigation underway and what is the time frame taken to do those investigations? Is there any general guide particularly in relation to GPs, sole practitioners, who have families depending on them for an income source?

Mr Fletcher: I might ask Matthew Hardy, our national director of notifications, to respond to that question.

Mr Hardy: Thank you very much for the question and the opportunity to respond. In terms of the threshold for where a suspension can occur, the provision in the national law is at section 156, which deals with the power for a national board to take what is called immediate action. That is interim action: it can only be taken where the board believes that there is a serious risk to public health and safety in these circumstances. There is a very high threshold for a board to take action which suspends or limits a practitioner's registration while they undertake an investigation. In fact, that provision is subject to an absolute right of appeal to a responsible tribunal. Those actions are never taken lightly, both because we understand the consequences to a practitioner and because they are subject to external legal scrutiny. The time to investigate these concerns obviously varies. I will have to take on notice the specific circumstance you have spoken about, which is practitioners who are general practitioners who practise in rural locations, to try to give you some more specific data. To give you an idea, the median time that it takes to complete an investigation is in the vicinity of 210 days.

Mr McARDLE: I note that in the penultimate paragraph of your submission you seek to exclude the first-contact advisory service in relation to practitioners; is that right?

Mr Fletcher: That is correct. We recommended that there might be value in looking at establishing an exemption for those people. The example that I gave earlier was these national board funded health programs.

Mr McARDLE: Would you support the doctors' health services, which are mentioned by the AMA in their submission, being exempted?

Mr Fletcher: Registered health practitioners in that context and also in the context of nursing, midwifery, health programs—essentially, any health program funded by a national board.

Mr McARDLE: You are talking about the first contact point?

Mr Fletcher: Yes.

Mr McARDLE: The second point I want to raise is that parliaments pass legislation on a daily basis. I cannot recall how many bills were passed last year. My concern is that every time a piece of paper is issued by a parliament, a body or an organisation, it can in fact create more confusion. I think you made the point that it would be very difficult for an education campaign to be assessed as to whether or not it is successful. Is it not the case that every time we push a bit of paper out into the ether it creates potentially more confusion? Is that not why we are here today? Is it not the fact that pushing out more paper will create more confusion?

Mr Fletcher: The point that I tried to make in my opening statement is that the reporting threshold in the national law is important, but I think the fundamental issue that we are seeking to address here is the fear and misunderstanding about what should or should not be reported.

Mr McARDLE: How many pages will you publish to try and rectify that?

Mr Fletcher: If the law is amended, we would need to revise the guidance that we provide to health practitioners with national boards on what is and is not required to be reported. Then we would obviously seek to work with others, as we have been asked by health ministers, to develop an education and awareness campaign and try to explain that as clearly as we can to registered health practitioners.

Mr McARDLE: How long would that take?

Mr Fletcher: I do not think it is going to be easy and I think it would be a focus over the longer term because, as I say, I think there are some very strongly held fears and concerns, as you have heard from others this morning.

CHAIR: Thank you very much, Mr Fletcher. I take it from that that it is difficult but not impossible when you have everyone on board to provide more rigour. I thank AHPRA for this morning's contribution. I also thank you for the work that you do in complaints management in Queensland. We look forward to meeting with you again in the near future. Answers to any questions taken on notice must be returned by 12 noon on Wednesday, 12 December. I thank all witnesses for their attendance today. The committee appreciates your attendance. I declare this hearing closed.

The committee adjourned at 11.25 am.