



# **Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2018**

**Report No. 17, 56<sup>th</sup> Parliament**  
**Health, Communities, Disability Services and Domestic  
and Family Violence Prevention Committee**  
**February 2019**

## **Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee**

**Chair** Mr Aaron Harper MP, Member for Thuringowa  
Mr Joe Kelly MP, Member for Greenslopes (Acting Chair, 31 January to 4 February 2019)

**Deputy Chair** Mr Mark McArdle MP, Member for Caloundra

**Members** Mr Martin Hunt MP, Member for Nicklin  
Mr Michael Berkman MP, Member for Maiwar  
Mr Barry O'Rourke MP, Member for Rockhampton  
Ms Joan Pease MP, Member for Lytton

During the course of the committee's inquiry into the Bill, the following members were appointed under Standing Order 202 to replace members who were unable to attend: Mr Joe Kelly MP, Member for Greenslopes; Mr Bart Mellish MP, Member for Aspley, Ms Corrine McMillan MP, Member for Mansfield.

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### **Acknowledgements**

The committee acknowledges the assistance provided by the Department of Health and the Queensland Parliamentary Library.

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## Abbreviations

ADA	Australian Dental Association
AHPRA	Australian Health Practitioner Regulation Agency
AMA	Australian Medical Association
AMAQ	Australian Medical Association Queensland
AMSA	Australian Medical Students' Association
ANZCA	Australian and New Zealand College of Anaesthetists
the Bill	Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2018
CHC	COAG Health Council
COAG	Council of Australian Governments
the department	Department of Health
LSA	<i>Legislative Standards Act 1992</i>
National Law	Health Practitioner Regulation National Law
OHO	Office of the Health Ombudsman
PDL	Pharmaceutical Defence Limited
RACGP	Royal Australian College of General Practitioners
RANZCP	The Royal Australian & New Zealand College of Psychiatrists
'WA lite'	Description by the AMA of an alternative model for mandatory reporting by health practitioners, see p 16

## Chair's foreword

This report presents a summary of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's examination of the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2018.

The committee's task was to consider the policy to be achieved by the legislation and the application of fundamental legislative principles – that is, to consider whether the Bill has sufficient regard to the rights and liberties of individuals, and to the institution of Parliament.

I acknowledge the contribution to this inquiry of the committee chair, Mr Aaron Harper MP, who was unable to attend the meeting at which the committee adopted this report.

On behalf of the committee, I thank those individuals and organisations who made written submissions on the Bill. I also thank our Parliamentary Service staff and the Department of Health.

I commend this report to the House.

A handwritten signature in black ink, reading "Joe Kelly". The signature is written in a cursive style with a large initial "J" and "K".

Joe Kelly MP

Acting Chair

## Recommendations

### **Recommendation 1**

**4**

The committee recommends the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2018 be passed.

### **Recommendation 2**

**28**

The committee recommends the Minister for Health and Minister for Ambulance Services advise the House of the scope and timing of the proposed education program to raise awareness and understanding of the proposed mandatory reporting requirements.





## 1 Introduction

### 1.1 Role of the committee

The Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (committee) is a portfolio committee of the Legislative Assembly which commenced on 15 February 2018 under the *Parliament of Queensland Act 2001* and the Standing Rules and Orders of the Legislative Assembly.<sup>1</sup>

The committee's primary areas of responsibility include:

- Health and Ambulance Services
- Communities, Women, Youth and Child Safety
- Domestic and Family Violence Prevention, and
- Disability Services and Seniors.

Section 93(1) of the *Parliament of Queensland Act 2001* provides that a portfolio committee is responsible for examining each bill and item of subordinate legislation in its portfolio areas to consider:

- the policy to be given effect by the legislation
- the application of fundamental legislative principles, and
- for subordinate legislation – its lawfulness.

The Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2018 (the Bill) was introduced into the Legislative Assembly and referred to the committee on 31 October 2018. The committee is to report to the Legislative Assembly by 4 February 2019.

### 1.2 Inquiry process

On 6 November 2018, the committee invited stakeholders and subscribers to make written submissions on the Bill. Thirty-nine submissions were received (see Appendix A for a list of submitters) by the closing date of 26 November 2018.

The committee received a public briefing about the Bill from the Department of Health (the department) on 12 November 2018. A transcript is published on the committee's web page (see Appendix B for a list of officials in attendance).

The committee received written advice from the department in response to matters raised in submissions on 3 December 2018.

The committee held a public hearing and a second departmental briefing on 5 December 2018 (see Appendix C for a list of witnesses and Appendix B for a list of officials in attendance).

The submissions, correspondence from the department and transcripts of the briefing and hearing are available on the committee's webpage.

### 1.3 Policy objectives of the Bill

According to the explanatory notes, the Bill amends the Health Practitioner Regulation National Law (National Law) as agreed by the Council of Australian Governments (COAG) Health Council on 12 October 2018 to:

- introduce reforms to mandatory reporting by treating practitioners, to ensure health practitioners have confidence to seek treatment for health conditions, while protecting the public from harm, and

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<sup>1</sup> *Parliament of Queensland Act 2001*, section 88 and Standing Order 194.

- double the penalties for holding out and related offences under the National Law from \$30,000 to \$60,000, and introduce a maximum imprisonment term of three years for the most serious offences.<sup>2</sup>

The Bill makes consequential amendments to the Queensland local application provisions of the *Health Practitioner National Law Act 2009* (Qld) to:

- align Queensland's approach to mandatory reporting by treating practitioners with the approach in the National Law by removing a Queensland-specific provision, and
- provide for circumstances in which the holding out and related offences are prosecuted on indictment and summarily in Queensland.

The Bill also makes consequential amendments to the *Ambulance Service Act 1991* (Qld) and *Hospital and Health Boards Act 2011* (Qld).

If the Bill is passed the amendments would automatically apply in all states and territories except Western Australia,<sup>3</sup> which must pass corresponding legislation, and South Australia, which must make regulations to apply the changes.

## **1.4 Consultation on the Bill**

Any amendments to the national law must be agreed to by the health ministers of all states and territories and the Commonwealth at COAG Health Council before an amendment is introduced into the Queensland Parliament (the host jurisdiction). On 12 October 2018, after national consultation on the issues, the COAG Health Council approved the proposed amendments to the National Law.

### **1.4.1 Reforms to mandatory reporting by treating practitioners**

As outlined in the explanatory notes, the amendments in the Bill dealing with mandatory reporting by treating practitioners were the subject of two rounds of national consultation.

In September 2017 a discussion paper<sup>4</sup> was released inviting submissions on four options for reforms to mandatory reporting by treating practitioners. Appendix D of this report explains the current mandatory reporting requirements and the issues identified in the discussion paper which may impact on a registered practitioner's likelihood of seeking treatment. Those issues include: concerns about respecting patient confidentiality; the requirement to report past conduct; and a lack of national consistency.

Forty-seven written submissions were received in response to the national discussion paper. Approximately half of the submissions supported the Western Australian model of providing a complete exemption from mandatory reporting by treating practitioners. The balance of written submissions supported a model that would continue to require mandatory reporting by treating practitioners for intoxication, practice outside of professional standards and sexual misconduct, however they were divided on whether there should be mandatory reporting for impairment.<sup>5</sup>

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<sup>2</sup> Explanatory notes, p 1; COAG Health Council, *Communique*, 12 October 2018, <https://www.coaghealthcouncil.gov.au/Portals/0/CHC%20Communique%20121018.pdf>

<sup>3</sup> Western Australia has notified health ministers that it does not intend to adopt the mandatory reporting reforms in the Bill.

<sup>4</sup> Australian Health Ministers' Advisory Council, *Mandatory reporting under the Health Practitioner Regulation National Law*, Discussion paper, 12 September 2017, <https://www.coaghealthcouncil.gov.au/Portals/0/Mandatory%20reporting%20under%20the%20Health%20Practitioner%20Regulation%20National%20Law.pdf>.

<sup>5</sup> Impairment is defined in section 5 of the National Law as '... a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect ... the person's capacity to practise the profession.'

In April 2018, the COAG Health Council considered the results of the consultation. It decided to progress amendments for mandatory reporting requirements for treating practitioners (including impairment).<sup>6</sup> The committee was advised by Queensland Health that the COAG Health Council did not support the Western Australian model.<sup>7</sup>

In August 2018, the COAG Health Council approved a targeted consultation process for the proposed mandatory reporting amendments with stakeholders.<sup>8</sup> They included:

- Australian Medical Association (AMA)
- Royal Australian College of General Practitioners (RACGP)
- Consumers Health Forum
- National Board Chairs<sup>9</sup>
- Australian Health Practitioner Regulation Agency (AHPRA) Professions Reference Group
- AHPRA Community Reference Group.

Stakeholders were provided with a consultation draft of the proposed amendments and a consultation paper explaining the reforms. The Department of Health advised ‘the purpose of the consultation was to consider whether the Bill adequately reflected the ministers’ policy intent, rather than another round of consultation on the policy underpinning the reforms’.<sup>10</sup>

In Queensland, meetings were held with the Australian Medical Association Queensland, Queensland Nurses and Midwives’ Union and Health Consumers Queensland.

Twenty-nine written submissions were received from stakeholders in response to the targeted consultation. The majority of stakeholders supported the overall approach of the draft amendments, although some stakeholders suggested changes to the draft legislation in three key areas:

- threshold for reporting—some stakeholders argued that both the likelihood of the harm occurring and the level of harm should be specifically referred to in the threshold test, such as requiring a test of ‘substantial risk of substantial harm’ rather than the proposed ‘substantial risk of harm’. They argued that the proposed test could be interpreted to require mandatory reporting of low-level or trivial harm provided that there is substantial risk that the harm will occur. Health ministers were satisfied that the threshold of ‘substantial risk of harm’ achieves the appropriate balance.
- holistic assessment of risk—some stakeholders argued that the Bill should specifically recognise that instances of intoxication or departure from professional standards may be linked to an underlying impairment and, in these circumstances, should be required to be assessed using the same guidance factors that apply to an impairment. Health ministers were satisfied that the proposed legislation provides a sufficient basis for a treating practitioner to consider a practitioner-patient’s conduct in its entirety.

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<sup>6</sup> COAG Health Council, *Communique*, 13 April 2018, [https://www.coaghealthcouncil.gov.au/Portals/0/CHC%20Communique%20130418\\_corrected\\_1.pdf](https://www.coaghealthcouncil.gov.au/Portals/0/CHC%20Communique%20130418_corrected_1.pdf).

<sup>7</sup> Department of Health, Correspondence, 3 December 2018.

<sup>8</sup> COAG Health Council, *Communique*, 2 August 2018, [https://www.coaghealthcouncil.gov.au/Portals/0/CHC%20Communique%20020818\\_1.pdf](https://www.coaghealthcouncil.gov.au/Portals/0/CHC%20Communique%20020818_1.pdf).

<sup>9</sup> The National Law establishes 15 National Boards that register and regulate health practitioners from 16 regulated health professions.

<sup>10</sup> Ms Kathleen Forrester, Deputy-Director-General, Strategy, Policy and Planning Division, public briefing transcript, Brisbane, 12 November 2018, p 4.

- telephone advisory services—some stakeholders sought an exemption from mandatory reporting for telephone advisory services that provide early intervention or referrals for practitioners. Some consumer groups were wary that such an exemption could be perceived to be, or could be used as, a ‘loophole’ for practitioners to avoid mandatory reporting requirements. Health ministers were not satisfied that such an exemption was necessary or appropriate.

Commenting on the assessment by ministers that the issues raised did not require further changes, the Department of Health stated:

*... ministers considered that the Bill as it is presented strikes the right balance between ensuring health practitioners can seek help for health conditions while also maintaining strong protections for health consumers by retaining mandatory reporting if there is a substantial risk of harm.<sup>11</sup>*

#### **1.4.2 Increased penalties for holding out and related offences**

As set out in the explanatory notes, in April and May 2017 targeted consultation was undertaken with stakeholders about the proposals to increase penalties in the National Law and introduce a term of imprisonment. Three national consultation forums were held by teleconference and 36 written submissions were received. Stakeholders broadly supported changes to increase penalties and introduce a term of imprisonment for the ‘holding out’ and related offences.

#### **1.5 Should the Bill be passed?**

Standing Order 132(1) requires the committee to determine whether or not to recommend that the Bill be passed.

The committee considers that the Bill strikes an appropriate balance between ensuring health practitioners can seek help for health conditions by raising the mandatory reporting threshold for treating practitioners, while at the same time maintaining strong protections for health consumers. It does this by retaining mandatory reporting where a treating practitioner reasonably believes the public is at ‘substantial risk of harm’.

The committee supports the new custodial sentences and increased fines for offences committed by people who hold themselves out to be registered health practitioners, including those who use reserved professional titles or carry out restricted practices when not registered.

#### **Recommendation 1**

The committee recommends the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2018 be passed.

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<sup>11</sup> Ms Kathleen Forrester, Deputy-Director-General, Strategy, Policy and Planning Division, public briefing transcript, Brisbane, 12 November 2018, p 5.

## 2 Examination of the Bill

This section discusses issues raised during the committee's examination of the Bill.

### 2.1 Mandatory reporting by treating practitioners

The Bill proposes to raise the mandatory reporting threshold for treating practitioners—a treating practitioner will only be required to make a mandatory report if their practitioner-patient's conduct involving impairment, intoxication, or substandard practice *places the public at substantial risk of harm*. These reforms are aimed at ensuring health practitioners seek treatment for health conditions (such as a mental health issue or an alcohol or drug problem) without fear of being subject to mandatory reporting. However, this higher threshold would not apply to the mandatory reporting of sexual misconduct.<sup>12</sup>

The Bill proposes to strengthen requirements for reporting of sexual misconduct, including a new requirement to report risks of future sexual misconduct. This will ensure that if a treating practitioner becomes aware a practitioner-patient is, for example, grooming a child or a patient, they would be required to report the matter to the regulator (in Queensland, the Office of the Health Ombudsman).

The Bill proposes that treating practitioners use their professional judgement and expertise in considering whether a health condition is being managed appropriately by taking a holistic assessment of risk of harm to the public. As the explanatory notes to the Bill state:

*A treating practitioner may make an overall assessment about a practitioner-patient's conduct relating to impairment, intoxication or departure from professional standards in deciding whether a mandatory report should be made. All three types of conduct are measured against the same threshold for reporting. If an impairment issue is connected to, or a significant cause of, intoxication or departure from professional standards, a treating practitioner is able to take into account the effectiveness of treatment or engagement in treatment of an impairment by the practitioner-patient in deciding whether there is likely to be an ongoing risk of harm to the public.*<sup>13</sup>

The Bill provides guidance to treating practitioners about the matters they may consider when deciding whether an impairment is being managed appropriately.<sup>14</sup> The Bill provides guidance factors treating practitioners may consider when deciding whether a mandatory report is required. These factors were outlined in the explanatory notes as follows:

- *the nature, extent and severity of an impairment*
- *the steps a practitioner-patient is taking or willing to take to manage an impairment*
- *the extent to which an impairment can be managed with appropriate treatment*
- *any other matter a treating practitioner considers is relevant to the risk of harm the impairment poses to the public.*<sup>15</sup>

The guidance factors allow for a more nuanced assessment by a treating practitioner of a patient as described by the Department of Health:

*It is not just does the person have an impairment; does the person have a mental illness; does the person have depression. That is not enough to require a mandatory report. You need to*

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<sup>12</sup> Clause 19 inserts proposed new sections 141A to 141C about mandatory reporting; also see explanatory notes pp 5 – 6 and pp 18 – 21.

<sup>13</sup> Explanatory notes, p 5.

<sup>14</sup> Proposed new section 141B(5), inserted by clause 19.

<sup>15</sup> Explanatory notes, p 5.

*consider what is the nature, type and extent of the illness.*<sup>16</sup>

The higher threshold for reporting of intoxication and substandard practice, together with the inclusion of guidance factors for impairment, attempt to make it clear that only serious health conditions that are not being appropriately managed through treatment or mitigation strategies need to be reported—because they place the public at substantial risk of harm. The proposed changes aim to provide registered health practitioners with greater confidence to seek treatment for their health conditions.

The Department of Health noted that the proposed changes to mandatory reporting for impairment are relatively minor for Queensland:

*In 2014, Queensland modified the national law to recognise the special position of treating practitioners. Queensland's current approach is similar to the approach in the Bill, as both use a threshold of substantial risk of harm to require reporting of impairment. However, to avoid confusion about the application of the current Queensland provision, and to ensure greater national consistency, Queensland has agreed to adopt the national law approach to mandatory reporting by treating practitioners. This means that all elements of the mandatory reporting reforms in the bill will apply in Queensland, including the guidance factors, which are not part of Queensland's current provisions.*<sup>17</sup>

The Department of Health suggested that one way to consider the Bill is that the higher threshold for reporting impairment set by Queensland in 2014 is now proposed for adoption in the National Law:

*Queensland changed its mandatory reporting laws in 2014 to create an exemption for treating practitioners when a patient-practitioner has an impairment. Currently, Queensland only requires a treating practitioner to report another registered health practitioner's impairment if the impairment would place the public at substantial risk of harm. One way to consider the Bill is that the higher standard for reporting impairment set by Queensland in 2014 is now being proposed for adoption to the National Law.*<sup>18</sup>

The National Law also contains requirements for treating practitioners to report medical students who have an impairment that may place the public at substantial risk of harm when the student is undertaking clinical training. The Bill does not propose to change the threshold for mandatory reporting of a student's impairment by a treating practitioner. However, similar to the approach for mandatory reporting of a practitioner-patient explained above, the Bill lists guidance factors that a treating practitioner may consider in deciding whether a mandatory report about a student's impairment is required.

Table 1 below provides a summary of differences between the National Law provisions, Queensland provisions and the new provisions in the Bill.

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<sup>16</sup> Ms Kathleen Forrester, Deputy-Director-General, Strategy, Policy and Planning Division, public briefing transcript, Brisbane, 12 November 2018, p 6.

<sup>17</sup> Ms Kathleen Forrester, Deputy-Director-General, Strategy, Policy and Planning Division, public briefing transcript, Brisbane, 12 November 2018, p 3.

<sup>18</sup> Public briefing transcript, Brisbane, 5 December 2018, p 3.

**Table 1: Treating practitioner mandatory reporting requirements: summary of differences**

	<b>Current provisions of National Law</b>	<b>Current provisions applied in Queensland</b>	<b>Proposed new provisions as amended by the Bill</b>
Impairment	Practitioner has placed the public at <b>risk of substantial harm</b> by practising with an impairment	Practitioner is placing the public at <b>substantial risk of harm</b> by practising with an impairment	Practitioner is placing the public at <b>substantial risk of harm</b> by practising with an impairment. Guidance factors in Bill also apply
Intoxication	Practitioner has practised while intoxicated by alcohol or drugs		Practitioner is placing the public at <b>substantial risk of harm</b> by practising while intoxicated by alcohol or drugs
Substandard practice	Practitioner has placed the public at <b>risk of harm</b> because they have practised in a way that constitutes a significant departure from accepted professional standards		Practitioner is placing the public at <b>substantial risk of harm</b> by practising in a way that constitutes a significant departure from accepted professional standards
Sexual misconduct	Practitioner has engaged in sexual misconduct in connection with the practice of their profession		Practitioner has engaged or <b>is at risk of engaging</b> in sexual conduct in connection with the practice of their profession

**Source:** Department of Health, tabled paper, public briefing, Brisbane, 12 November 2018.

Western Australia notified the COAG Health Council on 13 April 2018 that it will not implement the changes to mandatory reporting by treating practitioners in the Bill.<sup>19</sup> Western Australia will retain its current arrangements of a complete exemption for mandatory reporting by treating practitioners.<sup>20</sup>

### 2.1.1 Outcomes of mandatory notifications in Queensland

Data from OHO shows that 45 mandatory notifications were made by treating practitioners in the 16 and a half month period from 1 July 2017 to 13 November 2018. The actions taken by OHO are summarised in Table 2.

**Table 2: Action taken for mandatory notifications received by OHO from treating practitioners, 1 July 2017 to 13 November 2018**

<b>OHO action</b>	<b>No. of notifications</b>	<b>Per cent</b>
Referred to AHPRA	23	51 %
Referred for assessment	7	16 %
Referred for investigation	7	16 %
Immediate action (e.g. imposing conditions on registration or suspending registration)	5	11 %
No further action	2	4 %
Referred to another agency	1	2 %
<b>Total</b>	45	100 %

**Source:** Department of Health, Correspondence, 21 November 2018, data provided by OHO

Five of the mandatory notifications resulted in immediate action by OHO (such as suspension of registration or the imposition of conditions). The grounds for 'immediate registration action' under

<sup>19</sup> COAG Health Council, *Communique*, 13 April 2018, [https://www.coaghealthcouncil.gov.au/Portals/0/CHC%20Communique%20130418\\_corrected\\_1.pdf](https://www.coaghealthcouncil.gov.au/Portals/0/CHC%20Communique%20130418_corrected_1.pdf).

<sup>20</sup> Western Australia exempts treating practitioners from mandatory reporting for all forms of notifiable conduct if their patient is a registered health practitioner. However, treating practitioners may make voluntary reports based on their professional and ethical obligations to report matters that may place the public at risk of harm.

section 58 of the *Health Ombudsman Act 2013* include that, because of the practitioner's health, conduct or performance, they pose a serious risk to people and it is necessary to take action to protect public health or safety. Fourteen notifications (31 per cent) were referred for assessment or investigation, suggesting that further information was needed to determine what action was appropriate. Approximately half of mandatory notifications to OHO by treating practitioners were referred to AHPRA.

## **2.1.2 Mandatory reporting reforms and practitioner confidence to seek treatment**

### ***2.1.2.1 Concerns about mandatory reporting reforms***

The stated objective of the mandatory reporting reforms is 'to ensure health practitioners have confidence to seek treatment for health conditions, while protecting the public from harm'.<sup>21</sup> Health practitioner stakeholders gave limited support for the proposed mandatory reporting reforms, questioning whether the reforms would give confidence to health practitioners to seek treatment for their health conditions. While some submissions stated that the proposed amendments in the Bill represented an improvement from the existing legislation or a 'step in the right direction', many submissions advocated the Bill should go further to support health practitioners seeking treatment.

For example, Dr Michael Clements of the RACGP stated the Bill 'does not go far enough':

*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 practitioners that may or may not need to be notified under the voluntary system.*<sup>22</sup>

Many stakeholders were not confident that the proposed legislative change would encourage health practitioners to seek help for their conditions or discourage over-reporting by treating practitioners.<sup>23</sup> Some stakeholders blamed this lack of confidence on the ambiguity and complexity of the proposed amendments in the Bill.

For example, the AMA stated:

*Looking at it 'through the eyes' of a doctor in consulting room, with time pressures and the weight of responsibility of having to make an incredibly difficult decision, we need simplicity and certainty about the threshold that is the line in the sand and the proposed amendments do not do this. This is not a situation where a doctor has the luxury of going away and contemplating things before making a decision—the Health Practitioner Regulation National Law (National Law) must be clear, it must be unambiguous.*

*To do this, we must remove language that creates any level of ambiguity for the treating practitioner. Otherwise, as with the current National Law, they will seek to manage their own risk by over reporting, or equally the patient practitioner will adopt an overly cautious approach and not seek treatment. The Bill as it currently stands, does not remove this ambiguity and will cause patient practitioners to question their ability to seek treatment, without risking their future*

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<sup>21</sup> Explanatory notes, p 1.

<sup>22</sup> Public hearing transcript, Brisbane, 5 December 2018, p 6.

<sup>23</sup> The Royal Australian & New Zealand College of Psychiatrists (sub 5), Dr Mark Raines (sub 7), Queensland Doctors' Health Programme (sub 11), Dr Bill Glasson and Professor Claire Jackson (sub 12), Benjamin Veness et al (sub 14), Victoria Point Surgery (sub 18), Australian Medical Association (sub 21), Australian Medical Students' Association (sub 22), MIGA (sub 25), Dr Kerry Breen (sub 27), Royal Australasian College of Surgeons Queensland (sub 28), Australian Society of Anaesthetists (sub 29), Elizabeth Kable (sub 32) and Dr Marianne Cannon (sub 37).



*livelihoods and careers. The AMA believes that, like the current legislation, this Bill will risk health practitioners' well-being and their lives.*<sup>24</sup>

Benjamin Veness and seven other junior doctors, while recognising the proposed amendments were a 'step in the right direction', indicated they were not sufficient to provide reassurance to doctors at risk or to prevent 'defensive notifications' by treating practitioners:

*The creation of doubt and uncertainty in the existing legislation (except for Western Australia) has severely undermined the success of our current framework, and the proposed reforms do not remove such doubt. It must be remembered that the doctors at greatest risk are those suffering mental illness—symptoms of which often include exaggerated self-doubt and feelings of hopelessness. In order not to perturb doctors from seeking help for fear of being reported, the law must be perfectly clear both to them and to their potential treating doctor. If they fear that the law is ambiguous and thus incentivises defensive behaviour by treating doctors (i.e. over-reporting), then it will have failed to protect either the doctors at risk or the patients they continue to treat. Given such ambiguity remains in the current Bill, we believe it will fail in its goal to promote help-seeking among doctors.*<sup>25</sup>

The issue of defensive notifications was also raised by Dr Michael Clements of the RACGP:

*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 [medical defence organisation] 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.*<sup>26</sup>

Mr Timothy Bowen of MIGA (medical defence and professional indemnity insurer) highlighted the concerns of treating practitioners when considering making a mandatory report, including the risks to the public and the practitioner-patient, and the ways the matter is managed after reporting:

*We 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.*<sup>27</sup>

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) suggested the 'exceedingly nuanced language' in the Bill would not give health practitioners the confidence to seek help:

*In the Bill's ... speech, the Hon. Dr Steven Miles MP correctly notes that the reform should not simply aim to create a legislative change but an attitudinal one—that is, health practitioners*

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<sup>24</sup> Submission 21, p 1.

<sup>25</sup> Submission 14, p 3.

<sup>26</sup> Public hearing transcript, Brisbane, 5 December 2018, p 7.

<sup>27</sup> Public hearing transcript, Brisbane, 5 December 2018, p 12.

*must have the confidence, not merely the legal protection, to seek help. The RANZCP is concerned that the proposed reform may not improve the confidence of health practitioners in the legal protections afforded them to seek help for an ‘impairment’, in part due to its exceedingly nuanced language.<sup>28</sup>*

Dr Kerry Breen suggested that no matter how much effort is put into qualifying the legal duty for mandatory reporting (of impairment) by treating practitioners, the outcome will be the same and the National Law will continue to have unintended and perverse effects on the community:

*My deepest concern however is that via these proposed changes, the Health Ministers of Australia have refused to listen to the many experts and other who have urged that the legal duty to report must be removed from the shoulders of treating doctors. No matter how much effort is put into qualifying that duty, the effect will remain the same: sick doctors will delay or avoid seeking help for fear of being reported. Thus the national law will continue to have the perverse effect of increasing the risk to the community that an impaired doctor will continue to practise when it may be unsafe to do so.*

*... As I wrote several years ago, this aspect of the National Law has set back the care of ill doctors and will continue to do so. The deaths of doctors, including some tragically by suicide, can be partially blamed on Health Ministers who refuse to take professional advice and seem driven by populist pressures.<sup>29</sup>*

#### 2.1.2.2 Health professions and misunderstandings of mandatory reporting

Mr Martin Fletcher, CEO of AHPRA suggested there is a misunderstanding in the health professions about what mandatory reporting means and what it requires practitioners to do. Importantly, no registered health practitioner has had their registration cancelled as a result of a mandatory report (related to impairment):

*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.<sup>30</sup>*

Mr Fletcher also made the point that in less than one per cent of notifications (both mandatory and voluntary) for all grounds (sexual misconduct, intoxication, impairment, substandard practice) do registered health practitioners have their registration cancelled:

*The wider point I would also like to make is that if I look across all 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.<sup>31</sup>*

Mr Matthew Hardy of AHPRA also stated that there is ‘a very high threshold’ for a board to take action to suspend a practitioner’s registration while AHPRA undertakes an investigation and such decisions are ‘never taken lightly’:

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<sup>28</sup> Submission 5, p 1.

<sup>29</sup> Submission 27, p 1.

<sup>30</sup> Public hearing transcript, Brisbane 5 December 2018, p 23.

<sup>31</sup> Public hearing transcript, Brisbane, 5 December 2018, p 25.

*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.<sup>32</sup>*

The Department of Health also sought to address stakeholders' misunderstandings of mandatory reporting as a 'career-ending event':

*Some stakeholders have equated the making of a mandatory report in which a practitioner will lose their livelihood. This is simply not the case. The outcome of each report is considered on its merits and a range of regulatory responses may be appropriate, depending on the circumstances of each case.*

*Some mandatory reports result in no regulatory action being taken against the practitioner. However, reports made to the regulator can be used to assess patterns of behaviour over time and particularly where the health impairment is worsening or becoming a higher risk to the public. Almost every step in the process is subject to either review or appeal to a tribunal.<sup>33</sup>*

### **2.1.3 Evidence about impacts of current mandatory reporting arrangements**

#### **2.1.3.1 Consumer perspective**

Ms Melissa Fox, CEO of Health Consumers Queensland was concerned there was not a good understanding of the extent of problems with the current arrangements:

*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.<sup>34</sup>*

As a consequence, Health Consumers Queensland wanted ongoing monitoring and a transparent evaluation process established so that the public confidence in the system could be maintained.

*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? Did the treating practitioners feel that they had the information and supports they*

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<sup>32</sup> Public hearing transcript, Brisbane, 5 December 2018, p 25. Note that in Queensland, the Health Ombudsman makes initial 'immediate action' decisions; the decision is subject to appeal.

<sup>33</sup> Public briefing transcript, Brisbane, 5 December 2018, p 3.

<sup>34</sup> Public hearing transcript, Brisbane, 5 December 2018, p 14.

*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?*<sup>35</sup>

### 2.1.3.2 *Beyond Blue national mental health survey of doctors - barriers to seeking help*

Many submissions cited the findings of Beyond Blue's survey of doctors and medical students to justify the repeal of current mandatory reporting laws.<sup>36</sup> This 2013 study surveyed just under 43,000 doctors, resulting in 11,379 completed surveys (a 26.5% response rate). The authors noted the response rate was a modest proportion of the total of Australian doctors' population participating in the survey, '... and it is possible that respondents and non-respondents may differ significantly with regards to other variables of interest.'<sup>37</sup>

The report identified barriers to seeking help for and support for a mental health condition. They included a lack of confidentiality and the impact on registration and right to practice; however a range of other barriers to seeking help were reported by doctors, including:<sup>38</sup>

- lack of confidentiality/privacy (52.5 per cent)
- embarrassment (37.4 per cent)
- impact on registration and right to practice (34.3 per cent)
- preference to rely on self or not seek help (30.5 per cent)
- lack of time (28.5 per cent)
- concerns about career development or progression (27.5 per cent)
- fear of unwanted intervention (25.4 per cent)
- impact on colleagues (24.9 per cent)
- stigmatising attitudes to mental illness (24.7 per cent)
- lack of confidence in professional treatment (22.0 per cent), and
- not wanting to burden others (21.9 per cent).

Few doctors in the survey reported being highly impacted by their mental health symptoms:

*Although levels of mental health distress were high in doctors and students, a higher proportion of doctors with mental health problems seek and receive treatment for their problems. For most doctors with mental health problems, the impact on work and life was relatively modest.*<sup>39</sup>

While it has been argued that raising the mandatory reporting threshold (or repealing the mandatory reporting laws) may help to overcome some barriers, the survey results suggest that legislative reforms

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<sup>35</sup> Public hearing transcript, Brisbane, 5 December 2018, p 14.

<sup>36</sup> Queensland Nurses and Midwives' Union (sub 4), Dr Mark Raines (sub 7), Dr Nicole Higgins et al (sub 9), Associate Professor Louise Nash (sub 10), Dr Bill Glasson and Professor Claire Jackson (sub 12), Benjamin Veness et al (sub 14), Royal Australian College of General Practitioners (sub 17) Australian Medical Association (sub 21) and the Australian Medical Students' Association (sub 22).

<sup>37</sup> Beyond Blue, National Mental health Survey of Doctors and Medical Students, October 2013, p 13, [https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report\\_web](https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report_web).

<sup>38</sup> Beyond Blue, National Mental health Survey of Doctors and Medical Students, October 2013, [https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report\\_web](https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report_web).

<sup>39</sup> Beyond Blue, National Mental health Survey of Doctors and Medical Students, October 2013, p 6. [https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report\\_web](https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report_web).

must be part of a broader effort to address the full range of cultural, institutional and other factors that may prevent practitioners from seeking treatment for their mental health issues.

This view was echoed by the Department of Health when commenting on the Beyond Blue survey:

*I think this is looking at the bigger picture issue about wanting to encourage health practitioners and the whole of the community really to make sure they get help when they need it. These are important reforms. It is really important to understand that there is probably more work to be done to address the challenges that people across the community experience if they do have mental illness. There are a range of factors that come into play that we need to work on to encourage people to get help when they need it.*<sup>40</sup>

The Department of Health suggested there are many factors that prevent practitioners from seeking assistance for mental health issues and these remain unresolved:

*There is evidence I think that there is a multiplicity of factors that prevent practitioners from seeking assistance for mental health issues. Changes to legislation can go some way to addressing those concerns, but I think the evidence that the committee has seen in the submissions and heard this morning points to the fact that there is a raft of issues that need to be changed to fully address those concerns.*<sup>41</sup>

### 2.1.3.3 Calls to doctors' advisory services with introduction of mandatory reporting

At the public hearing Dr Rod Willett from the RACGP commented on the demand for doctors' advisory services and telephone hotlines decreasing over the last 12 months:

*... there has been a 50 per cent decrease in calls to the doctors support lines in the last 12 months.*<sup>42</sup>

In response to a question from the committee about evidence to support the statement, the RACGP provided the following response which refers to a 2014 journal article discussing the reduced number of calls that coincided with the introduction of mandatory reporting legislation in 2010, rather than the last 12 months:

*Available data around the decrease in calls to doctors' health advisory services is difficult to measure as many services are voluntary and do not keep databases of information. However, the 2014 article in *Journal of Law and [Medicine]* 'Mandatory reporting of health professionals: The case for a Western Australian style exemption for all Australian practitioners'<sup>43</sup>, reports:*

- *The Doctors' Health Advisory Service [in Queensland] experienced a '50 per cent decline in calls since this legislation has come into effect'*
- *The Doctors' Health Advisory Service in the ACT saw 'a dramatic fall' in calls.*<sup>44</sup>

The RACGP response also referred to the Beyond Blue report (discussed above) and a *Medical Journal of Australia* online poll in which 59 per cent of the 2,663 respondents either disagreed or strongly disagreed that doctors can disclose their mental illness without fear for their career.<sup>45</sup> It is important to note that the self-selected sample for an online poll may not represent the views of all doctors.

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<sup>40</sup> Public briefing transcript, Brisbane, 12 November 2018, p 8.

<sup>41</sup> Public briefing transcript, Brisbane, 5 December 2018, p 6.

<sup>42</sup> Public hearing transcript, Brisbane, 5 December 2018, p 8.

<sup>43</sup> Hon Nick Goiran MLC, et al, Mandatory reporting of health professionals: The case for a Western Australian style exemption for all Australian practitioners, *Journal of Law and Medicine*, 22, pp 209-220, <http://www.abc.net.au/cm/lb/6118382/data/journal-of-law-and-ethics-article-data.pdf>

<sup>44</sup> Royal Australian College of General Practitioners, Correspondence, 12 December 2018.

<sup>45</sup> Medical Journal of Australia, *MJA Insight Polls*, 22 October 2018.

#### 2.1.3.4 *Rate of suicides of health professionals in Australia*

Some submissions linked a rise in suicide by health professionals with the introduction of mandatory reporting. For example, Dr Bill Glasson and Professor Claire Jackson stated:

*Reporting can harm a practitioner's reputation and lead to a lengthy investigation. This has led to health practitioners not seeking help for these conditions and ultimately to a high number of suicides. From 2001 to 2012, 369 suicides were reported across a range of health professionals across Australia.<sup>46</sup> But between January 1, 2011, and December 31, 2014, there were 153 health professionals who died as a result of suicide.<sup>47 48</sup>*

Dr Dilip Dhupelia, President of the AMA Queensland, also referred to the more recent national suicide data in response to a question from the chair of the committee seeking data for health professionals in Western Australia:

*I do not have data specific to Western Australia, but as you have seen in the weekend papers ... they have stated figures from the National Coronial Information System that shows 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 the 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.<sup>49</sup>*

It is not clear to the committee the extent to which the existence of mandatory reporting by treating practitioners is a contributing factor to the suicide of health professionals. As Robert D Goldney alluded to, there are many factors that could be involved:

*Facets such as ensuring good workplace relationships and equal opportunity, eliminating bullying, reducing access to means of suicide, and addressing the stigma that still attaches to seeking help for mental disorders, are clearly important ...<sup>50</sup>*

#### 2.1.3.5 *Review of impact of implementation of reforms to mandatory reporting*

The committee notes there is very limited evidence of the impact of current mandatory notification by treating practitioners.

The committee considers that it would be beneficial if an independent review of implementation of the proposed changes was undertaken on behalf of the COAG Health Council. 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. This could ensure stakeholders and the community are better informed about whether the

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<https://www.doctorportal.com.au/mjainsight/polls/>.

<sup>46</sup> Allison J Milner et al, 'Suicide by health professionals: a retrospective mortality study in Australia, 2001-2012', *Medical Journal of Australia*, 205(6): pp 260-265, 19 September 2016, <https://www.mja.com.au/journal/2016/205/6/suicide-health-professionals-retrospective-mortality-study-australia-2001-2012>.

<sup>47</sup> Sean Parnell, "'Disincentive' stops medics seeking help', *Australian*, Online edition, 4 August 2017.

<sup>48</sup> Submission 12, p 1.

<sup>49</sup> Public hearing transcript, Brisbane, 5 December 2018, p 19.

<sup>50</sup> Robert D Goldney, 'Suicide by health care professionals', *Medical Journal of Australia*, 2016, p 258, [https://www.mja.com.au/system/files/issues/205\\_06/10.5694mja16.00249.pdf](https://www.mja.com.au/system/files/issues/205_06/10.5694mja16.00249.pdf).

objectives of the amendments (improved public safety and better outcomes for practitioner-patients) have been achieved.

## **2.1.4 Stakeholders proposal to adopt the Western Australian model**

### **2.1.4.1 *Western Australian model***

The Western Australian model (WA model) provides treating practitioners with a complete exemption from mandatory reporting across all forms of 'notifiable conduct'. Notifiable conduct means a health practitioner has:

- practised their health profession while intoxicated by alcohol or drugs ('intoxication')
- engaged in sexual misconduct in connection with the practice of their profession ('sexual misconduct')
- placed the public at risk of substantial harm in the practice of their profession because of an impairment ('impairment')
- placed the public at risk of harm by practising their profession in a way that constitutes a significant departure from accepted professional standards ('substandard practice').<sup>51</sup>

This means that a treating practitioner is not required to report a practitioner-patient for intoxication, sexual misconduct, impairment or substandard practice.

In place of mandatory reporting by treating practitioners, Western Australia relies on health practitioners' ethical and professional obligations to report a practitioner-patient who may put public safety at risk. Professional and ethical obligations are referred to in the codes of conduct published by National Boards. For example, section 9.3 of the Medical Board of Australia's code of conduct deals with the professional and ethical obligations of doctors. It states in part:

*Doctors have a responsibility to assist medical colleagues to maintain good health. All health professionals have responsibility in certain circumstances for mandatory notification under the National Law. Good medical practice involves:*

- *Notifying the Medical Board of Australia if you are treating a doctor whose ability to practise maybe impaired and may thereby be placing patients at risk. This is always a professional, and in some jurisdictions, a statutory responsibility under the National Law.*
- *Encouraging a colleague [whom you are not treating] to seek appropriate help if you believe they may be ill and impaired. If you believe this impairment is putting patients at risk, notify the Medical Board of Australia. It may also be wise to report your concerns to the doctor's employer and to a doctor's health program.*<sup>52</sup>

### **2.1.4.2 *Practitioner stakeholders' views - adopt the Western Australian model in the National Law***

To address the concerns outlined in the section above, most submissions on the Bill advocated for a complete exemption from mandatory reporting by treating practitioners. This is in line with the approach that currently applies in Western Australia.

For example, the AMA suggested an exemption from mandatory reporting was necessary to save lives:

*The law in Western Australia (WA) works well to protect patients and save doctors. The AMA has strongly advocated for the National Law to more closely reflect the protections provided to doctors by the WA legislation. The Committee has the opportunity to effect real change and save*

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<sup>51</sup> Section 140 of the Health Practitioner Regulation National Law.

<sup>52</sup> Medical Board of Australia, *Good medical practice: a code of conduct for doctors*, 17 March 2014, <https://www.medicalboard.gov.au/codes-guidelines-policies.aspx>.

*lives, if they were to recommend that Health Ministers reconsider their decision not to adopt the WA model.*

*The AMA has provided advice on this in 2018 which followed on from advice we provided in 2017. This advice was echoed by medical defence organisations, other medical groups, and other health professions. But Ministers rejected the WA model. The AMA then worked to support a model known as 'WA lite'—but again this was rejected by Ministers.<sup>53</sup>*

Similarly, the Australian Doctors Federation maintained an exemption was required to ensure doctors sought treatment:

*... that introducing the WA approach to mandatory reporting (whereby the treating doctor is exempted from mandatory reporting requirements) is a proven, successful and clearly understood model which enhances the ability of troubled health professionals to seek urgent treatment.*

*It should be noted that the WA approach does not remove any ethical obligation on a treating doctor to protect the public. Treating doctors may still report patients who they believe need to be reported. However, they will not be mandated to do so.<sup>54</sup>*

The 'WA Model' was also the RACGP's preferred approach to ease the burden on health professionals:

*The RACGP's preferred approach is a complete exemption for health practitioners from reporting doctors under their care, in line with the model adopted by Western Australia. Rewording the current legislation does not go far enough to ease the burden on our health professionals.<sup>55</sup>*

Dr Michael Clements from the RACGP reiterated this support for the WA Model at the public hearing and alluded to AHPRA data that showed (voluntary) notifications made by treating practitioners in WA 'are within the range of other states and territories':

*Treating doctors in Western Australia are exempt from reporting practitioners who are under professional care. Under this model, the practitioners are able to seek help when needed without fear of repercussions. ... 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.<sup>56</sup>*

Mr Timothy Bowen of MIGA (medical defence and professional indemnity insurance organisation) also referred to '... the data or the experience in WA which suggests there has been no increase to risks posed to patients by their mandatory reporting regime'.<sup>57</sup>

Other stakeholders cited a range of reasons why a complete exemption is desirable, including: providing certainty to treating practitioner and practitioner patients about their rights and obligations; promoting national consistency; ensuring trust and confidentiality in the treatment relationship; preventing reporting in circumstances where a practitioner has insight into their impairment or is taking other steps to mitigate risks to the public; and reducing the volume of 'unnecessary' notifications.

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<sup>53</sup> Submission 21, p 2.

<sup>54</sup> Submission 33, p 1.

<sup>55</sup> Submission 17, p 4.

<sup>56</sup> Public hearing transcript, Brisbane, 5 December 2018, p 6.

<sup>57</sup> Public hearing transcript, Brisbane, 5 December 2018, p 12.



Some submissions also referred to a proposal known as the ‘WA lite’ model, which was put forward by some stakeholders, including the AMA, as a viable alternative option. The WA lite model proposed a treating practitioner would not be required to report a practitioner-patient for intoxication, impairment or substandard practice, but would be required to report sexual misconduct.

Dr Michael Clements of RACGP saw the professional and ethical obligations of doctors as sufficient for the reporting of practitioner-patients by treating practitioners:

*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 laws. 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 practitioners seeing us in the first place. Once they see us, our job is actually pretty straightforward.<sup>58</sup>*

#### 2.1.4.3 Consumer and regulator’s views – mandatory reporting and patient safety

Ms Melissa Fox from Health Consumers Queensland argued that mandatory reporting remained essential for patient safety:

*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.*

*... 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 ...<sup>59</sup>*

AHPRA also saw mandatory reporting as an important regulatory tool to manage risks to patient safety:

*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.<sup>60</sup>*

The Department of Health was critical of the codes of conduct of various health professions, particularly the broad nature of their respective codes of conduct and the lack of guidance about when a practitioner is expected to make a report:

*The Western Australian model relies on the professional ethics and expectations of the individual treating practitioner. Practitioners do have a legal duty to protect the public from harm. That is*

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<sup>58</sup> Public hearing transcript, Brisbane, 5 December 2018, p 9.

<sup>59</sup> Public hearing transcript, Brisbane, 5 December 2018, p 14.

<sup>60</sup> Public hearing transcript, Brisbane, 5 December 2018, p 23.

*set out in their ethical and professional conducts. However, they are generally broad and do not provide guidance or detail about when a practitioner is expected to make a report.*

*... In relation to, for example, the Medical Board it is about notifying the Medical Board if someone is treating a doctor whose ability to practise may be impaired and may thereby be placing patients at risk. That is the test. The tests are different for the different boards. The Optometry Board talks about taking steps to protect patients from risk of being placed at harm. The Nursing and Midwifery Board has a different test again.*

*In our national regulatory scheme we have all of the boards that play their very important roles working with their professions. Each of them has their various ethical obligations set out. Those ethical obligations are not consistent. They vary quite a bit. That is one issue. The law actually provides a consistent framework.<sup>61</sup>*

#### 2.1.4.4 COAG Health Council consideration of Western Australian model

COAG Health Council considered the WA and WA lite models at its meetings in November 2017 and April 2018.<sup>62</sup> Queensland Health advised the committee that Health Ministers decided not to adopt these models.<sup>63</sup> The COAG Health Council Communique issued for the 13 April 2018 stated:

*... Ministers agreed unanimously to take steps to protect patients and strengthen the law to remove barriers for registered health professionals to seek appropriate treatment for impairments including mental health.*

*Ministers agreed to a nationally consistent approach to mandatory reporting which will be drafted and proposes exemptions from the reporting of notifiable conduct by treating practitioners [if the treating practitioner considered is will not place the public at substantial risk of harm](noting Western Australia's current reporting arrangements are retained) ...*

*The legislation will include strong protection for patients and will remove barriers for registered health professionals to seek appropriate treatment. The legislation will specifically include a requirement to report past, present and the risk of future sexual misconduct and a requirement to report current and the risk of future instances of intoxication at work and practice outside of accepted standards.*

*Western Australia endorsed continuance of its current approach that has been operational in WA since 2010 for treating health practitioners. Health practitioners in a treating relationship based on the reasonable belief can make a voluntary notification as part of their ethical obligations in relation to any type of misconduct.<sup>64</sup>*

The communique stated that Ministers endorsed preparation of legislation that would include strong protection for patients. Ministers also decided to retain mandatory reporting by treating practitioners for intoxication, impairment and substandard practice and to strengthen reporting of sexual misconduct by requiring treating practitioners to report risks of future sexual misconduct. While the communique did not specifically refer to rejecting the WA or WA lite models, the endorsed approach differs from those models.

The Department of Health elaborated on health ministers' consideration of ensuring protection of the public and the welfare of practitioner-patients:

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<sup>61</sup> Public briefing transcript, Brisbane, 5 December 2018, p 3.

<sup>62</sup> COAG Health Council, *Communique*, 13 April 2018, p 2, [https://www.coaghealthcouncil.gov.au/Portals/0/CHC%20Communique%20130418\\_corrected\\_1.pdf](https://www.coaghealthcouncil.gov.au/Portals/0/CHC%20Communique%20130418_corrected_1.pdf) and Department of Health, Correspondence, 3 December 2018.

<sup>63</sup> Department of Health, Correspondence, 3 December 2018.

<sup>64</sup> COAG Health Council, *Communique*, 13 April 2018, p 2, [https://www.coaghealthcouncil.gov.au/Portals/0/CHC%20Communique%20130418\\_corrected\\_1.pdf](https://www.coaghealthcouncil.gov.au/Portals/0/CHC%20Communique%20130418_corrected_1.pdf).

*For several years health ministers have heard from stakeholders representing health professionals of their desire for the Western Australian model for mandatory reporting to be adopted throughout Australia. Commonwealth, state and territory ministers, aside from the Western Australian minister, specifically considered the Western Australian model on multiple occasions and decided not to adopt it. Health ministers wanted to ensure any changes to mandatory reporting strike the right balance by retaining sufficient protections for health consumers while also addressing concerns that mandatory reporting is a barrier to health practitioners seeking treatment. Ministers also decided to retain mandatory reporting requirements for treating practitioners in legislation rather than leaving them solely to professional or ethical obligations.<sup>65</sup>*

#### 2.1.4.1 Data on the impact of the Western Australian model compared to other jurisdictions

A number of witnesses at the public hearing and public briefing suggested that the proportion of treating practitioner notifications in Western Australia (where treating practitioners are not required to report) is not significantly different to other jurisdictions where there are both voluntary and mandatory notifications for treating practitioners.

For example, in response to a question from the chair of the committee on the evidence that the Western Australian model is superior, Mr Jamie Shepherd of the Queensland Nurses and Midwives' Union stated:

*... 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.<sup>66</sup>*

Similarly, Dr Michael Clements from RACGP stated:

*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.<sup>67</sup>*

The statements made by stakeholders about the notifications data were similar to correspondence from the Department of Health received by the committee:

*The available data suggests the proportion of notifications made by treating practitioners in Western Australia is not significantly lower than in several other jurisdictions.<sup>68</sup>*

The committee considered data to compare the Western Australian model of treating practitioner voluntary reporting with the other jurisdictions (which have both voluntary and mandatory reporting). The committee does not consider the available data enables any reliable conclusions to be drawn about the relative impact of the WA exemption from mandatory reporting for treating practitioners, and the requirement for mandatory reporting by treating practitioners in other jurisdictions. Variations in data collection in NSW and Queensland (discussed earlier), and the potential impact of a range of factors other than reporting laws, mean it is difficult to draw firm conclusions.

It is not possible to draw clear conclusions about the impact of mandatory notifications, compared to voluntary notifications, from the data available; nor is it possible to make reliable comparisons between jurisdictions. The data limitations include:

- in New South Wales notifications are not managed by AHPRA, but by 14 professional councils (supported by the NSW Health Professional Councils Authority) and the Health Care Complaints Commission

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<sup>65</sup> Public briefing transcript, Brisbane, 5 December 2018, p 2.

<sup>66</sup> Public hearing transcript, Brisbane, 5 December 2018, p 3.

<sup>67</sup> Public hearing transcript, Brisbane, 5 December 2018, p 5.

<sup>68</sup> Department of Health, Correspondence, 3 December 2018.

- in Queensland, the OHO receives all complaints (notifications) about health practitioners and determines which of these complaints are referred to AHPRA; those organisations use different data methodologies to record complaints and notifications<sup>69</sup>
- OHO had responsibility for receiving notifications (both mandatory and voluntary) from its establishment in July 2014, but did not record whether mandatory notifications were made by treating practitioners until 2017-18. Before that, these notifications were categorised as mandatory notifications made by a ‘colleague’, and
- in Western Australia, a treating practitioner of a patient-practitioner is exempt from mandatory reporting of ‘notifiable conduct’. AHPRA data about notification of ‘notifiable conduct’ is recorded as a mandatory report where the treating practitioner has indicated they are obliged to notify under the National Law; the information provided to AHPRA may not clearly indicate under which provision/s of the legislation the treating practitioner makes the notification when they indicate they are obliged by the National Law to notify.

### 2.1.5 Reporting threshold of ‘substantial risk of harm’

The Bill proposes to change the threshold for mandatory reporting to a ‘substantial risk of harm’ instead of a ‘risk of substantial harm’.<sup>70</sup>

#### 2.1.5.1 Support for a raised reporting threshold

A small number of stakeholders supported the proposed threshold in the Bill that a mandatory report is only required if the treating practitioner reasonably believes a practitioner-patient is placing the public at ‘substantial risk of harm’.<sup>71</sup> For example, the Royal Australasian College of Surgeons Queensland State Committee stated:

*Raising the bar to ‘substantial risk of harm’ as opposed to ‘risk of substantial harm’ appears in principle to be a step in the right direction.*<sup>72</sup>

The Queensland Nurses and Midwives’ Union also supported the proposed (higher) reporting threshold:

*These proposed changes along with the list of factors a treating practitioner may consider in their assessment should provide clarity around mandatory reporting.*<sup>73</sup>

The Department of Health explained that the key motivation of health ministers for raising the mandatory reporting threshold was to reduce the requirement on treating practitioners to make mandatory reports, and by doing so, increase the level of confidence for practitioner-patients to seek treatment when they need it:

*The intent of changing those terms to be substantial risk of harm, as opposed to a risk of substantial harm, was to set that test at a higher level so that, as the test is set at a higher level, there would be fewer occasions where a mandatory report would be required. Certainly that is the intent—that the threshold is raised for a requirement to provide a mandatory report and in*

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<sup>69</sup> The Department of Health advised that AHPRA and OHO have established a Data Sharing Working Group to improve the collection, reporting and sharing of data, including data on mandatory reporting. The outcomes of this Working Group are expected to improve the coordination and interoperability of data between AHPRA and OHO for future reporting. Correspondence, 21 November 2018.

<sup>70</sup> Proposed section 141B, inserted by clause 19.

<sup>71</sup> Queensland Nurses and Midwives’ Union (sub 4), Australian Dental Association Victorian Branch (sub 24) and Royal Australasian College of Surgeons Queensland State Committee (sub 28).

<sup>72</sup> Submission 28, p 1.

<sup>73</sup> Submission 4, p 5.

*so doing create that increased level of assurance for health practitioners to seek treatment when they need to seek it.*<sup>74</sup>

#### 2.1.5.2 Concerns about clarity of the reporting threshold

While submissions supported the intent of the Bill to raise the reporting threshold for treating practitioners, some were unconvinced that it would occur in practice because the proposed revised threshold lacked clarity and remained open to interpretation. For example, the Australian Doctors Federation stated:

*... for treating doctors, the risk threshold has moved up from risk to substantial risk, and the harm threshold has moved down from substantial harm to harm. Even to those who are familiar with the details and peculiarities of legal definitions, this is a very confusing and problematic change. Clearly any legislative construct with such serious implications for both health professionals and the public should not carry this level of ambiguity.*<sup>75</sup>

Some submissions maintained that the proposed reporting threshold was not 'unequivocally' higher. For example, the Australian and New Zealand College of Anaesthetists (ANZCA) stated:

*... the college does not agree that the change in wording from 'risk of substantial harm' to 'substantial risk of harm' unequivocally represents a higher reporting threshold. ANZCA concurs with feedback received from other stakeholders in previous consultations that this change could be interpreted as a lower threshold of reporting which will result in reporting of low-level or trivial harm provided there is a 'substantial risk' that the harm will occur.*<sup>76</sup>

Similarly, the Australian Medical Students' Association (AMSA) stated:

*AMSA believes the proposed wording implies that the threshold of reportable harm is actually lowered encompassing an entire spectrum of possible harms, in contrast to the previously worded 'substantial harm'.*<sup>77</sup>

Elizabeth Kale suggested that the change of wording in the proposed legislation from 'risk of substantial harm' to 'substantial risk of harm' would unequivocally lower the threshold and increase the risk of health professionals not seeking or delaying the treatment required to address their physical and mental health conditions:

*This change will lower the threshold for reporting (despite the explanatory note suggesting the wording will increase the threshold). The common understanding of the terminology proposed will reduce the confidence of health practitioners wishing to seek treatment for medical conditions.*<sup>78</sup>

#### 2.1.5.3 Stakeholder's proposals for reporting threshold

To address these concerns, numerous submissions proposed adopting an even higher reporting threshold such as 'substantial risk of substantial harm', 'significant risk of substantial harm' or 'considerable risk of substantial harm'.<sup>79</sup> For example, Avant Mutual Group Limited, a medical defence organisation, supported 'substantial risk of substantial harm':

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<sup>74</sup> Public briefing transcript, Brisbane, 5 December 2018, p 7.

<sup>75</sup> Submission 33, p 1.

<sup>76</sup> Submission 23, p 2.

<sup>77</sup> Submission 22, p 6.

<sup>78</sup> Submission 32, p 2.

<sup>79</sup> Dr Nicole Higgins et al (sub 9), Australian Dental Association (sub 13), Royal Australian College of General Practitioners (sub 17), Avant Mutual Group Limited (sub 20), Australian Medical Association (sub 21), Australian Medical Students' Association (sub 22), Australian Society of Anaesthetists (sub 29) and Australian Psychological Society (sub 30).

*... 'substantial risk of harm' still requires a treating practitioner to report a high likelihood of minimal harm which is arguably not consistent with a higher threshold. Although the wording is clunky, 'substantial risk of substantial harm' would, in our view, better reflect the higher threshold.<sup>80</sup>*

The Australian Dental Association (ADA) raised concerns about lowering the harm threshold (from 'substantial harm' to 'harm') and expressed its support for 'significant risk of substantial harm':

*... lowering the harm threshold is not supported. It would be more appropriate to retain the harm threshold while raising the risk threshold so that the wording in the legislation for the treating practitioner read as 'significant risk of substantial harm'. Significant risk of substantial harm would maintain the current wording in relation to harm while raising the level of risk to significant for the treating practitioner. Such wording would seem to better meet the intention of Health Ministers which is to adopt a higher threshold for mandatory reporting by treating practitioners while not deterring affected practitioners to seek treatment.<sup>81</sup>*

Finally, the RACGP was concerned that the wording change 'simply shifts the focus from harm to risk' and proposed the threshold for reporting should be 'considerable risk of substantial harm':

*A semantic amendment is not enough to alleviate concerns or clear up confusion for practitioners. The RACGP suggested the wording be further amended to 'considerable risk of substantial harm'.<sup>82</sup>*

The threshold of 'substantial risk of harm' was agreed by health ministers to 'represent a significantly higher threshold for reporting than currently applies. As the explanatory notes state, the test of 'substantial risk of harm' is not intended to require reporting of 'low level or trivial types of harm or mere inconvenience'. Only harm that is 'material' is intended to require reporting.<sup>83</sup>

In response to a question from the committee on why the 'substantial risk of harm' test for reporting is a superior test, the Department of Health advised:

*The challenge has been to find that test, that form of words that does indeed provide enough guidance to the treating practitioner to enable them to make a judgement about when a mandatory report is required. The challenge between substantial risk of harm versus substantial risk of substantial harm comes down to considering the scenario that a treating practitioner might be in under the substantial risk of harm scenario, and asking the question: Would it be acceptable if a treating practitioner was treating their patient who is also a health practitioner and formed a view that there was a substantial risk that the person's patients might be placed at moderate harm?*

*The test 'substantial risk of substantial harm' actually enables no reporting in the case where a treating practitioner, with all the information that they have on treating that patient, forms that informed view that there is a substantial risk of moderate harm being caused to consumers. With that as the possibility under that scenario, that was not felt to strike the right balance and so the test has been settled at substantial risk of harm.<sup>84</sup>*

#### 2.1.5.4 Committee view

The committee considers that the 'substantial risk of harm' test for mandatory reporting by treating practitioners strikes the right balance between the health of the practitioner-patient and the health of the broader community. The Bill does include a higher threshold for reporting. In the committee's

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<sup>80</sup> Submission 20, p 2.

<sup>81</sup> Submission 13, pp 1-2.

<sup>82</sup> Submission 17, p 4.

<sup>83</sup> Explanatory notes, p 11.

<sup>84</sup> Public briefing transcript, Brisbane, 12 November 2018, p 5.

view, this sends a clear signal that treating practitioners are not required to automatically make a mandatory report if a practitioner patient has a health condition. As the explanatory notes made clear, the Bill allows treating practitioners to use their professional judgement and expertise to consider the nature of a practitioner-patient's impairment and the proposed treatment plan. The proposed reforms make it clear that not every impairment needs to be reported. A mandatory report is only required if the practitioner-patient's impairment exceeds the threshold of substantial risk of harm.

The committee expects that, if the Bill is passed, AHPRA and the National Boards will provide further guidance on the higher threshold for reporting in guidelines to be developed. Under section 40 of the Health Practitioner Regulation National Law, there must be wide-ranging consultation with stakeholders about a guideline developed by a National Board. The committee also noted advice from the Department of Health that it is intended guidelines will be developed before commencement of the proposed mandatory reporting reforms in the Bill.<sup>85</sup>

### **2.1.6 Guidance factors to be considered by treating practitioners for impairment**

A number of submissions supported the guidance factors (in proposed section 141B(5) of the Bill) that a treating practitioner may consider when deciding whether they are required to make a mandatory report about a practitioner-patient who has an impairment.<sup>86</sup> These submitters considered the guidance factors would encourage treating practitioners to consider management of the impairment and the risk it poses to the public before deciding whether to make a mandatory report.

For example, Mr Martin Fletcher of AHPRA stated:

*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.*<sup>87</sup>

The RANZCP also supported inclusion of guidance factors in the Bill, stating they are '...important to ensure that treating health practitioners can consider the management of the impairment when making their determinations.'<sup>88</sup>

The ADA saw the guidance factors as helpful for treating practitioners to consider:

*This change would appear to provide additional 'space' for the treating-practitioner to do what they are trained to do—consider the patient's situation and treat them accordingly, without the mandatory reporting laws requiring a report to be made in most cases.*<sup>89</sup>

However, some submissions stated it would be more appropriate, and clearer for treating practitioners, for the guidance factors to apply more broadly.<sup>90</sup> Those submitters believed that the factors should apply to assessing the risk of intoxication and departure from professional standards, arguing that these issues are often interrelated.

For example, Avant Mutual Group Limited stated:

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<sup>85</sup> Department of Health, Correspondence, 3 December 2018.

<sup>86</sup> Queensland Nurses and Midwives' Union (sub 4), The Royal Australian & New Zealand College of Psychiatrists (sub 5), Australian Dental Association (sub 13), Avant Mutual Group Limited (sub 20), Australian and New Zealand College of Anaesthetists (sub 23) and the Australian Health Practitioners Regulation Agency (sub 38).

<sup>87</sup> Public hearing transcript, Brisbane, 5 December 2018, p 23.

<sup>88</sup> Submission 5, p 2.

<sup>89</sup> Submission 13, p 2.

<sup>90</sup> Australian Dental Association (sub 13), Royal Australian College of General Practitioners (sub 17), Avant Mutual Group Limited (sub 20), Australian Medical Association (sub 21), Australian and New Zealand College of Anaesthetists (sub 23) and Australian Psychological Society (sub 30).

*We believe that it will be clearer for treating practitioners if the impairment factors applied to the three types of notifiable conduct in the decision tree because it will allow for a more holistic assessment of the risk and avoid the confusion of having a different approach to treatment of drug and alcohol issues.<sup>91</sup>*

Similarly, the RACGP stated:

*... for consistency, simplicity and ease of reporting, the list of factors should be applied consistently across intoxication, impairment, and departure from professional standards. The approach taken to assess risk would be substantially similar for these issues, recognising that departure from professional standards is often the result of an underlying impairment, and therefore the framework for assessing risk of impairment would be applicable.<sup>92</sup>*

On the other hand, MIGA agreed with the view expressed in the explanatory notes that the guidance factors specific to impairment do not lend themselves to being automatically applied to other categories of conduct. Instead, it recommended guidance factors 'specific to intoxication and practice significantly below standards'.<sup>93</sup>

MIGA considered that under the proposed amendments, where an impairment causes an intoxication problem, a treating practitioner would still need to report on intoxication grounds:

*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.<sup>94</sup>*

Dr Dilip Dhupelia from the AMA had similar concerns:

*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.<sup>95</sup>*

The explanatory notes outline how the guidance factors for impairment can be used in considering issues of intoxication and departure from professional standards.<sup>96</sup> The Department of Health elaborated on how the guidance factors could be used to assess an impairment that is related to an ongoing alcohol (or drug) abuse problem, as opposed to being intoxicated at work where this is not related to an ongoing impairment. The Department of Health clarified that if intoxication is related to impairment it is not the case that a mandatory report will necessarily follow:

*Those guidance factors in the legislation were developed specifically for impairment ... The intoxication ... we are referring to talks about intoxication at work. It does not require there to be a long-term alcohol abuse issue or a substance dependence abuse issue. That is likely to fall within the category of impairment. What we are talking about here is a case of someone*

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<sup>91</sup> Submission 20, p 2.

<sup>92</sup> Submission 17, p 4.

<sup>93</sup> Submission 20, p 5.

<sup>94</sup> Public hearing transcript, Brisbane, 5 December 2018, p 13.

<sup>95</sup> Public hearing transcript, Brisbane, 5 December 2018, p 19.

<sup>96</sup> Explanatory notes, p 5.



*practising while they are under the influence. In that case, those factors about the nature, extent and severity of practising under the influence at work do not really fit. It is not about treatment or the steps that a practitioner is taking or willing to take to manage an impairment. Intoxication at work is very serious. If that has happened and there is a substantial risk of harm to the public, it is appropriate then that there is that report. If the intoxication is connected with an impairment—if we are talking about a situation when we have a practitioner who has a substance abuse problem—the treating practitioner can consider those guidance factors and determine whether that intoxication impairment is being treated appropriately and whether there is a need to report.<sup>97</sup>*

#### 2.1.6.1 Committee comment

The committee supports the guidance factors (proposed section 141B(5)) that a treating practitioner may consider when deciding whether they are required to make a mandatory report about a practitioner-patient who has an impairment. The guidance factors should encourage treating practitioners to consider the management of any impairment and the risk it poses to the public before deciding whether they are required to make a mandatory report. The committee considers there is no need to provide guidance factors for practitioner-patient conduct involving intoxication or departure from professional standards.

#### 2.1.7 Reporting of sexual misconduct by treating practitioners

The RANZCP, the Australian and New Zealand College of Anaesthetists and Dr Kerry Breen supported the provisions to strengthen reporting of sexual misconduct by treating practitioners.

However, some stakeholders such as the RACGP and Victoria Point Surgery believed the reporting requirement should be limited to past or present sexual misconduct and should not extend to reporting risks of sexual misconduct that may occur in the future. The RACGP stated:

*The proposed amendments to the National Law require a treating practitioner to report if they believe a practitioner-patient is at risk of engaging in sexual misconduct. Mandatory reporting of sexual misconduct should only be required when the practitioner-patient has in fact engaged in inappropriate behaviour, rather than ‘at risk’ of engaging in the behaviour.*

*If the amendments are to be implemented, the RACGP recommends that at a minimum, wording be amended to ‘considerable/substantial risk’ to be consistent with the rest of the legislation, [to] prevent over-reporting and ensure another barrier to care is not created.<sup>98</sup>*

Victoria Point Surgery claimed there are no evidence-based tools to make an assessment of the future risk of sexual misconduct:

*We are also concerned with the provision to report practitioners “at risk of sexual misconduct” there being no evidence-based tools to make this assessment, it places both the treating practitioner and the practitioner [being] treated [at] unreasonable and unconscionable risk.<sup>99</sup>*

The Australian Psychological Society recommended that clear guidelines be developed to assist practitioners to identify behaviours that would be indicative of the threshold being met:

*The legislation refers to the treating practitioner forming a reasonable belief that there is a ‘risk of sexual misconduct’. This is a newly introduced term that while having legal meaning, has limited meaning for practitioners and is difficult to reliably and validly assess. This will create considerable lack of clarity among both treating practitioners and practitioner patients about when the threshold for a reasonable belief has been reached. Without clear guidance for*

<sup>97</sup> Public briefing transcript, Brisbane, 5 December 2018, p 7.

<sup>98</sup> Submission 17, p 4.

<sup>99</sup> Submission 18, p 2.

*practitioners as to what behaviours constitute threshold risk level, there will continue to be barriers to help seeking.*<sup>100</sup>

As outlined in the explanatory notes, reporting a risk of future sexual misconduct would be required, for example, if a practitioner-patient disclosed a plan to engage in sexual misconduct or disclosed conduct that amounts to ‘grooming’ a patient or child.<sup>101</sup> AHPRA and the National Boards are expected to provide further guidance on the reporting of sexual misconduct by treating practitioners if the Bill is passed.

#### **2.1.7.1 *Committee comment***

The committee considers that the strengthened reporting requirements for sexual misconduct by taking into account future risk of sexual misconduct are justified.

#### **2.1.8 Need for a comprehensive education program**

Numerous submissions emphasised the need for a comprehensive implementation, communication and education program.<sup>102</sup> Some submissions emphasised the need for input from stakeholders in developing the education program and the need to maximise consistent interpretation of the National Law by stakeholders. Most submissions wanted to ensure that all registered health practitioners were made aware of and understand the proposed reforms, including the opportunities they provide for practitioners to seek treatment for their health issues.

For example, the RACGP stated:

*A shared understanding between policy makers and practitioners of the intent of any amendments to the National Law is vital, so that practitioners feel confident about their rights and responsibilities. All practitioners will require education and further information to enable them to understand the mandatory reporting requirements that apply in their jurisdiction.*<sup>103</sup>

The AMA expressed similar sentiments, however they highlighted difficulties in implementation:

*Finally, if the Queensland Parliament passes the Bill as currently drafted, there is obviously a critical need for an extensive education and communication campaign with the profession. This education and communication will need to communicate that the law is intended to allow practitioners to seek treatment; it will need to highlight what Ministers, Governments and Regulators interpret as the increased harm threshold, and therefore work to align the professions interpretation to match this. This will be a difficult proposition as health practitioners are not likely to trust the Regulator in delivering this message.*<sup>104</sup>

Dr Dilip Dhupelia from the AMA reinforced this view at the public hearing:

*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*

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<sup>100</sup> Submission 30, p 3.

<sup>101</sup> Explanatory note, p 18.

<sup>102</sup> Queensland Nurses and Midwives’ Union (sub 4), The Royal Australian & New Zealand College of Psychiatrists (sub 5), Royal Australian College of General Practitioners (sub 17), Avant Mutual Group Limited (sub 20), Australian Medical Association (sub 21), Australian and New Zealand College of Anaesthetists (sub 23), MIGA (sub 25), Australian Psychological Society (sub 30), Health Consumers Queensland (sub 34) and the Australian Health Practitioner Regulation Agency (sub 38).

<sup>103</sup> Submission 17, p 1.

<sup>104</sup> Submission 21, p 3.

*time to educate practitioners and there will always be confusion in regard to the interpretation of laws.*<sup>105</sup>

Notwithstanding the AMA's concerns, AHPRA appeared aware of the challenges of implementing the proposed reforms and achieving the necessary stakeholder awareness of the higher reporting threshold:

*While AHPRA will work with National Boards to review the current guidelines on mandatory reporting in light of amendments to the National Law, we note that treating practitioners and practitioner-patients may not immediately recognise that these amendments to mandatory reporting present a higher reporting threshold.*

*As requested by Ministers, we will also work on a broader awareness campaign. This will aim to achieve the intent of Ministers in making these amendments and will also need to reflect the requirements of the National Law as determined by the Parliament. An effective awareness campaign will also require the active involvement of stakeholders including jurisdictions, professional associations, employers and our co-regulatory partners.*<sup>106</sup>

Mr Martin Fletcher from AHPRA emphasised the importance of professional bodies and others contributing to awareness raising and overcoming health professionals' apprehension:

*I think [the education campaign] 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.*<sup>107</sup>

*... If the law is amended, we would need to revise the guidance that we provide to health practitioners with national board on what is and what 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.*<sup>108</sup>

The Department of Health saw the proposed education and awareness campaign as critical to address the misunderstanding 'that every health condition must be reported, regardless of its severity or effect':

*The education and awareness campaign is a critical element of these reforms. It is clear from the submissions and from the evidence given this morning that much of the concern with the proposed mandatory reporting provisions in the Bill stems from a misunderstanding that every health condition must be reported, regardless of its severity or effect. That is not the case.*

*... I expect this education and awareness campaign will reassure health practitioners that these reforms should give treating practitioners greater discretion not to make a mandatory report if they are satisfied that their practitioner-patient is adhering to treatment or taking steps to manage their impairment.*<sup>109</sup>

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<sup>105</sup> Public hearing transcript, Brisbane, 5 December 2018, p 18.

<sup>106</sup> Submission 38, p 2.

<sup>107</sup> Public hearing transcript, Brisbane, 5 December 2018, p 25.

<sup>108</sup> Public hearing transcript, Brisbane, 5 December 2018, p 26.

<sup>109</sup> Public hearing transcript, Brisbane, 5 December 2018, p 3.

### 2.1.8.1 *Committee comment*

The committee supports the development of a comprehensive education program to raise awareness and encourage compliance with the proposed new mandatory reporting regime. Case studies and examples of what is and what is not notifiable conduct should be included in the education program. Education of registered health practitioners will be critical to changing stakeholders' perceptions of mandatory reporting requirements.

#### **Recommendation 2**

The committee recommends the Minister for Health and Minister for Ambulance Services advise the House of the scope and timing of the proposed education program to raise awareness and understanding of the proposed mandatory reporting requirements.

### 2.1.9 **Calls for exemptions from mandatory reporting**

A number of submissions called for exemptions from mandatory reporting for certain service providers including registered health practitioners: engaged by a health advisory service; who provide non-legal advice to other practitioners about professional indemnity insurance; and those in educational roles.

#### 2.1.9.1 *Exemptions for practitioner support and advisory programs*

Some submissions that called for an exemption from mandatory reporting for registered health practitioners engaged by a health advisory service or other support programs to provide advice, treatment referrals and other early intervention services to health practitioners who may be in need of treatment.<sup>110</sup>

For example, Avant Mutual Group Limited wanted doctor's health services exempt from the proposed new National Law:

*Doctors' health advisory services provide an important service to doctors by way of advisory and referral services but many practitioners engaged by doctors' health advisory services ... do not consider themselves to be in a treatment relationship with the doctors who call them. Contact with a doctors' health advisory service is often an important first step to an impaired doctor seeking treatment, yet practitioners can be reluctant to make contact due to the fear of being reported. Providing an exemption to practitioners engaged by doctors' health advisory services would remove another barrier to practitioners seeking appropriate treatment.*<sup>111</sup>

Mr Martin Fletcher from AHPRA reiterated at the public hearing that AHPRA supported an exemption for 'any health program funded by a national board' and gave the example of the Medical Board of Australia and the Nursing and Midwifery Board of Australia which provide 'more than 3.5 million of funding for independent health and wellbeing programs to support doctors, nurses and midwives'.<sup>112</sup>

As outlined in the explanatory notes, Health Ministers were not satisfied that such an exemption was necessary or appropriate at this time:

*Health Ministers were concerned about protection of health consumers and ensuring that mandatory reporting occurred in appropriate cases if a practitioner's practice poses a substantial risk to public safety, in circumstances where an early intervention may be the only point of*

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<sup>110</sup> Dr Hannerose Falkiner (sub 8), Dr Philip Morris (sub 15), Avant Mutual Group Limited (sub 20), Australian Medical Association (sub 21), National Association of Practising Psychiatrists (sub 26), Australian Society of Anaesthetists (sub 29) and the Australian Health Practitioner Regulation Authority (sub 38).

<sup>111</sup> Submission 20, p 3.

<sup>112</sup> Public hearing transcript, Brisbane, 5 December 2018, pp 25-26.

*contact. Ministers considered these services could continue to provide valuable support without an exemption.*<sup>113</sup>

#### 2.1.9.2 Committee comment

The committee considers that whether a practitioner-patient seeks advice in person or by phone from a treating practitioner is not relevant to the threshold for mandatory reporting. The focus should be on whether the treating practitioner reasonably believes the public is at substantial risk of harm due to the practitioner-patient's intoxication, impairment or departure from professional standards—no matter how the information to inform that assessment is obtained. If a treating practitioner staffing a helpline has only limited information from a health practitioner calling for assistance they may not, in many instances, be in a position to make a mandatory report.

#### 2.1.9.3 Exemptions for practitioners who provide insurance advice

Submissions from Pharmaceutical Defence Limited (PDL) and the Australian Dental Association Victorian Branch proposed the exemptions from mandatory reporting under the proposed section 141C of the Bill be extended to registered health practitioners who provide non-legal advice to other practitioners regarding professional indemnity insurance.

For example, according to PDL:

*It is a condition of professional indemnity insurance policies that any claim needs to be reported to the insurer at the time the claim is made against the practitioner. If this does not occur, there is the potential for the claim to be reduced or denied leaving both the practitioner and any innocent third parties potentially disadvantaged. This is the reason for the current exception.*

*However, the drafting has left a gap by way of inclusion of the word 'legal' ... As a result, there is a disincentive for impaired practitioners to notify PDL of a claim due to the risk of a mandatory notification, thereby leaving both the practitioner and any innocent third parties potentially uninsured and exposed.*<sup>114</sup>

The exemptions from mandatory reporting in the Bill align with the existing exemptions under section 141 of the National Law.

#### 2.1.9.4 Exemptions for education providers

Under section 143 of the National Law, mandatory reporting of students by education providers currently applies only if a student has an impairment that, in the course of the student's clinical training, may place the public at substantial risk of harm. 'Substantial risk of harm' is a high threshold for reporting and is the same threshold that would apply to mandatory reporting by treating practitioners under the reforms in the Bill.

The Australian Medical Students' Association (AMSA) proposed that the exemption from mandatory reporting be extended to health professionals in concurrent roles as education providers, such as members of a university medical faculty:

*AMSA believes that medical professionals in concurrent roles as education providers of pastoral and supportive care, and so, they should be exempted from the mandatory reporting requirements, alongside treating doctors.*<sup>115</sup>

AMSA's submission portrayed the position of universities in the following manner:

*The mandatory reporting requirements placed on universities puts them in the difficult position of simultaneously having a duty of care to support students and being legally required to report*

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<sup>113</sup> Explanatory notes, p 13.

<sup>114</sup> Submission 6, p 4.

<sup>115</sup> Submission 22, p 4.

*students who disclose. This creates a paradoxical situation where faculty may discourage students from approaching them about their mental health in order to protect them from reporting requirements. Multiple students have reported that they had been advised by members of faculty to not seek support and counselling services or disclose mental health conditions to other faculty members because they would be reported to AHPRA, despite having sought appropriate management for their condition.*<sup>116</sup>

A student registered under the National Law would be able to seek health care or support from a university health service or their regular health care provider, who would be subject to the mandatory reporting reforms in the Bill as a 'treating practitioner'. The reforms allow treating practitioners to take into account the same guidance factors for students as for registered health practitioners, such as the extent to which the student is taking, or is willing to take, steps to manage an impairment and the extent to which an impairment can be managed with appropriate treatment. The committee considers that education providers should not be exempted from mandatory reporting requirements.

## **2.2 Increased penalties for 'holding out' and related offences**

The Bill proposed to amend the National Law to increase penalties and introduce a imprisonment terms for certain offences, including:

- improper use of protected titles for each health profession
- making false or misleading claims about a person's registration under the National Law
- contravention of restrictions on who can carry out certain dental acts, prescribe optical appliances and perform spinal manipulation
- contravention of prohibition orders.

The Bill proposes to double the maximum monetary penalty for these offences to \$60,000 for an individual and, where relevant, \$120,000 for a body corporate. In addition, the maximum penalty for each of these offences will include a term of imprisonment of up to three years. According to the explanatory notes:

*High-profile cases of individuals holding themselves out as registered health practitioners when they are not registered prompted a review of the adequacy of penalties for the National Law offences of holding out, using a protected title, undertaking restricted practices and contravening a prohibition order. The current penalties of \$30,000 for an individual and \$60,000 for a body corporate for these offences are considered inadequate for the significant harm to patients that could occur if a person does not hold registration as a health practitioner and the breach of trust it involves for members of the community. In several cases of this type, magistrates have stated that they would have imposed an imprisonment term for these offences if one was available.*<sup>117</sup>

At its meeting of 24 March 2017 the COAG Health Council agreed that new multi-year terms of imprisonment were needed for these offences.<sup>118</sup>

### **2.2.1 Offences under the National Law**

Offences are prosecuted by AHPRA, which provided data to the Department of Health about prosecutions for these offences from 2014 to November 2018.<sup>119</sup> The Department of Health provided

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<sup>116</sup> Submission 22, p 4.

<sup>117</sup> Explanatory notes, p 4.

<sup>118</sup> COAG Health Council, *Communique*, 24 March 2017, [https://www.coaghealthcouncil.gov.au/Portals/0/Final%20CHC%20Communique\\_24%20March%202017\\_1.pdf](https://www.coaghealthcouncil.gov.au/Portals/0/Final%20CHC%20Communique_24%20March%202017_1.pdf).

<sup>119</sup> There were no prosecutions for these offences between the commencement of the National Law in 2010 and 2014.

information about cases where magistrates have commented on, or sought clarification of, whether imprisonment is available for sentencing the holding out and related offences under the National Law. A summary of the type and outcomes of cases prosecuted by AHPRA is provided in Appendix E.

Between 2014 and November 2018, there were 51 prosecutions for these offences involving 94 charges across Australia. All 51 prosecutions resulted in findings of guilt, and 93 of the 94 charges were upheld. Five of the prosecutions occurred in Queensland, and involved 18 charges, all of which resulted in convictions.

The most common offences across Australia were:

- taking or using a protected title (section 113(1)) – 25 charges
- holding out as a registered health practitioner (section 116(1)(c)) – 25 charges
- taking or using a title or another description that indicates the person is authorised or qualified to practise in a health profession (section 116(1)(b)) – 22 charges.

Further information on the number of completed prosecutions by jurisdiction, by offence and by health profession between 2014 and November 2018 is provided in Appendix F.

### 2.2.2 Support for increased penalties

Few submissions commented on the provisions in the Bill that increase penalties and introduce a term of imprisonment for holding out and related offences under the National Law.<sup>120</sup> Submitters suggested that higher penalties would enable more effective deterrence, provide greater protection for the public and promote increased trust and confidence in registered health practitioners and the health care system.

For example, AHPRA supported the increased penalties:

*Our data shows that these cases are not large in number, however, the nature of these prosecutions are serious. In the past twelve months successful prosecutions have occurred for people falsely representing themselves as one of a medical practitioner, dentist, chiropractor and psychologist. Cases involving unregistered individuals using restricted titles or holding out as being registered creates significant risks to patient safety and violates the trust of patients in health practitioners. Accordingly, we support the proposed increased penalties (and custodial sentences) for the unlawful use of restricted titles and restricted acts under the National Law.<sup>121</sup>*

MIGA supported the need for an effective deterrent to people claiming to be registered health practitioners when they are not. However, MIGA was concerned about increased penalties applying to registered health practitioners who make claims in good faith about the training, expertise and experience of themselves or their colleagues, inadvertently or due to misunderstanding. MIGA stated:

*These are not [cases] which should involve civil penalties or terms of imprisonment. Instead, they should be dealt with through education and, only if required, disciplinary processes.*

*The following are possible examples of such cases:*

- *Unintentionally making insufficient efforts to ensure correct category of registration*
- *Properly claiming certain expertise or experience in a particular specialty field, when not a specialist under the National Law*

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<sup>120</sup> Queensland Nurses and Midwives' Union (sub 4), The Royal Australian & New Zealand College of Psychiatrists (sub 5), Health Consumers Queensland (sub 34) and the Australian Health Practitioner Regulation Authority (sub 38).

<sup>121</sup> Submission 38, p 1.

- *Representations in good faith about the training, expertise or experience of a colleague who is a registered health practitioner, which ultimately turns out to be mistaken.*<sup>122</sup>

In relation to MIGA's submission, AHPRA provided the following information to the Department of Health:

*The offences referred to [by MIGA] contain the mental element of 'knowingly or recklessly'. If there is inadvertence by the practitioner, not amounting to recklessness, the offences would not be made out. For example, if a registered health practitioner is holding out another person as being registered based on a reasonable misunderstanding, the offences would not apply. If the conduct was intentional or reckless, a prosecution may be commenced.*

*AHPRA has a Model Litigant policy and Prosecution Guidelines which require AHPRA to consider whether it is appropriate to proceed in each case, by exercising its prosecutorial discretion. AHPRA will only proceed with a prosecution if there are reasonable prospects of success and it is in the public interest. This allows AHPRA to consider the intentions of the parties, including a registered health practitioner.*

*All matters involving complaints of advertising breaches or complaints about breaches by unregistered practitioners are risk assessed. The risk assessment determines the approach adopted for the complaint. Matters assessed as being low to moderate risk are usually the subject of a 'check, correct, comply' approach where the subject of the complaint is provided with an opportunity to correct any potentially offending conduct or material. If the matter is appropriately addressed, it is usually regarded as resolved. The example of a registered practitioner inadvertently suggesting that they or another person holds registration when they do not is likely to be addressed through this process.*

*Matters assessed as presenting high risk to the public are referred to an inspector for investigation. These more serious matters may result in prosecution.*<sup>123</sup>

#### 2.2.2.1 Committee comment

The committee understands from AHPRA's advice that registered health practitioners who make claims in good faith about the training, expertise and experience of themselves or their colleagues are unlikely to face significant fines or imprisonment.

The committee supports the proposed new custodial sentences and increased fines for offences committed by people who hold themselves out to be registered health practitioners, including those who use reserved professional titles or carry out restricted practices when not registered.

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<sup>122</sup> Submission 25, p 9.

<sup>123</sup> Department of Health, Correspondence, 3 December 2018.



### 3 Compliance with the *Legislative Standards Act 1992*

#### 3.1 Fundamental legislative principles

##### 3.1.1 Introduction

Section 4 of the *Legislative Standards Act 1992* (LSA) states that ‘fundamental legislative principles’ are the ‘principles relating to legislation that underlie a parliamentary democracy based on the rule of law’. The principles include that legislation has sufficient regard to:

- the rights and liberties of individuals, and
- the institution of Parliament.

The committee has examined the application of the fundamental legislative principles to the Bill. The committee brings the following to the attention of the Legislative Assembly in relation to clauses 8 to 16 and 20 regarding the rights and liberties of individuals.

##### 3.1.2 Rights and liberties of individuals

Section 4(2)(a) of the *Legislative Standards Act 1992* requires that legislation has sufficient regard to the rights and liberties of individuals.

Clauses 8 to 16 and clause 20 of the Bill effect increases in existing maximum penalties for a range of offences, by amending sections 113, 115 to 119, 121 to 123, and 196A of the National Law. These sections establish various offences and set out maximum penalties.

- *Improper use of protected titles*

Sections 113 and 115 of the National Law provide offences for the improper use of protected titles for each health profession regulated by the National Law. Under section 113, a person must not take or use any of various specified or prescribed titles for a health profession (for example, ‘medical practitioner’) in a way that could be reasonably expected to induce a belief the person is registered under the National Law in the corresponding health profession, unless the person is so registered. Section 115 makes similar provision regarding the use of titles involving the term ‘specialist’.

- *False claims as to registration as a health practitioner*

Sections 116 to 119 create offences for making false or misleading claims about registration and specialist registration under the National Law, where a person does not have such registration.

- *Restrictions on ability to practise*

Sections 121 to 123 respectively place restrictions on who can carry out certain dental acts, prescribe spectacles and other optical items, and perform spinal manipulation. Contravention of these provisions is an offence.

- *Contravention of prohibition order*

Section 196A makes it an offence to contravene a prohibition order. A prohibition order may be authorised under section 196(4) by a responsible tribunal if it decides to cancel a person’s registration or if a person does not hold registration. The prohibition order may prohibit the person from providing health services or using a specified title, either permanently or for a stated period.

##### 3.1.2.1 Proposed penalty increases

Each of the offences above currently carries a maximum penalty of \$30,000 for an individual and, where relevant, \$60,000 for a body corporate.

The Bill would double the maximum monetary penalty for these offences to \$60,000 for an individual and, where relevant, \$120,000 for a body corporate (see clauses 8 to 16 and 20). In addition, each of these offences will carry an imprisonment term of up to three years.

It should be noted that these are 'cumulative' - that is, the new maximum penalty is \$60,000 or 3 years imprisonment *or both*.

### 3.1.2.2 Issue of fundamental legislative principle - proportionality and relevance of penalties

As the explanatory notes recognise, the increases in penalties and the provision for imprisonment terms for the various offences are relevant to the fundamental legislative principle that a penalty should be proportionate to the offence.<sup>124</sup>

Consequences imposed by legislation should be proportionate and relevant to the actions to which the consequences are applied by the legislation. A penalty should be proportionate to the offence. The OQPC Notebook states:

*the desirable attitude should be to maximise the reasonableness, appropriateness and proportionality of the legislative provisions devised to give effect to policy.*

...

*Legislation should provide a higher penalty for an offence of greater seriousness than for a lesser offence. Penalties within legislation should be consistent with each other.*<sup>125</sup>

The explanatory notes state:

*High-profile cases of individuals holding themselves out as registered health practitioners when they are not registered prompted a review of the adequacy of penalties for the National Law offences of holding out, using a protected title, undertaking restricted practices and contravening a prohibition order. The current penalties of \$30,000 for an individual and \$60,000 for a body corporate for these offences are considered inadequate for the significant harm to patients that could occur if a person does not hold registration as a health practitioner and the breach of trust it involves for members of the community.*

*In several cases of this type, magistrates have stated that they would have imposed an imprisonment term for these offences if one was available.*<sup>126</sup>

The committee has considered information about some of the cases referred to in the explanatory notes where the magistrate commented on the level of penalty available. A summary of matters is in Appendix E.

The provision regarding prohibition orders - and the associated penalty - were inserted by an amendment in 2017. According to the explanatory notes accompanying the relevant 2017 Bill:

*Contravening a prohibition order is considered a very serious offence. The penalty was set at \$30,000 to be equivalent to the highest maximum penalties for the most serious offences in the National Law, such as using a restricted title (section 113), holding out to be a registered health practitioner (section 116) or undertaking restricted practices (sections 121, 122 and 123).*<sup>127</sup>

### 3.1.2.3 Summary proceedings

By virtue of proposed section 241A (inserted by clause 6 of the Bill), certain offences will be dealt with summarily in the Magistrates Court. The maximum penalty that may be imposed upon a summary conviction for an indictable offence is 165 penalty units (this equates to \$21,540.75.)

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<sup>124</sup> Explanatory notes, p 9.

<sup>125</sup> Office of the Queensland Parliamentary Counsel, *Fundamental Legislative Principles: The OQPC Notebook*, p 120.

<sup>126</sup> Explanatory notes, p 4.

<sup>127</sup> Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2017 explanatory notes, p 36.

On this issue, the explanatory notes state:

*The Bill contains safeguards to ensure that penalties are proportionate to the offences to which they apply. It provides flexibility for offences to be dealt with either on indictment or summarily, depending on the circumstances of the case, which will allow the most serious instances with the greatest potential to cause harm to be liable to the higher penalties and consequences that result from conviction on indictment in exceptional circumstances .... Less serious cases will continue to be dealt with summarily.*

*The Queensland modifications to proposed section 241A of the National Law provide additional protections by limiting the monetary penalty that may be imposed in summary proceedings in accordance with the limit that applies under section 46 of the Penalties and Sentences Act 1992 ... The Queensland-specific section also provides that a Magistrates Court must abstain from dealing summarily with an offence if satisfied that, because of the nature or seriousness of the offence or any other relevant consideration, the defendant may not be adequately punished if convicted ...<sup>128</sup>*

The explanatory notes further explain:

*It is intended a prosecutor would seek an imprisonment term for the most serious cases.*

*As a result of these offences having an imprisonment term of up to three years, the offences will automatically be categorised as indictable offences in some States and Territories. To maintain national consistency in the way these offences are dealt with, the Bill inserts a new provision to provide that these offences are indictable offences in all jurisdictions ... Categorising these offences as indictable reflects the significant harm that may result from the conduct to which the offences apply.<sup>129</sup>*

The explanatory notes justify the new penalties this way:

*It is considered that the penalties provided in the Bill are appropriate in light of the significant breach of public trust and harm to patients that could occur if a person takes or uses a protected title or holds themselves out to be a registered health practitioner when they are not.<sup>130</sup>*

#### 3.1.2.4 Committee comment

After considering the information available to it, the committee considers that on balance the increased and high penalties are appropriate and justified in the circumstances. The high penalties are proportionate to the risks to public safety if a person who is not qualified and registered holds themselves out to so, or undertakes clinical practices for which they are not qualified. The penalties should act as a deterrent to actions that potentially place consumers at considerable risk.

## **3.2 Explanatory notes**

Part 4 of the *Legislative Standards Act 1992* requires that an explanatory note be circulated when a Bill is introduced into the Legislative Assembly, and sets out the information an explanatory note should contain.

Explanatory notes were tabled with the introduction of the Bill. The notes contain the information required by Part 4 and a sufficiently detailed level of information and commentary to facilitate understanding of the Bill's aims and origins.

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<sup>128</sup> Explanatory notes, p 10.

<sup>129</sup> Explanatory notes, p 7.

<sup>130</sup> Explanatory notes, p 9.

## Appendix A – Submitters

<b>Sub #</b>	<b>Submitter</b>
001	QUT Faculty of Health
002	Dr Diana Khursandi
003	Annette Attard
004	Queensland Nurses & Midwives' Union
005	The Royal Australian & New Zealand College of Psychiatrists
006	Pharmaceutical Defence Limited
007	Dr Mark Raines
008	Dr Hannerose Falkiner
009	Drs Nicole Higgins, Mark Raines, Kerry Summerscales, Emma Sedlacek, Samia Haider & Rebecca Perks.
010	Associate Professor Louise Nash
011	Queensland Doctors' Health Programme
012	Dr Bill Glasson & Professor Claire Jackson
013	Australian Dental Association
014	Benjamin Veness, Richard Arnold, Arghya Gupta, Edward Cliff, Jessica Dean, Steven Hurwitz, Martin Seneviratne, Hannah Cross & Georgia Carroll
015	Dr Philip Morris
016	Dr Edwin Kruys
017	Royal Australian College of General Practitioners
018	Victoria Pont Surgery
019	Royal Australasian College of Medical Administrators
020	Avant Mutual Group Limited
021	Australian Medical Association
022	Australian Medical Students' Association
023	Australian & New Zealand College of Anaesthetists

- 024 Australian Dental Association Victorian Branch Inc.
- 025 MIGA
- 026 National Association of Practising Psychiatrists
- 027 Dr Kerry Breen
- 028 Royal Australasian College of Surgeons Queensland State Committee
- 029 Australian Society of Anaesthetists
- 030 Australian Psychological Society
- 031 Brisbane South PHN
- 032 Elizabeth Kable
- 033 Australian Doctors' Federation
- 034 Health Consumers Queensland
- 035 Dr Stephen Dick
- 036 Dr Geoff Toogood
- 037 Dr Marianne Cannon
- 038 Australian Health Practitioner Regulation Agency
- 039 Form submission

## **Appendix B – Officials at public departmental briefings**

### **Brisbane, Monday 12 November 2018**

#### **Department of Health**

- Ms Kathleen Forrester, Deputy Director-General, Strategy, Policy and Planning Division
- Ms Kirsten Law, Director, Legislative Policy Unit, Strategy, Policy and Planning Division

### **Brisbane, Wednesday 5 December 2018**

#### **Department of Health**

- Ms Kathleen Forrester, Deputy Director-General, Strategy, Policy and Planning Division
- Ms Kirsten Law, Director, Legislative Policy Unit, Strategy, Policy and Planning Division

## **Appendix C – Witnesses at public hearing**

**Brisbane, Wednesday 5 December 2018**

### **Queensland Nurses and Midwives' Union**

- Mr Jamie Shepherd, QNMU Professional Officer
- Mr Elliott Dalgliesh, Hall Payne Lawyers
- Ms Kalina Pyra, Hall Payne Lawyers

### **Royal Australian College of General Practitioners**

- Dr Michael Clements, Deputy Chair of the RACGP Queensland Board
- Dr Rod Willett, member of the RACGP Queensland Board

### **MIGA Medical Defence Organisation**

- Mr Timothy Bowen, Senior Solicitor – Advocacy, Claims & Education

### **Health Consumers Queensland**

- Ms Melissa Fox, Chief Executive Officer

### **Australian Medical Association**

- Dr Tony Bartone, National President
- Dr Dilip Dhupelia, Qld President

### **Australian Health Practitioner Regulation Agency**

- Mr Martin Fletcher, Chief Executive Officer
- Dr Jamie Orchard, National Director, Legal Services
- Mr Matthew Hardy, National Director, Notifications

## Appendix D – Mandatory reporting requirements and issues identified for treating practitioners as described in COAG 2017 discussion paper<sup>131</sup>

### Mandatory reporting requirements

The National Law sets out mandatory reporting obligations for practitioners and employers. Under the National Law, employers and practitioners are required to notify AHPRA if they reasonably believe a registered health practitioner has behaved in a way that constitutes ‘notifiable conduct’. Notifiable conduct means that the practitioner has:

- (a) practised the practitioner’s profession while intoxicated by alcohol or drugs; or
- (b) engaged in sexual misconduct in connection with the practice of the practitioner’s profession; or
- (c) placed the public at risk of substantial harm in the practitioner’s practice of the profession because the practitioner has an impairment; or
- (d) placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.<sup>1</sup>

In the National Law, impairment is defined as meaning the person has a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect the person's capacity to practise the profession.

The mandatory reporting obligations are intended to protect the public by ensuring that AHPRA, the National Boards and co-regulatory complaints bodies are aware of practitioners who may be placing the public at risk of harm. This allows the appropriate regulatory body to decide whether action is required to protect the public, such as by placing conditions on the practitioner’s registration or suspending the practitioner’s registration and therefore preventing the practitioner from practising. There are currently a number of exemptions to the mandatory reporting obligations in the National Law. The exemptions generally apply to health practitioners who are involved in providing legal advice in the context of insurance requirements or as part of legal proceedings.

### Issues with the mandatory reporting requirements

There are three general issues with the current mandatory reporting requirements for treating practitioners which may impact on a registered practitioner’s likelihood of seeking treatment: concerns about respecting patient confidentiality; the requirement to report past conduct; and a lack of national consistency.

#### Patient confidentiality

There are concerns that the mandatory reporting requirements may deter practitioners from seeking treatment for serious health issues, particularly mental health concerns and/or drug and alcohol issues, as the requirements to report apply to treating practitioners. There is anecdotal evidence that some practitioners fear that a treating practitioner will notify AHPRA and this fear has discouraged them from seeking needed care or support. This is because an important element in seeking treatment from a registered health practitioner is the practitioner’s duty of confidentiality. Patients expect that their treating practitioner will generally keep details of their health issues confidential. Confidentiality is a cornerstone of an effective therapeutic relationship between a practitioner and a patient. If a registered health practitioner cannot be assured that their treating practitioner will maintain their confidentiality, they may be less likely to seek treatment. It is not in the public interest for a practitioner to avoid seeking, or continuing to receive, treatment for their health issues as this may cause harm to the practitioner and the wider community.

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<sup>131</sup> Australian Health Ministers’ Advisory Council, *Mandatory reporting under the Health Practitioner Regulation National Law*, Discussion paper, 12 September 2017, pp. 5 – 6.



Of course confidentiality of the treating relationship is not, and should not be, absolute. There are a range of circumstances, particularly in relation to protecting the public from serious threats of harm, in which confidentiality is not, and should not be, guaranteed. However, the mandatory reporting requirements under the National Law obligate a treating practitioner to breach confidentiality and disclose information even if treating practitioner believes there is no current or future risk to the public. The current challenge is to ensure the National Law provides an appropriate balance between maintaining patient confidentiality as much as possible while providing an appropriate mechanism for dealing with circumstances where a practitioner presents a serious risk to the public.

#### **Focus on past conduct**

The current mandatory reporting requirements, particularly in relation to impairment matters, require reporting of past conduct, regardless of whether a practitioner poses a current or future risk of substantial harm. A treating practitioner is required to report a patient who is a registered health practitioner who placed the public at risk of substantial harm in the practitioner's practice of the profession because of the practitioner's impairment. In such cases, the reporting requirements apply even if the practitioner is no longer placing the public at risk of substantial harm.

For example, if a practitioner is being treated for a substance abuse problem and discloses to their treating psychiatrist or psychologist that in the past, prior to receiving treatment, they practised whilst intoxicated, the treating practitioner would be obligated to notify AHPRA of the conduct. A notification would be required even if the patient practitioner was now managing their health condition with the support of a treating practitioner and the treating practitioner did not consider that there was any current or future risk. This requirement to report past conduct can mean that even if a practitioner with an impairment seeks treatment, the practitioner may be deterred from disclosing all relevant matters about their impairment and the effects of the impairment, including potential impacts on patients, to their treating practitioner. A failure to disclose all relevant information may compromise the treating practitioner's ability to properly diagnose and treat their patient.

#### **Lack of national consistency**

Another issue with the current arrangements is that the mandatory reporting requirements are not nationally consistent. Western Australia and Queensland have both modified the requirements to create a treating practitioner exemption, although the exemption is different in each state. A lack of national consistency can create difficulties in communicating with, and educating, practitioners across all states and territories about their reporting obligations. This is exacerbated if a practitioner works in more than one state or territory, such as Queensland and New South Wales, where the practitioner has to be aware of, and apply, the different mandatory reporting requirements.

## Appendix E – Cases prosecuted and heard for holding out and related offences under the National Law

Links in this table are to media releases by AHPRA and Australian registration boards

Registered health profession & jurisdiction	Penalty, costs & reported comments
<p><b>Dental</b> Victoria, August 2015  <a href="https://www.ahpra.gov.au/news/2015-08-13-media-statement.aspx">https://www.ahpra.gov.au/news/2015-08-13-media-statement.aspx</a>            Charges:</p> <ul style="list-style-type: none"> <li>• holding out to be a dentist</li> <li>• using protected title</li> <li>• carrying out ‘restricted dental acts’ (root canal procedures)</li> <li>• possession of schedule 4 drugs</li> </ul>	<ul style="list-style-type: none"> <li>• \$20,000 fine</li> <li>• 12 mth community corrections order, 250 hours community service</li> <li>• \$13,000 costs</li> </ul> <p>A term of imprisonment would have been imposed if court had the ability to do so</p>
<p><b>Nursing and midwifery</b> Western Australia, August 2015 and Queensland, August 2016  <a href="https://www.ahpra.gov.au/news/2015-07-29-media-statement.aspx">https://www.ahpra.gov.au/news/2015-07-29-media-statement.aspx</a>  <a href="https://www.ahpra.gov.au/news/2016-10-04-media-release-nmba.aspx">https://www.ahpra.gov.au/news/2016-10-04-media-release-nmba.aspx</a>            Charges:</p> <ul style="list-style-type: none"> <li>• holding out to be a registered nurse</li> <li>• using protected title</li> <li>• fraud and forgery re application for nursing role</li> </ul>	<ul style="list-style-type: none"> <li>• \$30,000 fine (WA)</li> <li>• \$3,500 fine (Qld)</li> <li>• \$8,250 costs (both states)</li> </ul> <p>Approached matter recognising need to have regard to the maximum penalty. Reduction for the guilty plea was 25 per cent of the otherwise appropriate penalty (WA).            Serious nature of offending does require a term of imprisonment (re fraud charges in Qld)</p>
<p><b>Chiropractic</b> Queensland, January 2018  <a href="https://www.chiropracticboard.gov.au/news/2018-02-06-ahpra-successfully-prosecutes-fake-ql-d-chir.aspx">https://www.chiropracticboard.gov.au/news/2018-02-06-ahpra-successfully-prosecutes-fake-ql-d-chir.aspx</a>            Charges:</p> <ul style="list-style-type: none"> <li>• using protected title</li> <li>• holding out to be a chiropractor, medical practitioner and acupuncturist</li> </ul>	<ul style="list-style-type: none"> <li>• \$12,000 fine</li> <li>• \$3537 costs</li> </ul> <p>The principle of deterrence is significant.            Commented that a fine is the only penalty available in magistrates discretion</p>
<p><b>Medical practitioner</b> New South Wales, April 2017  <a href="https://www.ahpra.gov.au/News/2017-04-03-media-statement.aspx">https://www.ahpra.gov.au/News/2017-04-03-media-statement.aspx</a>            Charges:</p> <ul style="list-style-type: none"> <li>• holding out to be a medical practitioner</li> </ul>	<ul style="list-style-type: none"> <li>• \$30,000 fine</li> <li>• \$22,000 costs</li> </ul> <p>Important that properly qualified people carry out the work which can have a direct impact on the public. Maximum possible fine imposed</p>
<p><b>Dental</b> New South Wales, October 2018  <a href="https://www.ahpra.gov.au/News/2018-10-26-AHPRA-acts-quickly-as-unregistered-dentist-is-convicted.aspx">https://www.ahpra.gov.au/News/2018-10-26-AHPRA-acts-quickly-as-unregistered-dentist-is-convicted.aspx</a>            Charges:</p> <ul style="list-style-type: none"> <li>• holding out to be a dentist (charges against both individual and business)</li> </ul>	<ul style="list-style-type: none"> <li>• \$30,000 fine</li> <li>• \$19,950 costs</li> <li>• \$13,950 court fees</li> <li>• \$11,250 fine for business</li> </ul> <p>Expressed surprise that fine was maximum penalty</p>

## Appendix F – Prosecutions and charges under the National Law since commencement in 2010

The following data was provided by AHPRA which prosecutes offences against the National Law.

- Sections 113 and 115 of the National Law contain offences for the improper use of protected titles for each health profession regulated by the National Law.
- Sections 116 to 119 provide offences for making false or misleading claims about a person's registration under the National Law.
- Sections 121 to 123 of the National Law place restrictions on who can carry out certain dental acts, prescribe optical appliances and perform spinal manipulation. A person who contravenes these provisions commits an offence.
- Section 196A makes it an offence to contravene a prohibition order.

The tables below show the number of prosecutions under sections 113, 115 to 119, 121 to 123 and 196A of the National Law since it commenced in 2010, by jurisdiction, by profession and section.

**Table 3: Completed prosecutions by jurisdiction**

	QLD	NSW	VIC	TAS	SA	WA	ACT	NT	Total
<b>2014</b>	1	-	1	-	1	1	-	-	<b>4</b>
<b>2015</b>	-	1	1	-	-	4	-	-	<b>6</b>
<b>2016</b>	1	3	4	-	2	-	-	-	<b>10</b>
<b>2017</b>	1	5	5	-	-	4	-	-	<b>15</b>
<b>2018</b>	2	5	7	-	2	-	-	-	<b>16</b>
<b>Total</b>	<b>5</b>	<b>14</b>	<b>18</b>	<b>-</b>	<b>5</b>	<b>9</b>	<b>-</b>	<b>-</b>	<b>51</b>

Source: Department of Health, Correspondence, 21 November 2018, data provided by AHPRA

Of the 51 prosecutions:

- 34 resulted in the person being found guilty with a conviction recorded
- 13 resulted in the person being found guilty with no conviction recorded
- 3 resulted in the person being found guilty, but the person was granted a spent conviction (this process only applies in Western Australia).

**Table 4: Completed prosecutions by health profession**

Health profession	Prosecutions
Chinese medicine	1
Chiropractic	5
Dental	6
Medical	10
Nursing and midwifery	10
Occupational therapy	1
Optometry	2
Pharmacy	4
Psychology	12
<b>Total</b>	<b>51</b>

Source: Department of Health, Correspondence, 21 November 2018, data provided by AHPRA

**Table 5: Completed prosecutions by offence provisions**

Section of National Law	Charges <sup>132</sup>
113(1)	25
113(2)	1
115	1
116(1)(b)	22
116(1)(c)	25
116(1)(d)	4
116(2)(b)	3
116(2)(c)	1
118	4
121	4
122	2
123	2
196A	-
<b>Total</b>	<b>94</b>

**Source:** Department of Health, Correspondence, 21 November 2018, data provided by AHPRA

Of the 94 charges involved across 51 prosecutions, 93 charges resulted in findings of guilt. In one prosecution, the Magistrate decided a charge against section 123 was not proved, but the person was found guilty of two charges against section 113(1). There have been no prosecutions under section 196A since that provision commenced on 11 October 2017.

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<sup>132</sup> Most prosecutions involve charges for more than one offence.

## **Statement of Reservations**

## Statement of Reservations

### By LNP Members

#### Health Practitioner Regulation National Law and other Legislation

#### Amendment Bill 2018

Whilst the LNP Members of the Committee generally support the passing of the above Bill, as it contains amendments to numerous Acts, there are very real concerns we wish to bring to the attention of the House in relation to Mandatory Reporting with regard to health practitioners and students.

The amendments to Mandatory Reporting are contained in Part 3 of the Bill entitled “Amendment of Health Practitioner National Law” and in particular new sections 141A – 141C (inclusive) are inserted into the Act if the Bill is passed. Attached to this document is an explanation of the current Queensland legislation and what it will be if the Bill is passed. This document is drawn from the Report of the Committee at page 7.

The question of Mandatory Reporting has been an issue for peak bodies, and indeed the public, for a considerable period of time. The Western Australian model is unique in that the Mandatory Reporting may not be required pursuant to section 141 of the Western Australian Health Practitioners Regulation National Law (WA) of 2010.

The clear distinction between Western Australia and what would be the case in Queensland is that, in Queensland irrespective of whether the practitioner or a student is receiving treatment from another practitioner and is complying with the requirements of treatment the treating practitioner may still, subject to the conditions contained in the Queensland Bill, be required to file a mandatory report.

On this question it is important to consider the submissions made to the Committee.

The QNMU recommends the Bill;

“provide a complete exemption for treating practitioners from the requirement to report all forms of notifiable conduct in respect to their practitioner patient;

mirrors the provisions contained in the Health Practitioner Regulation National Law (WA) Act 2010 (s) 141(4)(da) that state a mandatory obligation is not required if the “*first Health Practitioner forms a reasonable belief in the course of providing health services to the second Health Practitioner or student*”. (page 3)

The AMA in its submission states;

“The law in Western Australia (WA) works well to protect patients and save Doctors. The AMA has strongly advocated for the National Law to more closely reflect the protections provided to Doctors by the WA legislation. The Committee has the opportunity to effect real change and save lives, if they

were to recommend that the Health Minister reconsider the decision not to adopt the WA model. (page 2)

The Royal Australian College of General Practitioners stated;

“The current mandatory reporting arrangements are a serious concern to the RACGP and its members and have been since the inception of National Law in 2009. The amendments outlined in this Bill make no material difference the current arrangement which are as previously stated unsatisfactory” and

“The only issue that a treating practitioner should be subject to when mandatory reporting is where there is evidence of sexual misconduct”(page 1)

One of the concerns is the necessity for practitioners to access assistance and at the same time feel that they can do so without punitive consequences.

The QNMU in their submission made this comment:

“It has been the consistent position of the QNNU that it is not necessary for treating practitioners to make mandatory notifications if the health practitioner is engaged in and compliant with the treatment. International and Australian research (“Beran, 2014; RANIGA et al, 2005) indicates mandatory reporting carried a punitive quality rather than compassion towards rehabilitation. A focus on sanctions is weighted against a practitioner, particularly when they are aware but fear the retribution (page2)

The AMA makes this comment;

(a) “It is for this reason that, when the COAG Health Council at its meeting of August 2017, agreed “Doctors should be able to seek treatment for health issues with confidentiality whilst also preserving the requirement for patient safety”, the AMA saw the potential to finally fix the issue. (page 4 Attachment A)

The Royal Australian College of General Practitioner makes the following statement in their submission:

“ the RACGP has long supported exempting Health Practitioner from reporting Doctors under their care in line with the model adopted by WA”

The Health Practitioner and National Law WA Act 2010 exempt Doctors in Western Australia from reporting Doctors who are under their professional care. Under this model practitioners are able to seek help without the fear of repercussions.”(page 3).

As part of the submission by the AMA, attachment A raises the question of suicide within the medical profession.

“The AMA took part in the resulting public consultation process and lodged the attached submission (attachment A) outlining the case for change. This submission highlights the tragic rates of suicide in the medical profession and includes the statistics from the Beyond Blue study that confirms mandatory

reporting is a clear and present barrier for seeking help. We re-attach that submission as part of our response to this round of consultation. These statistics need to be front of mind when re drafting the National Law as they contribute to understanding the extent to which practitioner's interpretation deters access to treatment." (page 4 Attachment A)

Further comments from the AMA in relation to the W.A model and sexual misconduct include;

"There is no evidence to suggest diminished patient safety in WA. Adoption of the WA model would also provide much needed national consistency. Furthermore the AMA is supportive of removing the exemption for sexual misconduct and therefore strongly supported what was colloquially known as "WA lite". W.A lite on the basis that the likely interpretation of the law and therefore its practical effect were known"

"With no evidence that the WA model is doing anything other than improving practitioner Health, and therefore, improving consumer protection the AMA would still support Ministers choosing to implement the tried and tested WA or WA lite models" (pages 4 and 5 Attachment A).

The RACGP also support removing the exemption for sexual misconduct.

The LNP Members of the Committee feel there are two questions; the first is whether or not, where a practitioner has engaged in "sexual misconduct" a treating practitioner has an obligation irrespective of the terms of treatment being complied with to make a mandatory report.

To some it may be a case that if you are exempting one you exempt all. However it is felt that the question of sexual misconduct outweighs the right of the medical practitioner to privacy given the real public concern in relation to sexual misconduct. The second point is the balance of the Bill as it relates to Mandatory Reporting.

We recommend that the House adopt the WA model as on the evidence Western Australia consumers have not suffered as a consequence of its approach to mandatory reporting with the exception that the Queensland proposal to require Mandatory Reporting in cases of sexual misconduct be passed. The public necessity for sexual misconduct to be reported overrides any other right a doctor may have in the circumstances.

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Mark McArdle  
Deputy Chair Parliamentary Health Committ...

1/2/2019

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Marty Hunt  
Member Parliamentary Health Committee

1/2/2019



Attachment 1

**Table 1: Treating practitioner mandatory reporting requirements: summary of differences**

	Current provisions of National Law	Current provisions Applied in Queensland	Proposed new provisions as amended by the Bill
Impairment	Practitioner has placed the public at <b>risk of substantial harm</b> by practising with an impairment	Practitioner is placing the public at <b>risk of substantial harm</b> by practising with an impairment	Practitioner has placed the public at <b>risk of substantial harm</b> by practising with an impairment. Guidance factors in the Bill also apply
Intoxication	Practitioner has practiced while intoxicated by alcohol or drugs		Practitioner is placing the public at <b>substantial risk of harm</b> by practicing while intoxicated by alcohol or drugs
Substandard practice	Practitioner has placed the public at <b>risk of harm</b> because they have practiced in a way that constitutes a significant departure from accepted professional standards		Practitioner is placing the public at <b>substantial risk of harm</b> by practising in a way that constitutes a significant departure from accepted professional standards
Sexual misconduct	Practitioner has engaged in sexual misconduct in connection with the practice of their profession		Practitioner has engaged or <b>is at risk of engaging in</b> sexual conduct in connection with the practice of their profession

Source: Department of Health, tabled paper, public briefing, Brisbane 12 November 2018