National registration legislative proposals need more work and more time

Kerry J Breen

ABSTRACT

- The release for public consultation of the draft *Health Practitioner Regulation National Law 2009* represents a once-in-a-generation opportunity to ensure best practice in medical regulation.
- The draft law fails to build on the best aspects of existing state and territory legislation, particularly in regard to how allegations of misconduct, poor performance or impairment are to be handled.
- If adopted, this legislation has the potential to set back important improvements to professional regulation that have been implemented in Australia in the past 20 years.
- There are also legitimate concerns about mandatory reporting provisions and the likely increased cost of regulation.
- More time and more work are needed to get this new scheme right.

MJA 2009; 191: 464–465

eMJA Rapid Online Publication 21 September 2009

It is now 3 years since the Council of Australian Governments (COAG) decided to act on some of the recommendations of the Productivity Commission's health workforce report,[1] and 18 months since COAG announced that national registration for health professionals would begin on 1 July 2010.[2] Public debate has focused on the lack of evidence base for the Productivity Commission proposals,[3] whether national boards should be profession-specific,[4] and the independence of the associated accreditation system. However, none of these issues relate directly to the central role of registration, which is to protect the community.

The release of the exposure draft of the *Health Practitioner Regulation National Law 2009* (known as Bill B) for public consultation now brings this issue into focus.[5] Despite the original stated intention of the National Registration and Accreditation Implementation Project (NRAIP) that the legislation be framed in a way that "builds on the best aspects of [existing] State and Territory schemes",[6] and the extensive consultations the NRAIP has conducted, there is deep concern that the proposed legislation does not meet this intention and fails to reproduce existing, effective medical regulation legislation. As this is a once-in-a-generation opportunity to ensure best practice, I argue here that more work needs to be done and more time should be provided to allow the NRAIP to get this right.

These fundamental concerns are clearly articulated in the submission to the NRAIP from the Joint Medical Boards Advisory Committee of the Australian Medical Council and the individual submissions of the existing state and territory medical boards (all submissions are available at http://www.nhwt.gov.au/natreg-billbsubs.asp). These bodies, which, without question, have the most extensive experience in the complexities of health professional regulation, have accepted that national registration must proceed, and have engaged positively to seek good outcomes for the community and those they regulate. However, in their submissions, they have identified that the provisions of Bill B relating to alleged unprofessional conduct, substandard performance and impairment of practitioners will not be workable as presently drafted. The Bill takes a complaints-focused approach, inappropriately regarding substandard performance and impairment as less serious categories of misconduct. This "one size fits all" draft legislation has the potential to wind back important improvements to professional regulation implemented in Australia in the past 20 years.

The legislation must clearly differentiate between matters of conduct, performance and impairment to allow the Medical Board of Australia to make an early assessment about which pathway is to be followed in relation to a particular notification (which might, or might not, arise out of a complaint), and give the flexibility to reassess and reassign a matter to a different pathway as it unfolds. Bill B, as drafted, requires a complaint to initiate an investigation and, after an initial assessment, provides little flexibility for reconsideration until the selected pathway is exhausted. In addition, Part 8, Division 7 of the draft legislation lacks important details, without which the performance processes are likely to be legally contestable and hence often unworkable.

From the viewpoint of the individual practitioner, most doctors have not opposed the proposed national registration system. Their reactions may have been different if the proposal had raised the likelihood (as the draft Bill B now does) of:

- a regressive change in how ill and possibly impaired doctors are managed;
- a mandatory reporting regime that threatens to make neighbour suspicious of neighbour;
- a significant increase in registration fees; and
- the addition of another layer of accountability.

In regard to impairment, the draft legislation will set back improvements made in recent years that have resulted in earlier presentation of sick doctors and improved access to the best available help. It goes far beyond the modern legislation in most Australian jurisdictions in at least three ways: it extends the statutory reporting obligation to all doctors and not just treating doctors; it fails to separate illness from possible impairment; and it fails to identify that any possibly impaired doctor who agrees voluntarily to suspend practice is no longer a risk to the public and should not be reported to a medical board. If an existing template has been used for this legislation, the obvious source is the 2008 mandatory reporting amendments to the New South Wales *Medical Practice Act 1992*. However, those amendments only extend to doctors who may be practising while intoxicated, leaving more general notification of alleged impairment as an ethical and professional obligation.

The approach to mandatory reporting of possible unprofessional conduct now proposed in sections 155 and 156 of Bill B, in combination with its definition of reportable conduct, is likely to create problems without any benefits. In their breadth, lack of specificity and bluntness of instrument, these sections are contrary to most of the current state and territory legislation (much of which is recent, introduced after wide consultation and parliamentary

debate). An exception, as far as mandatory reporting is concerned, is the amended NSW Medical Practice Act, but Bill B creates far broader reporting requirements than even that legislation. The NSW legislation places the onus on doctors to notify possible "flagrant departure" from professional standards, whereas the exposure draft of Bill B asks the reporting health care professional (ie, not just doctors) to make a much more difficult judgement about conduct that poses a "risk of substantial harm" to the public.

If the primary intention of this aspect of the mandatory reporting provisions is to assist in identifying "problem doctors" in hospitals, the reporting obligation should be restricted to medically qualified hospital managers, as they have governance responsibility for the medical staff they employ and are best placed to have all or most of the necessary information on which to base a decision to report. Such obligations are more likely to be fulfilled where institutions succeed in developing a strong culture of clinical responsibility. The United Kingdom health care system, which has also had its share of problem doctors, has chosen to use education and promotion of a culture of professional responsibility rather than to legislate mandatory reporting. The proposed Australian approach of expecting any health practitioner to report another health practitioner will create problems, especially for junior doctors who may have reasons for concern but will not usually have all the necessary evidence, nor the experience, wisdom or confidence, to make such a judgement. Even well justified reporting by a junior doctor is likely to have ramifications for that doctor's professional career, as the history of "whistleblowing" here and elsewhere amply demonstrates.

A steep rise in annual registration fees seems an unavoidable conclusion, based on the costs involved in adding layers of national committees (including the Australian Health Practitioner Regulation Agency [AHPRA] and its Management Committee, and the Medical Board of Australia) and their associated staff, the requirement for criminal checks of all new registrants, the proposed new position of "Public Interest Assessor", and the decision that existing state and territory medical boards and disciplinary tribunals will be maintained very much in their current roles. Recent advice from the AHPRA Management Committee that national agency staff will be limited to 35, down from initial estimates of nearly double that number, does not alter this conclusion.[7]

The proposed addition of another layer of accountability in the form of the Public Interest Assessor — being a person who is charged with assessing complaints and, in combination with the relevant national board, deciding what action is to be taken — comes as a surprise. In the absence of any explanation, this proposal undermines the valuable role played by community (ie, public) members of medical boards and hearing panels, and can be interpreted as indicating a lack of trust in the existing health complaints agencies and regulatory boards that strive to do their best at all times. Consistent with a previous Medicare agreement, all jurisdictions now have health complaints agencies, and most of these agencies already perform, in part, the role proposed for the Public Interest Assessor. A more cost-effective way of addressing the concerns implied by this new proposal would be to push for uniformity of this role for health complaints commissions in all jurisdictions — a suggestion that the Australian Health Workforce Ministerial Council has recently indicated it will accept.[8]

By not adopting existing effective legislation, the NRAIP also brings attention to a serious flaw in the approach that COAG has chosen to bring about national registration; namely, that legislation will be prepared at the direction of the NRAIP, agreed to by health ministers (but not debated in public) and put before the Queensland Parliament. Doctors in all jurisdictions other than Queensland are clearly not represented in that parliament, yet COAG has agreed that other jurisdictions will use their best endeavours to adopt this legislation as their template.[2] The greater the departure of the draft Bill from the best of existing legislation, the more serious this flaw becomes.

Some public submissions to the NRAIP have questioned the insistence on the tight timeline of mid 2010 for a process that represents a crucial opportunity to develop best-practice regulation for protecting the community and guiding health professionals. COAG set this timeline 18 months ago, before the complexity of the task was fully appreciated. COAG and the health ministers would be wise to recognise that to "hasten slowly" is now appropriate. The existing regulatory system, although somewhat inefficient in terms of interstate mobility, will nevertheless continue to adequately protect the community.

Competing interests

I have made personal submissions to the initial consultation on the content of Bill B and to the draft legislation. I have also contributed to a submission from the Victorian Doctors Health Program on the draft Bill B.

At the time this article was finalised, public consultation on Bill B had closed, but a revised version of the proposed legislation had not been released.

Author details

Kerry J Breen, AM, MB BS, MD, FRACP, Chairman, Board of Directors (also Past President, Medical Practitioners Board of Victoria, and Past President, Australian Medical Council)

Victorian Doctors Health Program, Melbourne, VIC.

Correspondence: kerry.breen@bigpond.com

References

1 Productivity Commission. Australia's health workforce: research report. Canberra: Commonwealth of Australia, 2005. http://www.pc.gov.au/projects/study/healthworkforce/docs/finalreport (accessed Sep 2009).

2 Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions. 2008; 26 Mar. http://www.nhwt.gov.au/documents/National%20Registration%20and%20Accreditation/NATREG%20-%20Intergovernmental%20Agreement.pdf (accessed Sep 2009).

3 Van Der Weyden MB. What is a doctor, and what does a doctor do [editorial]? *Med J Aust* 2005; 183: 560-561.

4 Cousins MJ. The absence of many voices in protest [letter]. *Med J Aust* 2007; 186: 383-384.

5 Australian Health Workforce Ministerial Council. *Health Practitioner Regulation National Law 2009* (Bill B): exposure draft. http://www.nhwt.gov.au/natreg.asp (accessed Sep 2009).

6 Practitioner Regulation Subcommittee, Health Workforce Principal Committee, Australian Health Ministers' Advisory Council. National Registration and Accreditation Scheme for the Health Professions. Consultation paper: proposed arrangements for handling complaints, and dealing with performance, health and conduct matters. Canberra: AHMAC, Oct 2008: 7. http://www.nhwt.gov.au/documents/National%20Registration%20and%20Accreditation/Call%20for%20submissions%20on%20proposed%20complaints%20arrangements.pdf (accessed Sep 2009).

7 Allen P. Fourth meeting of the Australian Health Practitioner Regulation Agency (AHPRA) Management Committee [communiqué]. 2009; 27 Jul. http://www.ahpra.gov.au/documents/Communique%20230709.pdf (accessed Sep 2009).

8 Australian Health Workforce Ministerial Council. Ministers consider submissions on legislation on national registration scheme [communiqué]. 2009; 27 Aug. http://www.nhwt.gov.au/documents/National%20Registration%20and%20Accreditation/Communique%20-%20Ministers%20consider%20submissions%20on%20legislation%20on%20national%20registration%20scheme.pdf (accessed Sep 2009).

(Received 4 Aug 2009, accepted 31 Aug 2009) ❑