ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Patron: H.R.H. The Prince of Wales

7 August 2015

Legal & Regulatory Services – Legal Branch
NSW Ministry of Health
Locked Bag No. 961
North Sydney NSW 2059

Review of the Health Practitioner Regulation National Law (NSW)

To Whom It May Concern,

Thank you for the opportunity to provide comment on the discussion paper supporting the statutory review of the Health Practitioner Regulation National Law (NSW).

The Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand. The RACS NSW Regional Committee works closely with the Four Pillars of the Ministry of Health, and we hope to maintain our close working relationship with NSW Health to ensure the continued delivery of high quality surgical services in NSW.

The RACS NSW Regional Committee believes that the objectives of the National Law are appropriate; however it is timely to review how this law is applied in NSW.

The Committee has responded to the questions raised in the discussion paper that are most relevant to doctors, and in particular surgeons. Comments have also been made with respect to the lower complaints professions to contribute to the general discussion around these issues. The questions raised under section 3.11 of the discussion paper relating to pharmacy licensing are not relevant to our expertise. Below are our comments categorised under specific sections of the discussion paper.

2) Should the Health Practitioner Regulation National Law (NSW) have a provision that allows regulations to be made disallowing changes made to the Schedule of Health Practitioner Regulation National Law Act 2009 (Qld) or that requires regulations to be made in NSW before changes made to the Schedule of Health Practitioner Regulation National Law Act 2009 (Qld) take effect in NSW?

NSW should have the legal right to accept or reject changes to the Schedule of Health Practitioner Regulation National Law Act (2009) Qld. This protects the State from changes that might potentially impact the specific complaints process in NSW, but also allows other states to accept changes without the requirement for NSW to agree. Should NSW then decide to accept a change made in Queensland at a later time, this process should be facilitated.

3) Should the NSW specific provisions be amended to replace the existing Councils for the nine low complaints professions (Aboriginal and Torres Strait Islander health practice, osteopathy, podiatry, Chinese medicine, chiropractic practice, medical radiation practice, occupational therapy, optometry and physiotherapy) with a Combined Council?

College of Surgeons of Australia and New Zealand
ABN 29 004 167 766
Suite 1, Level 26, 201 Kent St, Sydney NSW 2000, Australia
Telephone: +61 02 8298 4500 Facsimile: +61 02 8298 4599 Email: College.NSW@surgeons.org
Website: www.surgeons.org

From an economic perspective it makes fiscal sense to combine the low complaints professions under one Council.

4) If so, what should be composition of the Combined Council?

It would be a matter of discussion with the low complaints professions to determine the most appropriate composition of a Combined Council.

5) If a Combined Council is established, should the NSW specific provisions be amended to require a complaint against a health practitioner to be heard and determined by a sub-committee of the combined health profession Council comprising members of the practitioner's profession as well as having access to community and legal members to sit on any complaint as appropriate?

If a complaint is made against a practitioner in one of the low complaints professions, they should have the right to have that complaint heard by peers, especially if the complaint concerns standards of clinical judgement or decision-making. However, a sub-committee could also comprise members of the other professions if the complaint concerns Code of Conduct breaches which can be assessed by other healthcare practitioners.

6) If a consolidated Health Professional Council is not created, should the legislation be amended to "future proof" the legislation in order to deal with the situation of a Council being financially unviable?

As it is predictable that other health professions may seek and receive registration with AHPRA in the future, it is appropriate that the legislation be "future proofed" to allow for a Council being financially unviable, and to allow for inclusion of other smaller, low complaints professions to be included under a Combined Council.

7) If so, should a regulation making power be included allowing regulations to be made amending the complaints handling processes for a profession in the event that the Council for that profession is not financially viable?

This would depend on whether being financially unviable interferes with the ability of the profession to continue to handle complaints. As an example, financial unviability may only be a temporary situation for a profession but if legislation is enacted removing or amending their ability to handle complaints, it may affect the process of restoring those rights in the future.

8) In respect of the Aboriginal and Torres Strait Islander Health Practice Council, what changes should be adopted to address the financial constraints of the Council?

It is prudent to put in a place a process whereby the administrative requirements are handled by an existing body that deals with Indigenous affairs, while keeping the complaints handling process the purview of the Council.

College of Surgeons of Australia and New Zealand
ABN 29 004 167 766

Suite 1, Level 26, 201 Kent St, Sydney NSW 2000, Australia
Telephone: +61 02 8298 4500 Facsimile: +61 02 8298 4599 Email: College.NSW@surgeons.org
Website: www.surgeons.org

9) Is the current complaints model whereby there are different and distinct streams, health, conduct and performance, to deal with complaints appropriate and effective?

While it might be reasonable to combine conduct and performance matters under one stream, health matters should be dealt with separately. A health practitioner needs to feel confident that health-related issues will be dealt with confidentially and sympathetically by a panel that has the welfare of the practitioner as its priority.

10) What changes, if any, are required for PSCs and Council inquiries to hearing complaints in a timely, cost effective manner that both protects the public and ensures natural justice for practitioners the subject of a complaint?

Before any changes are considered purely for the sake of consistency, it would be worth considering whether there have been any significant problems with the current system of Council Inquiries and PSCs. It would be appropriate to consider recording decisions made in both situations, for the protection of the practitioner and the deciding bodies. However, in low level matters these decisions could be stricken from the record of the practitioner after a suitable period of time. From a cost effectiveness viewpoint, it may be efficient to have a Council consisting of members from each of the specialties with one administrative system for the low complaints professions. Professionals should be capable of hearing complaints against members of another specialty and reaching a fair decision.

11) Should the requirement that a medical practitioner sit on an Impaired Registrants Panel remain in the legislation?

Since an individual facing an Impaired Registrants Panel will have had an appropriate assessment performed by a medical practitioner or psychologist, this requirement does not need to be mandatory.

12) If not, what should be the composition of the Panel?

There may be a case for having a panel comprised of two members of the specialty, and a member of the public would provide an appropriate balance to consider such matters.

13) What changes, if any, are required to the Impaired Registrants Panel, particularly in respect of the powers of the Panels, to ensure that complaints that raise impairment issues are handled in a cost effective, fair and timely manner?

An Impaired Registrants Panel may find that a practitioner is not impaired, but may be facing considerable stress in the workplace or in their personal life. It may be the view of the panel that the practitioner should be taking active steps to get assistance with that stress. In those circumstances it seems entirely reasonable for the Panel to make recommendations.

If a practitioner is found to be impaired then it would be efficient for the Panel to be able to take direct action. Any such action must fit with a pre-determined schedule of decisions that can be applied in the case of an impaired practitioner. These decisions would be determined by an expert panel comprising medical practitioners, psychologists, and experts in the field of drug and alcohol addiction.

College of Surgeons of Australia and New Zealand
ABN 29 004 167 766

Suite 1, Level 26, 201 Kent St, Sydney NSW 2000, Australia
Telephone: +61 02 8298 4500 Facsimile: +61 02 8298 4599 Email: College.NSW@surgeons.org
Website: www.surgeons.org

14) Should the Performance Review Panels be abolished?

Performance Review Panels should not be abolished. They provide a fair and balanced way of assessing the performance of a practitioner.

15) Are there other options to simplify and streamline the processes while maintaining the effectiveness of the Performance Stream?

To streamline the process the assessor could send a report directly to a Performance Review Panel. If the Panel felt that further review was warranted they should have the authority to perform that review. If the Panel was satisfied with the report of the assessor then the Panel would notify Council of the decision.

16) Should Assessment Committees be retained in the NSW specific provisions?

Since all Councils have access to the Performance Program, the need for Assessment Committees appears to have been superseded.

18) Are changes required to s150 to ensure that immediate action can be taken to protect the public while still ensuring natural justice for practitioners?

It should be possible for Councils to take "immediate action" where this is in the interests of the public. However, this must be coupled with the ability to provide immediate review of the decision face-to-face with the practitioner, maintaining scrupulous confidentiality in the interim.

19) Should the Tribunal have a power to make an interim suspension order?

If the matter before the Tribunal is serious enough to concern the competence or safety of a practitioner or student to continue in practice, then an interim suspension order should be within the Tribunal's powers. However, it must be remembered that Tribunal decisions are not punishments. All possible assistance must be given to the practitioner before such action is taken.

20) If so, in what circumstances should the Tribunal be able to make an interim suspension order?

An interim suspension order may be made while other interim orders, such as supervised practice, re-education or counselling are being arranged. Once those orders have been arranged or complied with, the Tribunal can lift the suspension order pending the final decision on the case.

21) If the Tribunal has a power to make an interim suspension order, what safeguards or appeal rights should be included in the legislation?

College of Surgeons of Australia and New Zealand
ABN 29 004 167 766

Suite 1, Level 26, 201 Kent St, Sydney NSW 2000, Australia
Telephone: +61 02 8298 4500 Facsimile: +61 02 8298 4599 Email: College.NSW@surgeons.org
Website: www.surgeons.org

The practitioner who is the subject of such a suspension order should have the right to review and appeal against the order if they can demonstrate that every effort is being made to comply with other interim orders, and that they have voluntarily self-imposed restrictions on the nature and type of practice that they undertake pending the Tribunal's final decision.

22) Should Part 8 of the Health Practitioner Regulation National Law (NSW) be amended to clarify that the Tribunal can hold an inquiry where a complaint has been admitted?

Yes.

23) Should a new section be included in Part 8 requiring the Tribunal to give written reasons when making orders in circumstances where a complaint has been admitted?

Yes - this will facilitate any appeal a practitioner may make.

24) Should the legislation be amended to clarify who should have a right to appear before, or be heard, in matters where an application for a review is made under s163A?

Yes.

25) If so, who should be that person or body?

The legislation should not be proscriptive but should include the provisions in Clauses 9 and 10 of Schedule 5, allowing the Secretary or HCCC to attend reviews if indicated.

26) Should Schedule 5D clause 12 be amended to give a list of mandatory factors a PSC or Tribunal must consider in determining whether it is not in the public interest for an inquiry or appeal to continue?

No, this appears to be unnecessary.

27) Are the current administrative arrangements for dealing with practitioners who have conditions on their registration adequate or are legislative amendments required? 28) If legislative amendments are required, what changes are needed?

If problems have been identified in reviewing, removing or amending conditions placed on a practitioner who then moves interstate or to a new jurisdiction, then changes to the legislation should be made to remove any administrative complexity to facilitate the process.

29) What is the best way to protect the public from practitioners who may be placing the public at risk of substantial harm in the professional practice because the of the practitioner's impairment? 30) Are any changes to the legislation required? 31) Should there be additional information provided to practitioners to ensure that they understand

their mandatory reporting obligations?

There is clear evidence that the mandatory reporting requirement for medical practitioners who have a patient who is also a practitioner is preventing practitioners from seeking help. This issue was dealt with in depth by the ABC in a Background Briefing program on Radio National in February this year.

Western Australia has seen an increase in interstate doctors requesting assistance with psychological problems. In Queensland and the ACT, calls to the Doctors Health Advisory Service fell by 50% after mandatory reporting was brought in. It is troubling that the Ministry is unaware of such evidence which was expounded clearly in an article in the Journal of Law and Medicine, "Mandatory reporting of health professionals: The case for a Western Australian style exemption for all Australian practitioners". (2014) 22 JLM 209.

32) Should the reporting requirements of medical superintendents under s151 remain?
33) Should s151 of the National Law be amended to require the medical superintendent to notify a health practitioner Council of a registered health practitioner or student who is detained in a mental health facility under the Mental Health Act only after either the s27 examinations have occurred or the patient has been seen Mental Health Review Tribunal?

Notification should only occur after appropriate review of the practitioner or student has occurred.

34) Should the Health Practitioner Regulation National Law (NSW) be amended to require the National Board to keep a public register of disqualified practitioners?

Since the National Board keeps a registrar of practitioners whose registration has been cancelled, this provides enough protection for the public.

35) What changes should be made to Part 8 to make it more user friendly?
36) Should the minor amendments set out in Appendix A be made?

It is essential that Part 8 is amended to ensure that the issues of how complaints are made; how they will be handled; and the powers of the Councils and Tribunals are clearly stated, logical and easy to comprehend. The Amendments in Appendix A provide some guidance but any future draft amendments should be reviewed by the professions.

Yours sincerely,

MLangcake

Dr Mary Langcake FRACS
NSW Regional Chair
Royal Australasian College of Surgeons