Royal Australasian
College of Surgeons

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250–290 Spring Street
East Melbourne VIC 3002 Australia
Telephone +61 3 9249 1200
www.surgeons.org
ABN 29 004 167 766

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
CANBERRA ACT 2600

Email: seniorclerk.committees.sen@aph.gov.au

SUBMISSION of the Royal Australasian College of Surgeons to the Senate Standing Committee on Community Affairs inquiry into 'Administration of registration and notifications by the Australian Health Practitioner Regulation Agency and related entities under the Health Practitioner Regulation National Law'

1. Introduction

The Royal Australasian College of Surgeons ('RACS' or 'the College') welcomes the opportunity to contribute to this inquiry.

RACS is the leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand. RACS supports the ongoing development, maintenance of expertise and lifelong learning that accompanies the surgical practice of more than 7,000 surgeons and 1,300 surgical trainees and Specialist International Medical Graduates (SIMGs).

RACS makes this submission as a key stakeholder in the Australian health system and in the National Registration and Accreditation Scheme (National Scheme).

RACS supports maintaining the Medical Board of Australia (Medical Board) together with AHPRA as regulators of medical registration and notifications. Nevertheless, there are a number of issues related to the administration of these systems which are of concern to RACS.

In this submission RACS describes its role in the National Scheme and then responds to each of the Terms of Reference in turn.

A summary of RACS' views in response to the Terms of Reference is as follows:

i) The current registration standards for medical practitioners are generally appropriate.

ii) The registration standards of at least one non-medical health profession are problematic.

iii) AHPRA and the National Boards should continue in their role as regulators of health practitioners including addressing concerns about practice.

iv) The role of medical colleges in the notifications process could be clarified.

v) Additional advice regarding legal protections of supervisors would be valuable.

vi) The current arrangements with regards to overseas-qualified medical practitioners, including surgeons, are appropriate.

vii) Current educational arrangements for medical registration are appropriate.

viii) All educational institutions which provide training and education in areas of practice which encroach or overlap onto surgical practice should be accredited by the AMC, and this is not currently the case.

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ix) AHPRA should increase focus on ensuring practitioners feel supported through the notifications process.

x) Doctors who seek treatment for their own medical conditions should not have to fear being the subject of a mandatory report by their own doctor.

xi) Focus needs to be maintained by AHPRA on ensuring the prompt identification of meritless claims.

xii) Prompt resolution of all claims must be a key objective of AHPRA, and so KPIs need to be considered or tightened, and internal processes or even legislative changes looked at.

xiii) Where a decision maker involved in the management of a notification is identified as having a conflict of interest, and if the conflicted person is a surgeon, RACS suggests working with the College to identify an appropriately qualified replacement

xiv) Relationships between different National Scheme decision-makers need clarification.

xv) AHPRA should consider working with medical colleges to identify the right people to provide clinical input in relation to notifications and in particular where matters reach the panel/tribunal stage.

xvi) Practitioners must be afforded natural justice and procedural fairness, including the right to respond to the allegations made and a right to challenge any adverse decisions before they are made public.

xvii) The fractured nature of the National Scheme as it currently exists is not optimal and should be harmonised.

2. The Royal Australasian College of Surgeons' role in the National Scheme

RACS is the sole education provider accredited by the Australian Medical College (AMC) to provide approved programs of study for nine of the ten recognised surgery fields of specialty practice, these being; Cardiothoracic surgery, General surgery, Neurosurgery, Orthopaedic surgery, Otolaryngology Head-and-Neck surgery, Paediatric surgery, Plastic and Reconstructive surgery, Urology and Vascular surgery.

RACS is also accredited to provide assessment of surgeon SIMGs.

The final surgical speciality is Oral and maxillofacial surgery, for which the Royal Australasian College of Dental Surgeons provides accredited training.

In addition, RACS is not responsible for providing accredited training in 'podiatric surgery'. Although this has been recognised as a 'specialty' under the National Scheme, it is not a medical specialty rather it is a specialty of podiatry.

3. Responses to the individual terms of reference

The administration of registration and notifications by the Australian Health Practitioner Regulation Agency and related entities under the Health Practitioner Regulation National Law, with particularly reference to:

(a) the current standards for registration of health practitioners by the Australian Health Practitioner Regulation Agency (AHPRA) and the National Boards under the Health Practitioner Regulation National Law (National Law);

RACS' view:

i) The current registration standards for medical practitioners are generally appropriate.

ii) The registration standards of at least one non-medical health profession are problematic.

RACS supports the current standards for the registration of medical practitioners. These standards ensure Australians have access to a safe, sustainable and high-quality medical workforce. To

support these standards RACS has embarked on a major review of its Continuing Professional Development (CPD) program to comply with new Medical Board guidelines, with the improved revised CPD program being released in July 2021.

The different health professions obviously focus on different areas of practice, however in some instances there is overlap or encroachment onto areas of practice of one health profession by other professions.

Where a health profession's scope overlaps or encroaches in a significant way onto that of surgical practice RACS believes that the Australian Medical Council (AMC) should be responsible for accrediting programs of study for that profession.

One area of allied health practice which overlaps surgical practice is 'podiatric surgery'. Podiatric surgery has been recognised as a 'specialty' of podiatry.

As under the National Law podiatry is considered its own health profession separate from the medical profession it has its own training accreditation authority. This means that despite the fact that the AMC performs this function for all other surgical education and training programs, it does not accredit podiatric surgery programs. In addition, podiatric surgery has separate registration standards recommended by the Podiatry Board of Australia, rather than the Medical Board of Australia.

RACS notes that the Australian Orthopaedic Association (AOA - with which RACS coordinates on training in orthopaedic surgery) has previously expressed concerns in relation to the standards of 'podiatric surgery' training programs and has expressed a willingness to craft a comprehensive and complete definition of the education required to undertake surgery in this area, and to define the educational standards of courses.[1]

Any surgery carries risks, and surgical professional standards and training must be maintained at a very high level to ensure patient safety and good outcomes. In this regard, RACS notes various studies have found issues with podiatric surgery training and outcomes internationally. For example, a study described in a 2017 article in the *Journal of the American Orthopaedic Foot & Ankle Society* demonstrated that surgical treatment by podiatrists was associated with higher mal-union/non-union rates among all types of ankle fractures, than orthopaedic surgeons[2]. In addition, operative treatment of ankle fractures by orthopaedic surgeons was associated with lower rates of certain postoperative complications compared with podiatrists[3]. Another article published in 2019 in *The Journal of Bone and Joint Surgery* demonstrated an increase in procedures performed by podiatrists was associated with increases in length of hospital stay and cost[4]. In addition, a study described in the *Journal of Foot & Ankle Surgery* in 2016 found that podiatric surgical residents had lower scores in a basic competency examination of musculoskeletal medicine, than those in orthopaedics.[5]

To maintain clinical standards and standardisation, RACS is of the view that for specialist areas of practice, there should be a single accredited body which establishes professional standards and provides training to meet those standards, such is the case with colleges in the medical profession (other than general practice and intensive care medicine). However, this is not the case for podiatric surgery. Rather than a single body carrying out these functions, there are currently two

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[1] AOA Submission, Podiatry Accreditation Committee consultation re: Draft proposed Professional Capabilities and Accreditation Standards for podiatry and podiatric surgery, 12 March 2021, p10

[2] Chan, Jeremy, et al, 'Lower Complication Rate Following Ankle Fracture Fixation by Orthopaedic Surgeons Versus Podiatrists', *American Orthopaedic Foot & Angle Society*, Volume: 2 issue: 3, 2017, https://doi.org/10.1177/2473011417S000031

[3] Chan, Jeremy, et al, 'Lower Complication Rate Following Ankle Fracture Fixation by Orthopaedic Surgeons Versus Podiatrists', *Journal of the American Orthopaedic Foot & Angle Society*, Volume: 2 issue: 3, 2017, https://doi.org/10.1177/2473011417S000031

[4] Chan, Jimmy, et al, 'Surgeon Type and Outcomes After Inpatient Angle Arthrodesis and Total Ankle Arthroplasty', *Bone Joint Surg Am*. 2019;101:127-35

[5] Creech, Corine, et al, 'Podiatric Resident Performance on a Basic Competency Examination in Musculoskeletal Medicine', *The Journal of Foot & Ankle Surgery* 55 (2016) 45–48

bodies providing approved programs of study, including one university[6]. RACS is of the understanding that among some podiatry stakeholders there is a view that such university programs should be made more widely available.

Hence, RACS does not believe that the current arrangements with regards to podiatric surgery training and professional standards are optimal. The accrediting authority for podiatric surgery training is not the AMC, despite the fact that the AMC accredits all other surgical training programs. Studies have found a variety of issues with podiatric surgery training and outcomes internationally, and training and professional standards for the specialisation are not being provided by a single body as they are in medical practice.

Because we hold these concerns about podiatric surgery training and standards, RACS has concerns about the registration standards for the profession.

To remedy these issues RACS believes the AMC should be made the accrediting authority assessing podiatric surgery training programs, and recommends that the AOA be consulted with regard to education required to undertake surgery in this area. In the case of foot and ankle surgery the training and education required for podiatric surgeons must be at the same level as has been established for orthopaedic surgeons in relation to foot and ankle surgery.

Registration standards for podiatric surgeons should require completion of training accredited by the AMC to meet this revised level.

(b) the role of AHPRA, the National Boards, and other relevant organisations, in addressing concerns about the practice and conduct of registered health practitioners;

RACS' view:

iii) AHPRA and the National Boards should continue in their role as regulators of health practitioners including addressing concerns about practice.

iv) The role of medical colleges in the notifications process could be clarified.

RACS supports AHPRA and the National Boards' role as regulators of health practitioners including in addressing concerns about practice.

Under its constitution RACS is able to remove Fellowship in some circumstances, however under the National Scheme RACS is not a regulator and does not seek to play a greater role in regulating specialist surgeons. RACS' view is that the role of medical colleges (providers of accredited specialist training and education) in the notifications process could be clarified.

Although it is not a regulator, RACS does receive complaints about its Fellows, as well as about SIMGs and trainees. Complaints are received by RACS in relation to a wide variety of matters from workplace bullying to clinical practice or outcomes. Where RACS believes the complaint may be within the remit of the Medical Board or another relevant organisation such as a particular state's health commissioner, RACS advises the complainant of this. RACS also provides general assistance to both the complainant and the respondent to help them navigate these systems. RACS would appreciate guidelines from the Medical Board/AHPRA as to best practice when it receives a complaint that may be within the remit of the Medical Board to support appropriate referral of the matter.

RACS also believes that AHPRA could clarify its policy regarding the circumstances in which it informs medical colleges of actions taken by the Medical Board in response to a notification. RACS' view is that it would be appropriate for AHPRA/Medical Board to proactively inform relevant medical colleges if a doctor who is a member of that specialty has a restriction on their registration or if a tribunal has made a decision in relation to them.

[6] Podiatry Board of Australia, Approved Programs of Study, https://www.ahpra.gov.au/Accreditation/Approved-Programs-of-Study.aspx?ref=Podiatrist&Type=Specialist

(c) the adequacy and suitability of arrangements for health practitioners subject to supervised practice as part of the registration process or due to a notification;

RACS' view:

v) Additional advice regarding legal protections of supervisors would be valuable.

Noting the *AHPRA information sheet for supervisors*, RACS would appreciate further clarity from AHPRA regarding legal arrangements for supervisors of practitioners subject to supervised practice as a result of a notification. In particular, RACS would appreciate advice on whether a supervisor who in good faith 'clears' a practitioner so that they have their practising rights restored, has legal protections against any subsequent findings of malpractice by the person they supervised.

Were such information provided RACS would be happy to discuss with AHPRA the possibility of communicating with its Fellows in relation to this issue.

(d) the application of additional requirements for overseas-qualified health practitioners seeking to become registered in their profession in Australia;

RACS' view:

vi) The current arrangements with regards to overseas-qualified medical practitioners, including surgeons, are appropriate.

As noted above RACS is accredited to provide assessment of surgeon SIMGs.

RACS supports the current arrangements for medical practitioners seeking to become registered in their profession in Australia. These processes ensure that practitioners with specialisations acquired overseas are competent while also ensuring standardisation of practice. Australia's welcoming yet rigorous process for assessment of SIMGs also ensures that this country is able to attract and register overseas specialists while maintaining the public's confidence in the country's specialist medical workforce. As we have seen very clearly during the pandemic, public confidence in the medical system can be eroded all too easily, with dangerous consequences.

If required, further information can be provided by RACS regarding its SIMG assessment program and we would welcome feedback from AHPRA if there were any concerns noted or improvements sought on RACS' processes.

(e) the role of universities and other education providers in the registration of students undertaking an approved program of study or clinical training in a health profession;

RACS' view:

vii) Current educational arrangements for medical registration are appropriate.

viii) All educational institutions which provide training and education in areas of practice which encroach or overlap onto surgical practice should be accredited by the AMC, and this is not currently the case.

RACS supports the current arrangements whereby the AMC accredits primary medical programs and specialist medical programs allowing registration.

RACS' view is that it is appropriate that in general, for specialist medical practice, education programs allowing registration should be provided by a single accredited expert body such as a college to ensure the consistent maintenance of high standards in specialist training.

In addition, as noted above, RACS' view is that all Australian providers of approved programs of study allowing registration in a health profession should be accredited by the AMC, if the scope of that profession overlaps or encroaches in a significant way into that of surgical practice.

(f) access, availability and adequacy of supports available to health practitioners subject to AHPRA notifications or other related professional investigations;

RACS' view:

ix) AHPRA should increase focus on ensuring practitioners feel supported through the notifications process.

x) Doctors who seek treatment for their own medical conditions should not have to fear being the subject of a mandatory report by their own doctor.

Receiving a notification is an extremely stressful event for a medical practitioner, as an adverse finding has the potential to put in jeopardy the practitioner's entire livelihood, and so the welfare of practitioners must be of central concern to AHPRA.

RACS acknowledges that AHPRA appreciates the stress that notifications can create[7], and also that the Medical Board funds doctors' health and advisory and referral services[8].

Yet, a 2019 report, 'Practitioner and community perceptions of AHPRA and the National Boards', found that only five percent of medical practitioners associated AHPRA with the word 'supportive'[9]. Anecdotally such views about AHPRA are reflected among RACS Fellows.

There are more complaints about surgeons than other doctors (2.3 times higher than physicians)[10], so it is possible that concerns with regards to AHPRA and negative views about how supportive it is may be more widespread among surgeons than among other health and medical profession cohorts. The reasons for this higher level of complaints are multi-facetted and are linked to the nature of services delivered, expectations regarding outcomes and the nature of practice.

RACS is thus of the view that more emphasis needs to be put on supporting practitioners to ensure their wellbeing during the notifications process. The support that is currently available also needs to be better communicated to them.

More emphasis also needs to be put on the clear explanation of processes and the statistical likelihood of particular outcomes, as well as mechanisms for appeal.

Such measures will be beneficial, but RACS is of the view that the best way to support practitioners who are subject to a notification is for the notification issue to be resolved as rapidly as possible (especially vexatious and meritless complaints). In addition, a clear appeal mechanism affording natural justice and procedural fairness to the practitioner, and assurance that no information is released publicly until outcomes are finalised post appeal processes is imperative for the wellbeing of practitioners.

RACS is also of the view that supporting doctors should mean that those who seek treatment for their own medical conditions are able to do so without fear of being subject to a mandatory report by their doctors. The West Australian model is an example of a state-based scheme which protects doctors who seek help for themselves and this should be encouraged nationally, as by doctors seeking treatment for any conditions they can remain fit for purpose, and in fact be more likely to provide safe care for the community. Fear of a mandatory report may well discourage doctors from seeking help, placing the community at greater risk.

(g) the timeliness of AHPRA's investigation of notifications, including any delays in handling, assessment and decision-making, and responsiveness to notifiers;

RACS' view:

xi) Focus needs to be maintained by AHPRA on ensuring the prompt identification of meritless claims.

xii) Prompt resolution of all claims must be a key objective of AHPRA, and so KPIs need to be considered or tightened, and internal processes or even legislative changes looked at.

RACS acknowledges that timeliness of investigation of notifications is an issue on which action is being taken, and notes that according to AHPRA's most recent annual report the average time

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[7] AHPRA, Has a concern been raised about you, https://www.ahpra.gov.au/Notifications/Has-a-concern-been-raised-about-you.aspx

[8] AHPRA, Practitioner support services, https://www.ahpra.gov.au/Notifications/Further-information/Practitioner-support-services.aspx

[9] Practitioner and community perceptions of the Australian Health Practitioner Regulation Agency (Ahpra) and the National Boards: 2019, Truly Deeply, 2019, p15

[10] Tibble, H, et al, *Why do surgeons receive more complaints than their physician peers?,* ANZ J Surg . 2018 Apr;88(4):269-273. doi: 10.1111/ans.14225.

taken to complete notifications has been reduced by 5.3% compared to the previous year.[11] However RACS also notes that on its website AHPRA advises that only 54% of all notifications about doctors are closed within 90 days. In addition, of the 35% of notifications which reach the 'investigation, health or performance assessment' stage of the notifications process, about half take more than a year to complete[12].

Being informed about a notification, as AHPRA acknowledges, is highly stressful for those the subject of the notification, as well as for those making the notification[13], thus prompt resolution must be a priority. We note that delays in AHPRA progressing a notification is a common reason why people complain to the National Health Practitioner Ombudsman[14].

As described above, because of the mental harm a merit-less claim has the potential to cause RACS believes focus needs to be maintained on ensuring the prompt rooting out of such claims. RACS acknowledges that AHPRA has a new vexatious complaints framework which may assist in this. However, RACS will need to be assured that this framework will enable the better identification of cases, which while they may not reach the standard of 'vexatious', could still be considered meritless. RACS notes that AHPRA has in the past commissioned research that found that vexatious complaints account for less than 1 percent of notifications received[15], but 'vexatious' has a specific meaning, which may not cover certain other cases which are clearly without merit.

RACS is thus of the view that improvements to AHPRA internal process in the management of notifications must be a priority. As a recommendation, in the first instance, RACS believes KPIs, particular with regards to case resolution time, should be looked at (or tightened). RACS is also of the view that increased funding including to enable the recruitment of more clinical advisors would be desirable.

In addition and acknowledging that some of the 'tranche 2' amendments[16] *may* be beneficial to this end, RACS supports further examination of legislative reforms which may contribute to the timely processing of notifications - as long as they are not to the detriment of the objectives of the National Scheme.

(h) management of conflict of interest and professional differences between AHPRA, National Boards and health practitioners in the investigation and outcomes of notifications;

RACS' view:

xiii) Where a decision maker involved in the management of a notification is identified as having a conflict of interest, and if the conflicted person is a surgeon, RACS suggests working with the College to identify an appropriately qualified replacement.

The surgical community (and many other health/medical profession communities) are not particularly large and so in the management of notifications there must be a heightened awareness of potential conflicts of interest, beyond direct and obvious conflicts. For example, RACS has concerns about panel members sitting in judgement against a practitioner they have previously found against, or someone from their workplace.

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[11] AHPRA Annual Report 2019-20, https://www.ahpra.gov.au/Publications/Annual-reports/Annual-Report-2020/Notifications.aspx
[12] AHPRA, Understanding the notifications experience, https://www.ahpra.gov.au/Notifications/Has-a-concern-been-raised-about-you/Understanding-your-experience.aspx
[13] AHPRA, Understanding the notifications experience, https://www.ahpra.gov.au/Notifications/Has-a-concern-been-raised-about-you/Understanding-your-experience.aspx
[14] National Health Practitioner Ombudsman Annual Report, 2019-20, p14
[15] AHPRA, Vexatious Notifications, https://www.ahpra.gov.au/Notifications/How-we-manage-concerns/Vexatious-notifications.aspx
[16] In March 2021 RACS was provided with a 'Consultation Draft Summary' document which describes the proposed 'Tranche 2' amendments to the National Law following the 2018 consultation on 'keeping the National Law up to date and fit for purpose'

In smaller surgery fields of specialty practice, it is very likely that a person involved in assessing a notification will know the surgeon involved, so the potential for conflicts of interest will be even greater.

Thus, clear and thorough conflict of interest policies and processes are required to ensure due process.

Where a decision maker involved in the management of a notification is identified as having a conflict of interest, and if the conflicted person is a surgeon, RACS suggests working with the College to identify an appropriately qualified replacement.

(i) the role of independent decision-makers, including state and territory tribunals and courts, in determining the outcomes of certain notifications under the National Law;

RACS' view:

xiv) Relationships between different National Scheme decision-makers need clarification.

xv) AHPRA should consider working with medical colleges to identify the right people to provide clinical input in relation to notifications and in particular where matters reach the panel/tribunal stage.

RACS finds the relationship between AHPRA and the state tribunals to be opaque and requiring of greater clarification. Common standards publicly communicated would be helpful so all parties, including colleges, can understand the processes/differentiations.

RACS is also of the view that any person called to provide clinical input in relation to a notification, compliance or registration matter should be registered in the same field of speciality practice as the practitioner concerned and have extensive recent experience in the sub-speciality relevant to the matter, while also ensuring there is no conflict of interest. If the person giving clinical input is not an expert as described then there is a real risk that any clinical opinion they provide may be incorrect or out of date.

For the same reason, RACS recommends that for matters which reach the panel/tribunal stage AHPRA works with RACS to seek appropriately qualified surgeons who are conversant with the clinical issue at hand. The scope of surgery is obviously extremely broad with a great many areas of subspecialty practice. Working with RACS to identify appropriately qualified surgeons would prevent tribunals making use of clinical opinion evidence given by clinicians on matters on which they lack expertise or in which their expertise may be out of date. To base a panel/tribunal decision on weak or incorrect clinical opinion is to risk a miscarriage of justice.

For other non-surgical medical matters RACS would recommend a similar approach of working with the relevant medical college.

RACS acknowledges that to bring these changes about funding would be required to enable remuneration sufficient to contract appropriate experts, but believes it is warranted to ensure just outcomes.

(j) mechanisms of appeal available to health practitioners where regulatory decisions are made about their practice as a result of a notification;

RACS' view:

xvi) Practitioners must be afforded natural justice and procedural fairness, including the right to respond to the allegations made and a right to challenge any adverse decisions, before they are made public.

A regulatory decision made against a practitioner can have devastating financial and mental health impacts on the practitioner. Thus, notwithstanding patient safety concerns, the wellbeing of the practitioner must be a priority in the notifications process, even where an adverse finding has been made against them.

Therefore, RACS is of the view that before any regulatory decisions by AHPRA or the Medical Board are made which could result in a negative imputation against a practitioner, there must have been a process whereby the practitioner was afforded natural justice and procedural fairness, including the right to respond to the allegations made and a right to challenge any adverse

decisions. In addition, no decision which could result in a negative imputation against a practitioner should be made public until all appeals have been concluded and a final determination reached.

(k) how the recommendations of previous Senate inquiries into the administration of notifications under the National Law have been addressed by the relevant parties

No comment.

(l) any other related matters.

RACS' view:

xvii) The fractured nature of the National Scheme as it currently exists is not optimal, and should be harmonised.

RACS supports the National Scheme and its objectives, not least because it (to some extent) simplifies and harmonises the regulation of health practitioners across Australia. However, the fact that different jurisdictions have slightly different arrangements, and in particular the existence of the co-regulatory systems of New South Wales and Queensland, detracts from this.

Many practitioners have at best only a vague understanding of the way their profession is regulated, and these co-regulatory systems add unnecessary complexity. For those with concerns about the practice and conduct of registered health practitioners and who are not likely to have had previous interaction with the system, navigating this co-regulatory system is also likely to be quite challenging.

RACS thus believes the fractured nature of the National Scheme is not optimal and would support efforts to harmonise all elements of the National Scheme across the jurisdictions.

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Again, RACS appreciates the opportunity to contribute to this inquiry. If any clarification is required, please do not hesitate to let us know. As an organisation we remain committed to the development and improvement of national health policy and stand ready to assist whenever required by the Government and stakeholders.

Yours sincerely

Dr Sally Langley
President

Office of the President
Telephone +61 3 9276 7404
college.president@surgeons.org