Speech By

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MEMBER FOR MAIWAR

Record of Proceedings, 26 February 2019

HEALTH PRACTITIONER REGULATION NATIONAL LAW AND OTHER LEGISLATION AMENDMENT BILL

Mr BERKMAN (Maiwar—Grn) (11.59 am): I rise to speak in support of the Health Practitioner Regulation National Law and Other Legislation Amendment Bill. Broadly speaking, I support the bill. The health committee heard very broad but somehow limited support from stakeholders in the medical profession on the basis that this reform moves mandatory reporting and the current framework in the right direction. However, the mandatory reporting framework at the centre of the bill raises really important and complex ethical questions, which I will address in a moment.

First of all, though, I want to note that, while the crossbench is used to having no role in the debate on the business motion for the week, it is disappointing that we do not have a bit more time to address this bill in the House. It is a very important bill, and to have had only two hours between the last sitting week and this week to deal with it I think is wholly inadequate. This is important legislation that at some point touches on each and every one of us, especially given the widely held view in the medical profession that mandatory reporting risks unnecessary harm to health practitioners and potentially worse patient outcomes.

This reform is driven by agreement at COAG. While that certainly provides a very important background for our work in the committee and here in parliament, I would suggest that agreement at COAG should not derogate from our responsibility as legislators in Queensland to very carefully consider each piece of legislation that comes before us.

There is no dispute about the fundamental importance of patient safety, yet the committee heard very real concerns about the consequences of mandatory reporting for health practitioners in need of medical assistance themselves. While I agree with the recommendations of the committee as set out in our report on the bill, I still have some concerns about the paucity of evidence to justify mandatory reporting and the potential unintended negative consequences for not only health practitioners who may be deferred from seeking the treatment they need but also the wellbeing of patients in the care of those health practitioners.

In simplest terms, we heard evidence that mandatory reporting requirements make health practitioners more reluctant to seek treatment themselves given the risk that they might find themselves reported in relation to the medical condition for which they are seeking treatment. This makes sense intuitively, and we heard accounts like this from a number of medical practitioners. The obvious consequence is that the system of mandatory reporting will in some cases deprive medical practitioners of the help they need, whether in respect of addiction, substance abuse or poor mental health. The less obvious consequence is that the patients of such a medical practitioner—the one deterred from seeking treatment—may also find themselves at a greater risk of harm. This point was succinctly put by Dr Michael Clements of the Royal Australian College of General Practitioners, who told the committee—

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 ...

The establishment of a higher threshold for mandatory reporting is certainly an improvement and, along with the additional guidance that is proposed to be developed for treating practitioners, is a development that the health profession broadly welcomes. However, this support for the proposed 'step in the right direction', as it is described, must be considered in the context of widespread opposition to mandatory reporting.

The Department of Health provided the committee a response to submissions on the bill, which makes clear that most submissions on the bill advocated for a complete exemption to mandatory reporting by treating practitioners in line with the approach that currently applies in Western Australia. This includes submissions from a number of health practitioners and various peak bodies including the Queensland Nurses and Midwives' Union, the Queensland Doctors' Health Program, the Royal Australian College of General Practitioners, the Royal Australasian College of Medical Administrators, the AMA, the Australian Medical Students' Association, the National Association of Practising Psychiatrists, the Australian Society of Anaesthetists, the Australian Psychological Society and the Australian Doctors Federation. It is a long and substantial list. Surely a united voice of concern from all these organisations warrants very careful consideration by this parliament and should not be dismissed as we simply legislate to implement an agreement reached by an unaccountable organisation like COAG.

The evidence from a number of these organisations noted the risk of overreporting by time-poor treating practitioners because of the remaining ambiguity in the proposed mandatory reporting framework. Alongside this, a number of submitters noted the terrible prevalence of mental health issues and higher suicide rates among the medical profession. No other group or class of patients faces the same kinds of limits on the confidentiality they are afforded in seeking treatment for poor mental health or addiction. There is a clear need for health practitioners to be provided better guidance on the threshold for reporting, and the factors to be taken into account under this new threshold, as is proposed alongside these changes to the reporting threshold. However, peak bodies representing the medical profession remain concerned that the nuanced change we are making to the Queensland law will make little practical difference for treating practitioners, resulting in at least a perception around the risk of overreporting and fewer medical practitioners seeking help when it is needed.

I do not think many of us would dispute that characterisation of the change we are making—a shift in the wording from 'risk of substantial harm' to a 'substantial risk of harm'—is indeed a nuanced one. It is difficult to argue that the new threshold does not carry much of the same ambiguity and could create the same uncertainty for medical practitioners as the former threshold.

The position of these professional bodies in line with the WA model is that medical practitioners' ethical and professional obligations are sufficient. For example, the obligations set out in section 9.3 of the Medical Board of Australia's code of conduct already quite clearly require medical practitioners to report a practitioner patient who may put public safety at risk. This brings us to the nub of the question before the House. Does more heavy handed regulation in the form of mandatory reporting improve public safety or diminish this by deterring our professionals from seeking treatment to ensure their own wellbeing?

Health Consumers Queensland, as always, provided the committee with really valuable insight from the consumer perspective, but their evidence also noted the difficulty in arriving at a position on the reform given the paucity of robust evidence and useful data on this question. Melissa Fox, the CEO of Health Consumers Queensland, highlighted vitally important questions to which we do not yet have evidence based answers. For example, 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?

In the same vein, the committee notes in the report that there is very limited evidence of the impact of the current mandatory notification regime. I would much prefer to see evidence based answers to these questions before we lead the COAG charge to implement this new regime. In the absence of this evidence, I would suggest that we take very seriously the committee's suggestion that there be an independent review of proposed changes through the COAG Health Council.

The committee in its report contemplates the following—

> A two stage review could initially consider existing data and make recommendations about data collection, including recommendations to identify the impact of the reforms on help-seeking by health practitioners. The second stage of the review could consider the impact of implementation of the mandatory reporting reforms.

I am very interested in the minister's view on this suggestion and I would implore him to advocate in the strongest possible terms at COAG for this kind of evidence gathering to better inform any future reform in this space.

I will turn very briefly to the LNP's proposed amendments and the explanations circulated in relation to these. In essence, they propose what was described in a number of submissions to the committee as the 'WA lite' model. The proposed amendments are afflicted by the same absence of an empirical evidence base, but I applaud the LNP for having erred on the side of harm minimisation in this instance. This position came as somewhat of a surprise to me, particularly in comparison to the 'tough on crime' and 'just say no' rhetoric that they are usually inclined to rely on. I would encourage the opposition as a whole to carefully consider harm minimisation strategies and medicalisation of our response to issues like drug use, addiction and substance abuse, and the intersection of these with our treatment of mental health issues.

I want to thank the committee members and the secretariat, as always, for the work that they put into the report on this bill. I want to thank everyone who assisted the committee with their evidence and experience in this space.