NSW HEALTH

Final Report of the Review of the Medical Practice Act 1992

December 1998

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EXECUTIVE SUMMARY AND SUMMARY OF RECOMMENDATIONS

Introduction (Chapter 1)

Section 199 of the Medical Practice Act 1992 requires the Minister for Health to review the Act to determine whether the policy objectives of the Act remain valid and whether the terms of the Act remain valid for securing those objectives.

The Council of Australian Governments (COAG) Competition Principles Agreement provides that legislation should not restrict competition unless it can be demonstrated that the benefits to the community as a whole outweigh the costs of restricting competition and that the objectives of the legislation can only be achieved by restricting competition. The Review of the Act has been carried out by the Department's Legal Branch.

The Department has prepared this Report for consideration by the Deputy Premier and Minister for Health, the Hon Andrew Refshauge, MP and the NSW Government in satisfaction of the review requirements under the Medical Practice Act and the Agreement.

Regulation of Medical Practitioners (Chapter 2)

The Medical Practice Act establishes a comprehensive system for the registration and disciplining of medical practitioners.

The principle requirements of the Act which may have an impact on competition can be summarised as follows:

- The restriction on the use of the title "medical practitioner" by unregistered persons may confer a competitive advantage on medical practitioners over other service providers.

- The requirements for registration may restrict competition where the number of persons that may gain registration (and hence use the title "medical practitioner") is limited beyond that which is necessary to ensure that the objectives of the Act can be achieved. Similarly, the power to impose conditions can, in certain cases limit competition.

- The complaints and disciplinary system or statutory restrictions on conduct, although generally directed at ensuring that high standards are adopted by practitioners, may inappropriately focus on the commercial conduct of medical practitioners thus limiting information to consumers on the difference services available.

- The Act contains a number of restrictions on the conduct of persons other than medical practitioners:
  (i) fees cannot be recovered for medical or surgical services provided by unregistered persons;
  (ii) unregistered persons are prohibited from advertising cures for certain diseases; and
  (iii) unregistered persons are not to give or offer cancer treatments.

A range of new regulatory requirements were canvassed in the Issues Paper and these are also assessed to ensure that they accord with the review principles.

Objectives of the legislation (Chapter 3)

The Department is of the view that there is a continuing rationale for the intervention to minimise the risks of harm or injury to consumers of medical services. The objective of legislation regulating the medical profession has been identified as the minimisation of harm for consumers of medical services.

Recommendation 1
That the Medical Practice Act be amended to provide that its objective is to protect the health and safety of members of the public by providing mechanisms to ensure that medical practitioners are fit to practise.

The Registration of Medical Practitioners (Chapter 4)

The primary form of intervention by which the Medical Practice Act seeks to achieve this objective is through the establishment of the registration system and the placement of restrictions on who may use the title "medical practitioner". The restriction aims to achieve the objectives of the legislation by providing consumers with a simple and understandable means of identifying practitioners capable of providing the full range of medical services.

The Department is of the view that this system is likely to produce an overall benefit to the community because it effectively and simply provides information to consumers about the competence and ethical standards of those holding themselves out as medical practitioners. The disciplinary system plays a role in regulating the conduct of medical practitioners. As titles legislation, other service providers continue to operate in competition with medical practitioners, minimising the costs for consumers. Other options have been considered, however, the Department has concluded that they are unlikely to meet the objectives of the legislation.

Recommendation 2
That medical practitioners continue to be registered by title.

Entry requirements and registration inquiries (Chapters 5 and 6)

The current Act creates two categories of registration (ie general registration and conditional registration at the discretion of the Board), each having slightly different criteria. Although most submissions were supportive of the current categories of registration, several proposals have been put forward by the Committee for the review of practices for the employment of medical practitioners in the NSW Health System which will require further consultation. A range of other amendments are also recommended to ensure that the registration criteria and the jurisdiction of the Medical Board over medical students adequately protects the public.

Recommendation 3
That the Act be amended to give the Medical Board the power to refuse registration where a charge has been proven but no conviction recorded and the Board is of the opinion that it renders the applicant unfit in the public interest to practise medicine.

Recommendation 4
That the Act be amended to give the Medical Board the power to refuse a non-mutual recognition applicant where he or she has been suspended indefinitely from an inter-state register on account of professional misconduct or any basis relating to the person's physical or mental capacity to practise medicine.

Recommendation 5
That the Medical Board continue to have jurisdiction over medical students in impairment matters and the definition of "medical student" in the Act be amended to more accurately cover medical students who are directly involved in patient care.

Recommendation 6
That the Act should be amended to clarify that the Medical Board has the power to conduct inquiries into eligibility for:

- all re-registration applications;
- all applicants transferring from internship/supervised training to general registration; and
- all applicants transferring from conditional/retired or non-practising registration to general registration.

Recommendation 7
That the Medical Board notify the Health Care Complaints Commission of all registration inquiries (with the exception of those which concern impairment) and at the discretion of the inquiry be permitted to appear before the inquiry.

Requirements for continuing registration (Chapter 7)

Under the current Act the Medical Board is required to rely heavily on the initial registration criteria and the ongoing competence of practitioners. The power of the Medical Board to protect the public would be enhanced if it had the power to assesses the performance of practitioners with broad based problems that warrant early intervention. The Medical Board has been developing such a model which is yet to be finalised.

Recommendation 8
That the Medical Board proposal for performance assessments be the subject of further consultation

Disciplinary System (Chapter 8)

Complaints and disciplinary systems play a central role in maintaining professional standards and protecting patients from harm. A number of recommendations have been made the object of which is to make the disciplinary system more effective. They include amendments to the types of conduct which can attract disciplinary action and improved

access by the Medical Board to information which is relevant to its protective jurisdiction.

Recommendation 9
That the grounds for complaint in the Act be amended to include not only convictions but instances where the charge has been proved but no conviction recorded.

Recommendation 10
That the definition of "unsatisfactory professional conduct" in the Act should be amended to include:

- both convictions and cases where a finding of guilt is made but no conviction recorded for the specified offences under the Mental Health, Children (Care and Protection), Guardianship, Private Hospitals and Day Procedure Centres , Nursing Homes and Health Insurance Acts;
- failure to disclose a conflict of interest in a service;
- conduct which involves:
  - (a) providing a person with medical services of a kind that is excessive, unnecessary or not reasonably required for that person's well being; or
  - (b) influencing or attempting to influence the conduct of a medical practice in such a way that patient care may be compromised;
- failure to respond to a Board request for information without reasonable excuse.

That the prohibition on the use of qualifications not recorded in the register be deleted from the definition of "unsatisfactory professional conduct" in the Medical Practice Act.

Recommendation 11
That the Medical Practice Act be amended to enable Codes of Conduct to be made by Regulation under the Act following consultation with the Board.

Recommendation 12
That the Medical Board should review its strategies for encouraging practitioners to notify it when they obtain information which raises issues about a practitioner's competence or sexual misconduct.

Recommendation 13
That the Medical Practice Act be amended to impose a positive obligation on practitioners to notify the Medical Board if they are convicted of an offence (irrespective of whether it is recorded or not) unless it is an offence of a type that is not required to be reported to the Medical Board.

Recommendation 14
That the Medical Practice Act be amended to oblige a medical practitioner to notify the Medical Board within seven days if charged with a "serious sex or violence offence" where the allegations relate to conduct occurring in the course of practice. A "serious sex or violence offence" means an offence involving sexual activity, acts of indecency, physical violence or the threat of physical violence that would be punishable by imprisonment for 12 months or more.

Recommendation 15
That the Medical Practice Act be amended to require applicants for registration to make declarations on:

- criminal convictions (recorded and unrecorded);
- charges for serious sex or violence offences where the allegations relate to conduct occurring in the course of practice;
- significant illness for the purpose of identifying whether there may be issues of impairment; and
- continuing medical education activities.

The general view among submissions was that for a disciplinary system to be effective at monitoring and enforcing standards among the profession it must be independent, transparent, accountable to the public and fair to all parties. A number of recommendations are made about the processes for the conduct of disciplinary proceedings which are designed to further this objective.

Recommendation 16
That the Medical Practice Act be amended to provide that members of Professional Standards Committees and the Medical Tribunal should be drawn from a panel of persons appointed by the Minister for Health.

That the Medical Board arrange training in procedural fairness and the administration of inquiries for members of Professional Standards Committees and the Medical Tribunal.

Recommendation 17
That the Medical Practice Act be amended to provide that:

- if a Professional Standards Committee or the Medical Tribunal is proposing to make an order which will place an appreciable burden on a third party, prior to making the order the third party will be given an opportunity to be heard on the proposed order; and
- a third party which is placed under an appreciable burden by a decision of a Professional Standards Committee or the Medical Tribunal will be provided with a copy of the decision within seven days of it being made.

It will remain a matter for the third party as to whether it is able to implement the order.

Recommendation 18
That in the interests of protecting the public, the emergency powers under the Medical Practice Act should be retained but reviewed to address:

- the timing of the various actions;
- the failure to include reference to an Impaired Registrants Panel as an outcome;
- the interaction with time frames under the Health Care Complaints Act; and
- the lack of a mechanism to review conditions pending a hearing.

Recommendation 19
That section 63 of the Medical Practice Act be amended to confer a right of appeal to the Supreme Court.

Recommendation 20
That the Medical Practice Act be amended to narrow the scope of review applications to preclude a person from challenging findings made by earlier Tribunals and to confer a right of appeal to the Supreme Court in circumstances where a substantial miscarriage of justice would arise from the discovery of fresh evidence.

Impairment (Chapter 9)

Most submissions have been supportive of the impairment system which enables the Medical Board to take action before the condition of a practitioner/student puts the public at risk and warrants disciplinary proceedings. A number of recommendations are proposed which will assist the Board to protect the public from the risk posed by practitioners and students who suffer from an impairment.

Recommendation 21
That the Medical Practice Act be amended to provide that a practitioner who has agreed to have conditions imposed on his or her registration may only have them lifted with the agreement of the Medical Board which will receive a recommendation from an Impaired Registrants Panel, and with an accompanying right of appeal from the Medical Board's decision to the Medical Tribunal.

Recommendation 22
That the Medical Practice Act be amended to give the Medical Board the power to direct a medical practitioner who is the subject of a matter referred or proposed to be referred to an Impaired Registrants Panel to undergo a medical examination.

Corporations engaged in the provision of medical services (Chapter 10)

An issue which emerged from consultation on the Issues paper was that unlike medical practitioners, essentially the Medical Practice Act does not regulate corporations providing medical services. There has been a proliferation of medical centres and specialised clinics where medical practitioners are retained as employees. Employers that are not medical practitioners are outside the scope of the disciplinary system. It can be argued that it is inequitable for an employer who influenced or attempted to influence a practitioner to engage in the offensive conduct to be beyond the reach of the law. Accordingly, the Department is

recommending that this issue be the subject further consultation.

Recommendation 23
That the Department undertake further consultation on whether legislative amendment is required to adequately address improper or unethical practices by corporations engaged in providing medical services and, if so, the form of such legislation.

Regulation of conduct and market information (Chapter 11)

Although the power to regulate advertising in the Medical Practice Act can constrain normal forms of competitive behaviour, the extent to which restrictions will impact on competition will depend on the precise terms of the regulation. The Department has concluded that the power to regulate advertising is linked to professional standards and is in the public interest. Amendments are also proposed which remove restrictions on when practitioners can initiate proceedings to recover fees and facilitate public access to information on the register.

Recommendation 24
That the Medical Practice Act be amended to remove the restrictions on when practitioners may initiate proceedings to recover fees for services provided.

Recommendation 25
That the Medical Practice Act be amended to clarify that orders of all disciplinary and impairment proceedings with the exception of impairment related conditions which have been recommended by an Impaired Registrants Panel should be publicly available.

Restrictions which impact on the practice of unregistered practitioners (Chapter 12)

The Department considers that the restrictions in the Medical Practice Act which prevent unregistered persons from carrying out particular types of activities (e.g. advertising cures for a range of diseases) should be removed on the ground that they do not provide more effective protections than those afforded by the broader regulatory environment and have shown to be unenforceable.

Recommendation 26
That the current restrictions on recovering fees for medical or surgical services, advertising cures for a range of diseases and providing cancer treatments be removed from the Medical Practice Act.

Administration of the Medical Practice Act (Chapter 13)

A number of other amendments are recommended which concern the administration of the Medical Practice Act and the turnover of the Medical Board.

Recommendation 27

That the Medical Practice Act be amended to give all medical reports which have been prepared at the request of the Board or pursuant to an order of a Professional Standards Committee or the Medical Tribunal the same protections which are currently given to reports of Impaired Registrants Panels.

Recommendation 28

That the Medical Practice Act be amended to provide that a person may not hold office as a member of the Board for consecutive terms totaling more than eight years.

Recommendation 29

That the Medical Practice Act be amended to provide that when a body corporate commits an offence, every director and person who takes part in the management of a body corporate is taken to have committed the same offence unless he or she proves that:

- the offence was committed without his or her consent of connivance; and
- he or she exercised all such due diligence to prevent the commission of that offence as he or she ought to have exercised, having regard to the nature of his or her functions in that capacity and to all the circumstances.

Other Issues (Chapter 14)

The Department recommends that the provisions in the Act which enabled the Medical Board to conduct an audit of its register in 1993 to identify those overseas trained practitioners who had not demonstrated a commitment to live in Australia be removed.

Recommendation 30

That Part 3 of Schedule 5 of the Medical Practice Act be deleted.

1. INTRODUCTION

1.1 Background to the Review

Section 199 of the Medical Practice Act 1992 requires the Minister for Health to review the Act during the 1998 calendar year. The purpose of the review is to determine whether the policy objectives of the Act remain valid and whether the terms of the Act remain valid for securing those objectives.

The Council of Australian Governments (COAG) Competition Principles Agreement provides that legislation should not restrict competition unless it can be demonstrated that the benefits to the community as a whole outweigh the costs of restricting competition and that the objectives of the legislation can only be achieved by restricting competition. In undertaking the Review, Governments agreed that:

(i) the objectives of the legislation will be clarified;
(ii) the nature of the legislation will be identified;
(iii) the likely effects of the restriction on competition and the economy generally will be analysed;
(iv) the costs and benefits of the restriction will be assessed and balanced; and
(v) alternative means for achieving the same result will be considered.

The Minister for Health requested that the Department of Health conduct a review in accordance with section 199 of the Medical Practice Act and to assess whether the Medical Practice Act accords with the principles outlined above. The requirements to be considered during a review are set out at **Appendix A**.

1.2 Conduct of the Review

The Review of the Act has been carried out by the Department's Legal Branch. An Issues Paper seeking public comment was released in September 1998. Approximately four hundred and twenty copies of the Paper were distributed to consumers, government bodies, medical practitioners, professional associations and other health care professionals. Approximately 50 submissions were received by the Department. A list of submissions is attached at **Appendix B**.

1.3 Other review processes

A number of other inquiry and review processes have been occurring concurrently with this Review which have some relevance. These are:

(i) the Ministerial Committee of Inquiry into Impotency Treatment Services in NSW; and
(ii) the Ministerial Committee of Inquiry into Cosmetic Surgery Services;
(iii) the Committee for the Review of Practices for the Employment of Medical Practitioners in the NSW Health System.

This Report discusses a number of the recommendations of these reviews in so far as they are relevant to the Medical Practice Act.

1.4 The Final Report

The Department has prepared this Report for consideration by the Deputy Premier and Minister for Health, the Hon Andrew Refshauge, MP and the NSW Government in satisfaction of the review requirements under the Medical Practice Act and the Agreement.

2. THE REGULATION OF MEDICAL PRACTITIONERS

2.1 Introduction

Workforce surveys[1] indicate that approximately 81 per cent of the registered medical practitioners in NSW are in paid employment in NSW. In 1996, almost 65 per cent of the total medical practitioner workforce were employed in the private sector (including private medical rooms/surgery, private acute care hospitals and other private facilities). The remaining 35 per cent were employed in the public sector. There has been a steady decline in medical practitioners employed in the private workforce, falling from 77.8 per cent in 1986 to 64.8 per cent in 1996.

As most practitioners are employed in the clinical field, patient care represents the bulk of their duties. Over 60 per cent of practitioners spend 40 hours or more per week attending to patient care as a result of their primary employment.. Roughly one third of all practitioners reported spending 50 hours or more per week on patient care.

Medicare statistics indicate that in the financial year 1996/97, 72,614,045 medical services were performed in NSW (note that these are based on billed Medicare items, one patient may account for several items). This is approximately 11.6 services for each resident of NSW in that year. Over half of these services were performed by general medical practitioners and specialists.

Of the total number of services performed, 75 per cent were direct billed to Medicare. Total services performed in 1996/97 in NSW attracted Medicare benefits of $ 2,260,262,510, or approximately $360 per capita. Nearly a third of these benefits were for services performed by general practitioners and vocationally registered practitioners.

2.2 The Medical Practice Act 1992

The Medical Practice Act 1992 which replaced the Medical Practitioners Act 1938 updated and streamlined the provisions governing the registration and discipline of medical practitioners in New South Wales.

Restriction on title

The Act provides that only those people meeting certain registration requirements can be registered as medical practitioners in NSW. Those who gain registration are entitled to use a title or description from which it may be inferred that he or she is a registered medical practitioner (eg "medical practitioner", "general practitioner"). Although unregistered persons may not use these descriptions, the Medical Practice Act itself essentially does not preclude such persons from offering or providing types of services which are also provided by registered medical practitioners. The legislation is therefore a 'titles' or 'certification' Act.

Registration requirements

There are two categories of registration under the current Act. For a person to be entitled to general registration he or she must:

(i) possess recognised medical qualifications and have successfully completed a period of internship or supervised training as required by the Medical Boards or be entitled to registration under mutual recognition;
(ii) be competent to practise medicine (ie adequate medical skills and command of the English language and sufficient physical and mental capacity to practise medicine); and
(iii) be of good character.

In circumstances where an applicant does not meet eligibility criteria for general registration he or she may apply for conditional registration at the discretion of the Medical Board. For the Medical Board to confer discretionary registration it must be satisfied that:

(i) registration is appropriate having regard to the categories of discretionary registration set out in the Medical Practice Act;
(ii) the applicant is competent to practise medicine (ie sufficient physical and mental capacity to practise medicine, adequate medical and English language skills); and
(iii) the applicant is of good character.

In addition, the Board can refuse to register a person otherwise entitled to be registered where:

(i) the person has been convicted of a criminal offence which in the opinion of the Board renders the person unfit in the public interest to practise medicine; or
(ii) the person's name has been removed from a register or roll in another jurisdiction, providing for the registration of medical practitioners, for misconduct or any basis relating to the person's physical or mental capacity to practise medicine.

Regulation of the Conduct of Medical Practitioners

The Act ensures that medical practitioners adopt appropriate standards of professional conduct. The primary means through which this is done is the complaints system. A complaint may be made to the Board (or the Health Care Complaints Commission) that a medical practitioner:

(i) has been convicted of an offence;
(ii) has been guilty of unsatisfactory professional conduct or professional misconduct;
(iii) is not competent to practise medicine;
(iv) suffers from an impairment; or
(v) is not of good character

The current Act contains a two tier disciplinary structure. Section 36 sets out the definition of "unsatisfactory professional conduct" and is attached at **Appendix C**. "Professional misconduct" is defined as unsatisfactory professional conduct of a sufficiently serious nature to justify suspension or deregistration of the practitioner.

While breaches of specific offence provisions of the Act can be pursued through criminal action in the Local Court, the definition of "unsatisfactory professional conduct" is such that breaches of the Medical Practice Act and regulations can be pursued through the Act's

disciplinary system. The Act currently contains a number of offence provisions (eg failure to appoint a person responsible for advertising by a corporation, the making of false entries in the register)

A complaint can be made to the Medical Board under the Medical Practice Act 1992 or to the Health Care Complaints Commission (the "HCCC") in accordance with the provisions of the Health Care Complaints Act 1993. Under the two Acts processes are in place to ensure that complaints are handled in a co-ordinated manner.

In the first instance, complaints made to one body are referred to the other. Action on a complaint is then determined through consultation between the Board and the HCCC. Matters can be referred to the Health Conciliation Registry for conciliation, referred to the HCCC for investigation or dismissed.

Following an investigation, the HCCC can make a recommendation that disciplinary action be taken. More serious complaints which may if substantiated provide grounds for suspension or deregistration must be referred to the Medical Tribunal. Less serious matters are referred to a professional standards committee (PSC). The PSC or the Medical Tribunal can inform itself of any matter as it sees fit, summons witnesses, take evidence and obtain documents. Neither body is bound by the rules of evidence. Legal representation is only permitted before the Medical Tribunal.

A wide range of penalties can be imposed by a PSC if it is satisfied a complaint is proved after a hearing. These penalties include a caution, medical or psychiatric treatment or counselling, the imposition of conditions on registration, continuing education and a fine of up to $5,500. The Medical Tribunal may impose any of these penalties and in addition impose a fine of up to $27,500 and deregister the practitioner concerned.

A diagram outlining the current complaints process is included at **Appendix D**.

2.3 Other Legislation

It is important to note the broader regulatory environment in which medical services are provided.

- The Health Insurance Act 1973 provides for the national Medicare Scheme under which only practitioners who have a Medicare Billing number are able to bill or receive a refund from Medicare for professional services they have rendered.

- Under State Poisons and Therapeutic Goods legislation the prescription of certain types of drugs for diagnostic or therapeutic use in humans is limited to registered medical practitioners and dentists.

- Consumer protection laws (ie the Commonwealth Trade Practices Act 1974 which is administered by the Australian Competition and Consumer Commission and the NSW Fair Trading Act 1987 which is administered by the NSW Department of Fair Trading) prohibit medical practitioners from making false and misleading representations in the course of providing a service, for example, falsely claiming to hold qualifications or membership of professional associations.

- The Health Care Complaints Commission has the power to investigate complaints about a person who provides a health service.

- The Public Health Regulation 1991 provides that no person with the exception of medical practitioners and dentists may carry out any procedures which penetrate the skin unless certain requirements the object of which is to avoid infection are met

- In the case of a dispute between a health professional and a consumer, either party could seek to resolve their differences through the civil court system, although it is recognised that this is generally an expensive process and is unsuitable for minor complaints. As an alternative such matters can also be heard before a Consumer Claims Tribunal which has the objective of providing a simple low cost mechanism for dispute resolution. Complaints about fees may also be pursued before the Consumer Claims Tribunal.

2.4 The Role of Professional Associations

In addition to the registration board, professional associations play a role in monitoring standards among medical practitioners. There is a significant number of Colleges in respect of specific areas of medical practice which play an active role in this area. In addition to requiring that applicants for membership meet certain entry criteria, Colleges are involved to varying degrees in continuing education, re-certification and a number of other initiatives which are performance related.

In addition, groups like the Australian Medical Association also play a role in this area. The AMA which represents approximately forty per cent of practitioners has issued a Code of Ethics which deals with the broader issue of professionalism.

It is important to note however that not all practitioners are members of professional associations.

2.5 Other Service Providers

There are a number of health professionals or para-professionals that provide some of the services that are ordinarily provided by medical practitioners as noted above. This includes but is not limited to paramedics, pharmacists, nurses, physiotherapists, optometrists, dentists and psychologists.

With the exception of paramedics, all of the other health professions listed above have statutory registration board. All persons providing health services, whether registered or not, are subject to the Health Care Complaints Act 1993 and the other consumer protection legislation outlined above.

2.6 The Regulation of Medical Practice in Other Jurisdictions

Medical practitioners are registered in all Australian States and Territories. While all jurisdictions provide for the establishment of a registration board and academic requirements for registration are broadly similar, different arrangements apply for the disciplining of members and the handling of complaints. While NSW restricts the use of the title of "medical

practitioner", some jurisdictions prohibit specific practices from being carried out by persons other than a registered medical practitioner. A summary of the main features of legislation regulating medical practice in other jurisdictions is provided at **Appendix E**.

2.7 Impact of the Legislation on Competition

Legislative controls imposed by Government often have positive outcomes for the community where they effectively address problems that arise from the provision of services in an unregulated environment. These problems are sometimes known as 'market failures'. An example of such a problem is where there is an imbalance of information between service providers and consumers, limiting the ability of the latter to make informed choices when seeking service providers. However, regulation may also restrict competition among service providers. This may result in new problems or costs for business, consumers and government which are not justified having regard to the nature of the problem which the intervention was seeking to address. Alternatively, regulation may not be effective in addressing the identified problems at all.

The principal requirements of the Act which may have an impact on competition can be summarised as follows.

- The restriction on the use of the title "medical practitioner" by unregistered persons may confer a competitive advantage on medical practitioners over other service providers, although this could be outweighed by the benefits to consumers of being able to identify competent and ethical service providers.

- The requirements for registration may restrict competition where the number of persons that may gain registration (and hence the right to use the title "medical practitioner") is limited beyond that which is necessary to ensure that the objectives of the Act can be achieved. Unjustified limitations on the number of practitioners, whether effected by requirements for academic qualifications and supervised practice or the imposition of specific requirements such as character, may result in a lessening of competition. Similarly, the power to impose conditions on registration can, in certain cases, limit competition.

- The complaints and disciplinary system or statutory restrictions on conduct, although generally directed at ensuring high standards are adopted by practitioners, may inappropriately focus on the commercial conduct of medical practitioners thus limiting information to consumers on the different services available.

- The Act contains a number of restrictions on the conduct of persons other than medical practitioners:

  (i) fees cannot be recovered for medical or surgical services provided by unregistered persons;
  (ii) unregistered persons are prohibited from advertising cures for certain diseases; and
  (iii) unregistered persons are not to give or offer cancer treatments.

One of the principles guiding this review in assessing the restrictions outlined above is whether the costs arising from the restrictions are outweighed by the benefits, and that the

objective of the legislation, as canvassed in Chapter 3, can only be met by restricting competition. A range of new regulatory requirements were canvassed in the Issues Paper and these are also assessed to ensure that they accord with the review principle.

3. THE OBJECTIVES OF LEGISLATION REGULATING MEDICAL PRACTICE

3.1 Objectives of the Current Act

The Medical Practice Act does not contain a clear statement of its objectives. Notwithstanding this, the preamble to the Act and the functions of the NSW Medical are quite informative.

The preamble to the Medical Practice Act states:

> *"An Act to provide for the registration of medical practitioners and medical students and the making of complaints and the taking of disciplinary action against medical practitioners: to repeal the Medical Practitioner's Act 1938; to amend certain Acts; and for other purposes."*

The functions of the Medical Board are set out in section 132.

> *"132(1) The Board has and may exercise the functions conferred or imposed on it by or under this or any other Act.*
> *(2) In addition, the Board has the following functions:*
> *(a) to promote and maintain high standards of medical practice in New South Wales ;*
> *(b) to advise the Minister on matters relating to the registration of medical practitioners, of medical practice and any other matter arising under or related to the Act or regulations;*
> *(c) to publish and distribute information concerning this Act and the regulations to registered medical practitioners and other interested persons;*
> *(d) to provide counselling services for registered medical practitioners and medical students."*

3.2 Original Rationale for the Objectives of the Act

The problem that the legislation seeks to address is the potential risk of harm from unqualified, unscrupulous or sub-standard operators in the market for medical services. In other words, the primary objective of the legislation at the time it was introduced was to minimise risks to the public. The Act recognises consumers need assistance to identify registered practitioners because they may lack the specialised knowledge and ability to make such a judgement themselves.

3.3 Submissions

Submissions overwhelmingly supported the view that the objectives of the legislation are protection of the public through the provision of information to patients. Professionals, their associations and consumers shared this view.

> *"The objective of the Medical Practice Act is primarily to protect the public by ensuring that all applicants for registration as medical practitioners are adequately educated and trained, and that the highest standards of conduct and practice are maintained through the disciplinary, impairment and performance powers of the NSW Medical Board."*[2]

> *"The Medical Practice Act should continue to protect the public."*[3]

A number of submissions were particularly supportive of the Health Care Complaints Commission proposal which was canvassed in the Issues Paper. That is, any objects clause should include:

> "*promotion and maintenance of professional standards of medical practice in New South Wales to facilitate public confidence in the profession and protect the community from unethical and incompetent practitioners*".

3.4 Conclusions

Submissions support the view that the objective of the Act is the minimisation of the risks of harm to those using or seeking to use the services of a medical practitioner. It is argued that the rationale underpinning this objective is that in the absence of government intervention, consumers will have difficulty identifying competent and ethical service providers. In short there is an imbalance of information which exposes consumers to harm.

What are the risks of harm to consumers?

A range of potential risks to consumers have been identified. The 'harm' that is sought to be addressed is not limited to acts of registered or unregistered persons that injure a patient, such as incompetent care, but includes the injury that may result if a patient is unable to obtain the services they need, or is discouraged from seeking those services. These can be summarised as follows:

- Consumers (most of whom lack specialised knowledge) have a limited ability to assess the need for medical services or the type of service required. There are a number of different service providers in the market for medical services not all of whom have the same training and skills or can offer the same service.

- The inability of consumers to identify competent service providers may result in a failure to detect chronic or severe illness. If an incompetent practitioner is consulted in the first instance, appropriate treatment may be delayed or inappropriate treatment administered. Consumers may be discouraged from seeking services. Unmanaged or untreated illness can result in reduced health, well-being and in some cases death.

The complaints history of the profession suggests that there are risks of harm to patients from those qualified to practise as medical practitioners.[4] In 1996/97 55 per cent of complaints received by the Medical Board concerned clinical competence.

Do general consumer protection laws and membership of a professional association provide assistance to consumers?

The prohibition on misleading and deceptive conduct contained in the *Trade Practices Act 1974 (Cth)* and the *Fair Trading Act (NSW)* does not provide sufficient protection to patients. While a consumer could clearly seek redress where a practitioner falsely claimed to hold qualifications, the provisions are unlikely to be effective in situations where qualifications are held but are not of sufficient standard for the services the consumer is seeking.

While the *Health Care Complaints Act 1993* enables consumers to make a complaint about any health service provider, registered or not, specific disciplinary action can only be taken

where the person is registered. Although complaints could be referred to a professional association for action, this may be inadequate as not all registered medical practitioners are members of a professional association. Further, a professional association may be unwilling to deal with a complaint and even where a complaint is properly dealt with it may lack appropriate sanctions.

The Department is of the view that there is a continuing rationale for intervention to minimise the risks of serious harm or injury to patients. However, the precise form of intervention, that is, registration by title or alternative means, is considered in the next chapter. To ensure that the welfare of patients is the paramount consideration in administering the legislation, it is proposed that the Act be amended to include a specific statement of its objectives. This should be complemented by a full description of the Medical Board's functions in the Medical Practice Act.

Recommendation 1

That the Medical Practice Act be amended to provide that its objective is to protect the health and safety of members of the public by providing mechanisms to ensure that medical practitioners are fit to practise.

4. THE REGISTRATION OF MEDICAL PRACTITIONERS AND COMPETITION

4.1 Introduction

The primary form of intervention by which the Medical Practice Act 1992 seeks to achieve the objectives outlined in the previous chapter is through the establishment of the registration system and the placement of restrictions on who may use the title 'medical practitioner'. The restriction aims to achieve the objectives of the legislation by providing consumers with a simple and understandable means of identifying practitioners capable of providing the full range of medical services. As consumers can identify such practitioners, risks of injury will be reduced along with costs to consumers of seeking qualified practitioners.

Although the Issues Paper noted that the prohibition on the use of the title "medical practitioner" by unregistered persons could have benefits for consumers, it was also noted that this may have disadvantages or costs, primarily through its impact on competition. A restriction on title may confer a competitive advantage on registered medical practitioners because it indicates that medical practitioners are able to provide a superior service. This may result in unnecessary costs for consumers. Further, by restricting the number of practitioners who may be registered, competition among medical practitioners may be affected. If prices rise substantially, then consumers could be discouraged from using the services of medical practitioners.

This chapter will focus on the impact of the restriction on the use of the title "medical practitioner", (the principal feature of the Act), and whether this form of intervention is necessary to achieve the objectives of the Act. Alternatives to these requirements are considered to determine whether they can achieve the objectives of the legislation, with less cost or adverse impacts on competition.

Before turning to discuss these alternatives it is important to reiterate that the Medical Practice Act is not the only legislation which regulates the delivery of medical services. The Health Insurance Act, Poisons and Therapeutic Goods legislation, the Trade Practices Act, the Fair Trading Act and the Health Care Complaints Act are also relevant in this regard .[5]

4.2 Submissions

Submissions were sought in regard to the effectiveness of the current Act, the costs and benefits of the current system and whether the objectives of the legislation could be achieved by other means. The overwhelming majority of submissions supported the continuation of restrictions on the use of the title.

> *"The model provides an objective and non-discriminatory means of regulation of the profession, the cost of which is borne entirely by the profession."*[6]

> *"The medical profession has maintained the confidence of the public through maintaining its high standards and by being a regulated profession underpinned by a statutory framework which sets high entry standards, introduced restrictions such as those included in ss 108-109 of the Act and which has a transparent and effective disciplinary system for those practitioners who have failed to maintain appropriate standards."*[7]

4.3 Options for Government intervention to achieve the objectives

In view of the submissions received concerning the current Act and the impact on competition, the Department has given further consideration to the issue of whether the current arrangements produce the greatest overall benefit for the community, and are the most effective means for achieving the objectives of the Act. Alternatives that limit the impact on competition have been identified.

Option 1 - Title restriction and registration of medical practitioners

For the purposes of this analysis, the current system outlined in paragraph 2.2 is Option 1.

Option 2 - Co-regulation

Rather than providing for the registration of medical practitioners by title, an alternative approach could be to provide information directly to consumers of medical services to assist them in identifying competent and ethical service providers. The professional associations would administer the disciplinary system to ensure the maintenance of professional standards. The Government would assume an accreditation role which would include the Government publishing a list of accredited associations and promoting the benefits of dealing with a practitioner who is a member of one of those associations. A practitioner who is not a member of an accredited association would not be prevented from practising or from using the title "medical practitioner".

Option 3 - Voluntary Certification by a Government Authority or Statutory Body

This is essentially the same as Option 2 but instead individual practitioners are certified by a Government authority or statutory body such as a board. Certification would involve the authority or body making an independent assessment as to whether a practitioner has sufficient skills or competencies to practise as a medical practitioner. Although certification by the board is voluntary, certified practitioners may hold themselves out as such while those falsely claiming to be certified could be dealt with by general restrictions under the Trade Practices and Fair Trading Acts on misleading and deceptive conduct. There would be no restrictions on who may practise as a medical practitioner or use this title.

Option 4 - Title and Core Practice Restriction

This option would involve restrictions on who may use a particular title and certain "core practices" which have been identified as carrying significant risks if performed by unqualified persons. Not all techniques used by the profession would be restricted. Non-registered persons would be precluded from using the title but be able to compete with registered practitioners by providing services which are not harmful but fall within the scope of the practise of the registered profession.

Option 5 - Title and Complete Practice Restrictions

This is the most restrictive form of professional regulation. It is similar to Option 4 however, the entire scope of a profession's practice would be limited to a particular professional group.

4.4 Assessment of options for government intervention

In assessing the five options, ***option one*** has been used as a benchmark against which other options are compared. However, it should be noted that it is not possible to quantify the benefits or costs of any of the options, including the current system due to a lack of comparative data.

The Department is of the view that substantial benefits will arise where risks are averted. As a consequence, in carrying out a comparative assessment of the options, it is likely that the option which has the highest overall benefits or advantages for the community will be the one which most effectively and simply provides information to consumers to assist them in using the service of a qualified practitioner. The effectiveness of the system in providing this information can then be compared to the costs of the system, in particular the anticipated impact on competition.

Option 1 - Title restriction and registration of medical practitioners

The ***disadvantages*** or costs of the current system have been identified as follows

- *The costs of administering the legislation*

The administrative costs of the Board of approximately $3 million (1997 figures) are recovered through registration fees. A substantial proportion of the costs of administering the Health Care Complaints Commission also need to be considered, although they cannot be calculated with precision as the Commission has jurisdiction to investigate providers of health services whether registered or not. In 1996/97 over three-quarters of complaints received by the Commission against professions concerned medical practitioners. The Commission's overall budget for that year was approximately $4.5 million.

- *Disadvantages or costs of restricting competition resulting in higher prices for consumers*

It can be argued that even where entry criteria are reasonable, registration of itself enables registered practitioners to attach a premium to their services resulting in higher prices for consumers. The presence of such a premium for any profession, including medical practice, would imply the presence of an additional cost to society from registration. If such a 'premium' for medical practitioners were to arise this may discourage consumers from seeking services from a registered professional.

Isolating a premium for any profession is complicated. Even if a price premium were observed, it is not clear that this can be directly attributed to registration, even where registration has served to elevate the pubic perception of the standard of services on offer.

- *The costs associated with qualifications and experience*

There are costs associated with the qualifications and work experience which individuals must obtain for the purposes of registration.

The ***advantages*** or benefits of the current Act that have been identified are as follows:

- most consumers who wish to access medical services are not easily able to judge the skill and competence of a medical practitioner before receiving treatment and a

restriction on title is a means of providing a signal that a registered person meets at least a minimum level of competence;[8]

- character, qualifications and training requirements necessary for registration result in more fit to practise practitioners;
- reduced risk of harm to patients, their families and the community;
- greater use of appropriate health service providers by patients reducing the social costs of illness to both the community and the health system;
- monitoring of standards among the profession resulting in reduced injury;
- reduced transaction costs for patients in identifying registered medical practitioners and settling disputes with professionals.

As noted above, these benefits could arise for the other options under consideration if they are effective in achieving the objectives of the Act. However, submissions attached a high degree of value to the title restriction, arguing it provides a simple and cost effective means of identifying practitioners, thus reducing risks of harm.

Option 2 - Co - regulation

Removal of registration of the profession would eliminate any impact on competition. However, this would reduce the amount of information available to consumers and increase the risk of harm and costs to consumers. Option 2 provides an alternative means of addressing the imbalance of information.

The provision of information regarding qualifications could assist consumers in identifying practitioners with minimal competence to provide services. However, such a system would have ***disadvantages*** or costs, as outlined below:

- This system does not adequately address the risk of harm (or death) which is associated with the provision of medical services as there would be no restrictions on who may use the title "medical practitioner".

- Consumers may place unwarranted weight on the fact that a practitioner is a member of an accredited association. Accreditation may be of limited value for the purposes of assessing quality as government may not always be in the best position to adequately oversee the day to day operation of professional associations.[9]

- A disciplinary system administered by professional associations may lack transparency, and the power to impose effective sanctions.

- While there would be no cost associated with a registration board, costs would be incurred through the assessment of qualifications and the provision of information to consumers. If an active advertising campaign is undertaken to promote the system or provide information to consumers, it is likely that those costs would exceed substantially the administrative costs incurred under the current system.

- In the absence of an active advertising campaign, consumers would incur costs in contacting the information service to determine whether practitioners hold entry qualifications.

On balance, the risk of harm to patients and other transaction costs together with

administrative costs for Government would be higher under such a system.

Realisation of the ***benefits*** of this system are highly dependent on the ability of the Government to provide information that can be easily understood by consumers. Consumers would also need to take an active role in seeking out such information to make it effective, otherwise substantial advertising and promotion costs would be incurred by Government. More importantly, such a system fails to acknowledge the risks to patients from 'qualified' practitioners that fail to maintain their skills overtime or engage in inappropriate conduct. The complaints history of the profession itself suggests a need for ongoing monitoring. While advice could be provided recommending consumers deal with members of certain professional associations, such an arrangement would have higher costs for government as such associations would need to be audited. Practitioners would also incur the costs of joining the recommended associations. Further, many associations have higher entry requirements than those under the current system thus increasing training costs and the level of restrictions on competition.

The Health Care Complaints Commission could continue to receive complaints about practitioners under this option, its role being to investigate the complaints or refer them for conciliation or to a professional associations for action.

On balance, therefore, the Department concludes that this option is unlikely to deliver substantial benefits to the community as occurs under option one. It is considered that this option would not meet the objective of the current legislation which is to minimise the potential risk of harm posed by unscrupulous, unqualified or substandard operators in the market for medical services.

Option 3 - Voluntary certification by a government authority or statutory body

This system would be broadly similar to the current system except there would be no restriction on title. The following points should be noted.

- This system does not adequately address the risk of harm (or death) which is associated with the provision of medical services as there would be no restrictions on who may use the title "medical practitioner".

- Administrative costs would be marginally lower than under the current system because it would not be necessary to monitor a restriction on title.

- The potential exists for confusion among consumers. Consumers, may not understand the difference between certified and uncertified practitioners and as a result not be able to make informed decisions. To address this problem, an information campaign would be required to promote the benefits of dealing with an 'accredited medical practitioner' as opposed to a non-accredited provider. Given that those requiring medical services are likely to be in distress, it is questionable whether such a distinction, whether promoted or not would have any benefit.

The Department is of the view that such a system would have an impact on competition comparable to option 1. However, it would not be effective in meeting the objectives of the current legislation.

Option 4 -Title and core practice restrictions

This system is more restrictive that the current one as it would involve restrictions on who may provide certain services. Before turning to the advantages and disadvantages of this model it is important to note the broader regulatory context in which medical practitioners operate. In particular, medical practitioners are conferred entitlements under the Health Insurance Act under which they can bill Medicare for professional services rendered and the Poisons and Therapeutic Goods legislation where the prescription of certain drugs for diagnostic or therapeutic use in humans is limited to registered medical practitioners and dentists. These measures alone limit the ability of unregistered practitioners to compete with medical practitioners in relation to a range of medical services.

The ***advantages*** of a system in which the Medical Practice Act would be amended to prohibit unregistered persons from providing certain services would be as follows.

- Consumers and referring practitioners who require services which carry a significant risk of injury would be able to make informed decisions about treatment needs.

- Non-registered practitioners would be able to compete with registered practitioners by providing services that do not carry significant risks but which nevertheless fall within the scope of the regulated profession.

The ***disadvantages*** or costs of such a system would be as follows.

- It provides a monopoly for the registered group in the practice of certain procedures. The experience with practice restrictions has been that greater activity has surrounded other registered groups entering into the restricted practice area than lay persons undertaking restricted practices. Practice restrictions are of limited effect in that they do not apply to instances of members of the registered group who practice beyond their level of competence.

- The task of drafting workable definitions of prescribed practices which only registered medical practitioners may provide that do not unnecessarily overlap with the legitimate scope of practice of other professions is difficult. The enforcement of such restrictions which involves satisfying a court that a particular activity which is proscribed has occurred, can be onerous.

- Practice restrictions can have an adverse impact on competition by hindering innovation and improved techniques both within the registered group and by other professional groups with closely related areas of practice. This may result in increased costs because of a perception that they are able to provide a superior service when providing services that fall outside the scope of the practise restriction.

- The costs associated with this option are comparable to the current system.

This option is unlikely to address the objectives of the legislation more than the current system but would lessen competition.

Option 5 - Title and complete practice

This is the most restrictive form of regulation. This option fails to recognise that there is some overlap between the legitimate scope of practice of most professions. The immediate impact of such a system would be to confer a monopoly over an entire professional area and substantially reduce competition.

The disadvantages of this option would be similar to those outlined in option 4 but be exacerbated.

Recommendation 2

That medical practitioners continue to be registered by title.

5. ENTRY REQUIREMENTS

5.1 Introduction

The Act contains a number of criteria for registration. The requirements for general registration and conditional registration at the discretion of the Medical Board are not uniform. (See 2.2.) The Board may also refuse registration on a number of grounds. Although failure to gain registration does not prevent a person from practising or providing services, it does prevent him or her from holding him of herself out to be a medical practitioner. If entry level requirements are set artificially high, this may restrict the number of people able to seek registration as a medical practitioner, with a resultant impact on competition. Alternatively, although the barriers may not be high or onerous, there may be limited access to appropriate educational courses and supervision opportunities creating a barrier to entry for intending practitioners.

The Department has assessed the current criteria in accordance with the Competition Principles Agreement.

5.2 General registration - qualifications and training

A national approach has been taken to qualifications for the purposes of entitlement to general registration; that is a person has recognised medical qualifications if he or she:

- is a graduate of a medical school accredited by the Australian Medical Council; or
- has successfully completed examinations held by the Australian Medical Council for the purpose of registration as a medical practitioner.

The standard of Australian Medical Council examinations is pitched at that of local graduates. To be eligible for general registration applicants who have "recognised medical qualifications" must undergo a period of supervised practice to ensure that minimum standards of safety, clinical skill and professional confidence is achieved. The Postgraduate Medical Council is responsible for running the program of supervised practice.

The Issues Paper sought comments on whether other accreditation procedures should be recognised as entitling a person to be registered as a medical practitioner.

The following points were made in submissions.

- When evaluating accreditation procedures competence must be a priority issue.[10]
- There needs to be minimum standards to ensure that the public is protected in an area where the potential for unskilled practitioners to cause harm is great.
- Equivalent minimum standards for entry are applicable to both local and overseas trained doctors.
- The Medical Board in its submission argued that:

  (i) it would not be discharging its statutory duty if it were to contemplate the introduction of any system of accreditation where there is no application of an

objective mechanism that is known and understood in the Australian context, and which recognises and takes into consideration the medical practice issues that are relevant in Australia; and

(ii) other recognition methodologies would not give the Board the same degree of confidence in meeting its objectives to protect the public of NSW as currently applies through the Medical Practice Act.[11]

- Some submissions have expressed concerns about Australian Medical Council examination rules and a lack of access to bridging courses or clinical exposure.

- The Health Care Complaints Commission has advocated the introduction of a national examination to be conducted by the Australian Medical Council after the period of internship/supervised training to determine entry to the profession. The "introduction of a national examination would ensure that all candidates could meet the standards expected of a medical practitioner in New South Wales and that their education and training had covered the minimum requirements of domestic medical practice."[12] It should be noted that no State or Territory has introduced such an examination. As the effectiveness of the proposed examination would be diminished by mutual recognition, in order for this proposal to be progressed it would need to be considered at a national level.

The Issues Paper sought comments on whether alternative accreditation procedures should be recognised as entitling a person to registration as a medical practitioner. Whilst several submissions put forward specific proposals concerning the structure of the Australian Medical Council examination process (eg introduction of bridging courses for overseas trained doctors) and the system for conditional registration at the discretion of the Board (which are discussed below), no submissions have put forward alternative mechanisms to recognise qualifications that should give rise to an entitlement to registration.

On the evidence presented the Department considers that the current qualifications and training criteria for an entitlement to general registration are adequate.

5.3 Conditional registration at the discretion of the Board

If a person does not have "recognised medical qualifications" and is therefore not eligible for general registration, the Medical Board may at its discretion register the person and impose such conditions as it sees fit, that is, the Medical Board cannot be compelled to register a person in a particular case. The Medical Practice Act contains seven categories of discretionary registration which the Medical Board may rely upon. All State and Territory medical boards have similar discretionary powers.

The Issues Paper sought comments on the current system for granting discretionary registration and whether it should be changed.

Most submissions were supportive of the current system.

- *"The Board believes that the current range of discretionary categories is adequate. The Board believes that it is vital that registration should only be conferred on graduates of accredited medical schools or those who have successfully completed the Australian Medical Council examinations. In this way an objective minimum*

standard is set which minimises the possibility for anomalies or inequitable treatment."[13]

- The Health Care Complaints Commission is supportive of the current system while noting that the guiding principle for the exercise of the discretion should be safety and protection of the public.[14]

Submissions critical of the system for conferring conditional registration at the discretion of the Board have focused on its impact on permanent residents who have received their medical training overseas.

Whilst the Ethnic Affairs Commission made it's own submission to the review of the Medical Practice Act, it appears to have been drawn predominantly from proposals put forward by the Committee which reviewed practices for the employment of medical practitioners in the NSW Health System. The Committee has put forward a number of proposals for reform on the ground that the current arrangements allow the Medical Board and the specialist Colleges to engage in anti-competitive and possibly racially discriminatory practices. It proposes that:

> *"[T]he Medical Practice Act should be amended to preclude the Medical Board from taking into account any matters other than medical standards, competency and professional conduct in the registration of individual medical practitioners and the setting of medical standards."*

The Department notes that this recommendation would effectively narrow the criteria for registration. The current criteria for registration relate to competence to practise, physical and mental capacity, English language skills and good character. The Board may also refuse to register a person who has been convicted of an offence where the Board is of the view that the person has been rendered unfit in the public interest to practise medicine. The current registration criteria are considered in the remainder of this Chapter.

The Committee has also put forward a number of other proposals which directly concern the system for conditional registration at the discretion of the Board as follows:

> *"Subsection 7(1)E of the Medical Practice Act should be amended to require the NSW Medical Board to provide conditional registration to overseas trained specialists for the purpose of their competence being assessed by the Australian Medical Council or any other prescribed body."*
>
> *"[T]hat legislative changes be made to allow individual medical practitioners refused registration, other than on the grounds of medical standards, competency and professional conduct, the right of appeal in the judicial system."*
>
> *"That s.7(1)F of the NSW Medical Practice Act [should] be amended to require the NSW Medical Board to provide conditional registration to overseas- trained specialists for preparation for examinations and any further training for the period prescribed by specialist colleges as necessary for recognition of the applicants' overseas qualifications."*

The first and third of these proposals would significantly alter the current arrangements for conditional registration at the discretion of the Board:

- the Medical Board would be compelled to conditionally register overseas trained specialists to enable them to obtain training/experience for the purpose of meeting the requirements of a College, the Australian Medical Council or a prescribed body. This would diminish the capacity of the Board to determine each application on its merits and in the public interest;

- the role of Colleges in assessing the competence of applicants would be considerably diminished as this function would in some instances be carried out by the Australian Medical Council and "prescribed bodies". The Australian Medical Council currently does not play any role in this area and its current practice is to refer applicants with specialist qualifications/experience to specific Colleges; and

- as all jurisdictions have similar powers in relation to discretionary registration in view of mutual recognition, the proposals which represent a fundamental shift from present practice should be considered at a national level.

The Department would have concerns with any proposals which would involve the existing categories of discretionary registration being replaced with an entitlement to registration which did not adequately take into account issues such as competence as they would not provide sufficient protection to the public.

In respect of the second proposal put forward by the Committee, the Department notes section 17 of the Medical Practice Act whereby a person may appeal to the Medical Tribunal against any determination where the Medical Board has refused an application for registration or imposed a conditional registration. It is understood that the usual practice of the Medical Board is to provide persons who have been refused conditional registration at the discretion of the Board reasons for that refusal. The Medical Board is under a duty to afford all applicants for registration procedural fairness. This duty would seem to require the Board to provide applicants with reasons for any refusal to register and information on the availability of appeal rights.

The Department proposes that as part of consultation on this Report's recommendations the Department will confer with interested groups on the specific proposals for legislative reform that have been put forward by the Committee. Other Committee recommendations are discussed in 13.1, 13.2, 13.4 and 13.6 of this Report.

5.4 Competent to practise

The current Act prevents the Medical Board from registering a person as a medical practitioner unless it is satisfied that the person is competent to practise, that is, the applicant must have sufficient physical capacity and mental capacity and skill to practise medicine; and communications skills for the practice of medicine including an adequate command of the English language.

The only qualification to this general rule is that the Medical Board may in the case of an applicant for conditional registration at the discretion of the Board accept a lesser standard of

English. These criteria are directed toward ensuring that patients have appropriate information as to whether a practitioner is an appropriate person to be practising medicine in New South Wales.

Some submissions have suggested that the competence of practitioners should be assessed on a regular basis. This issue is canvassed in Chapter 7.

5.4.1 Physical and mental capacity and medical skills

As a matter of practice, the Medical Board relies heavily on the possession of suitable qualifications, the satisfactory completion of a period of supervised practice for general registration and its own guidelines in the case of conditional registration at the discretion of the Board. There are significant benefits to including a power to refuse registration in overriding circumstance where information comes to the Board's attention which demonstrates that the applicant does not have sufficient physical or mental capacity and medical skills to practise medicine. This power facilitates improved information being made available to patients on the competence of registrants.

> "*The Board is of the view that the requirement that all registrants have sufficient medical skills and physical and mental capacity is not open to debate.*"[15]

5.4.2 English language

The Medical Practice Act currently provides that applicants for general registration must have an adequate command of the English language to practise medicine.

Most submissions argued for such a requirement. The risk of patient harm associated with inadequate English language skills can be great and is particularly acute where a medical practitioner is called upon to provide medical services in an emergency situation or works as part of a team. Even practitioners who work in isolation need sufficient English skills to communicate effectively with other service providers who are instrumental in the delivery of care to the patients.(eg pharmacists) Effective English language skills are essential if practitioners are to keep abreast of professional and legal requirements. Further, inadequate English language skills may preclude access to continuing professional development opportunities.

- "*While the Board recognises the multi cultural diversity of the Australian public, and the value to members of the public where a practitioner is available who speaks their own language, it does not accept that registration should be considered for practitioners who do not have an adequate command of English...Misunderstanding or failure to communicate in an emergency can have fatal consequences.*"[16]

- "*Communication is essential in good medicine. Mistakes are often made because of poor comprehension and language skills. It is essential that practitioners have a good command of English, particularly as many interactions occur on behalf of the patient with other practitioners... Practitioners should use interpreters for patients contact as necessary, but practitioners must themselves be fluent in written and spoken English.*"[17]

In the case of applicants for conditional registration at the discretion of the Board the current

Act provides more flexibility in relation to the level of English language that is required. The practice of the Medical Board has been to accept a lesser standard of English only in circumstances where patient care is not involved.(eg medical research)

On the basis of the submissions provided the Department does not support any amendments being made to:

- the prohibition on applicants being registered who do not have sufficient physical capacity, mental capacity and medical skills; or
- the discretion which the Medical Board has to accept a lesser standard of English in the case of applicants for conditional registration at the discretion of the Board.

5.5 Good Character

The current Act prohibits the Medical Board from registering a person unless it is satisfied that the applicant is of good character. The Issues Paper raised for consideration whether the requirement should be retained and, if so, whether more "objective" criteria should be developed.

The proposition that character requirements can unnecessarily restrict entry to the profession must be balanced against the important role which good character plays in minimising the risk of harm posed by inappropriate or unethical conduct through ensuring that disreputable people are precluded from registering as medical practitioners.

Submissions to the review overwhelmingly supported the need for a requirement for good character on the basis it is essential for minimising the risks of harm from inappropriate or unethical conduct.

> "*Public trust and confidence in the integrity, honesty and ability of the medical practitioner lies at the heart of medical practice .... It is felt that attempting to set more objective criteria will possibly serve to narrow the scope of the term and limit the Board's ability to apply it appropriately.*"[18]

> "*This criterion is essential to safeguard patients against harm from unscrupulous or exploitative practitioners. It is important that only fit and proper persons are registered ad good character is a major determinative factor which goes beyond conduct that only relates to the practice of medicine.*"[19]

The Department does not support the narrowing of the "good character" requirement on the ground that courts may be inclined to interpret it narrowly and that such an outcome would not be in the public interest.

The Department strongly supports the retention of the "good character" requirement as an essential part of satisfying the legislative objective of public protection and confidence in the profession.

5.6 Criminal convictions

The Medical Board currently has the power to refuse to register a person where he or she has

been convicted of an offence **and** the Board is of the view that the person has been rendered unfit in the public interest to practise medicine. Therefore, the Board cannot refuse registration unless it is satisfied that the conviction renders the person unfit in the public interest to practise medicine. The Board is obliged to have regard to the nature of the offence and the circumstances in which it was committed. Criminal convictions may be relevant to whether an applicant is of good character or impaired. Clearly, the Medical Board when determining whether a conviction renders a person unfit in the public interest must act in a manner which is fair, consistent, unbiased and not base its decisions on irrelevant considerations. A person who is aggrieved by a decision of the Board has a right of appeal to the Medical Tribunal.

The Issues Paper sought comments on the range of "criminal convictions" the Medical Board should be able to consider for the purposes of assessing whether the person should be refused registration.

(i) **Should the Medical Board be able to consider both recorded and unrecorded convictions? (ie where an order has been made under section 556A of the Crimes Act or equivalent provision)**

Under section 556A of the Crimes Act a court may find a charge proved but not record a conviction. In reaching such a decision the court is to have regard to a range of factors including "the character, antecedents, age, health or mental condition of the person charged, or to the trivial nature of the offence or to the extenuating circumstances under which the offence was committed".

Submissions to the Issues Paper have been divided on this question.

Submissions against the Medical Board having the power to consider unrecorded convictions have raised the following points.

- "*Orders made under section 556A often reflect the trivial nature of the offence or the extenuating circumstances under which the offence was committed. It would be unduly harsh to require a doctor to notify under section 556A and it certainly could not be seen as protecting the public's interest in any meaningful way.*"[20]

- "*The section was intended to allow courts discretion in circumstances where the judge did not feel that the conviction should affect the person's professional life, and the Medical Board should not have the power to second guess the judge.*"[21]

Submissions in favour of the Medical Board being able to consider a charge which has been proved but no conviction recorded have raised the following issues.

- The purpose of criminal proceedings is punitive. Accordingly, when a judicial officer makes an order under section 556A his or her paramount consideration is not whether the practitioner is unethical or incompetent. The only element differentiating a recorded from an unrecorded conviction is a decision of the criminal court made during sentencing when the court turns its mind to the appropriate penalty to impose for the offence.

- Courts when sentencing often take into account the effect that a conviction may have upon the professional registration of the accused. On occasions courts have declined to record convictions so as to prevent an accused being disciplined by the Medical Board or the Medical Tribunal and in doing so have demonstrated an inadequate understanding that any action by the Board or Tribunal is entirely protective and not punitive in character.[22]

- The Department has been made aware of a number of cases of indecent and sexual assault where medical practitioners have been given section 556As in circumstances where the conduct raised significant issues as to whether the person was unfit in the public interest to practise medicine.

- The current requirement that a person can only be refused registration where the Medical Board is satisfied that the conviction renders the person unfit in the public interest to practise medicine ensures that trivial offences will not result in refusal of registration.

The Department considers on balance that the public would be better protected by conferring on the Medical Board the power to refuse registration where an applicant has received a section 556A (or equivalent provision) thereby providing the Board with the opportunity to consider whether in any particular case the person has been rendered unfit in the public interest to practise medicine. Appeal rights to the Medical Tribunal provide safeguards against an improper exercise by the Board of this discretion.

(ii) **Should the range of offences be limited to those which relate to the practice of medicine or the practitioner's ability to practise medicine?**

As outlined above, the Medical Practice Act already provides that the Medical Board cannot refuse an application for registration unless:

> *"the Board is of the opinion that the conviction renders the person unfit in the public interest to practise medicine."*[23]

In view of the Board's public protection function, the Board, rather than the practitioner or any third party, is best placed to determine whether a conviction raises any issues of concern. Criminal convictions can be relevant not only to character but also impairment. It is understood that notifications of criminal convictions currently received by the Board concern drink driving and are of greatest relevance in relation to the detection of practitioners who may be impaired. Consequently, for several years all practitioners convicted of drink driving offences have been assessed on this basis.

In view of the Medical Board's charter which is to protect the public the Department does not support any narrowing of the range of offences which are to be reported to it.

Recommendation 3

That the Medical Practice Act be amended to give the Medical Board the power to refuse registration where a charge has been proven but no conviction recorded and the Board is of the opinion that it renders the applicant unfit in the public interest to practise medicine.

5.7 Conduct in another jurisdiction

The Medical Board may refuse an application for registration if the applicant's name has been removed from any register for the registration of medical practitioners for any reason relating to the conduct of the person amounting to professional misconduct or on any basis relating to the person's physical or mental capacity to practise medicine. Non-mutual recognition applicants who have been suspended indefinitely (rather than had their name removed from the register) have effectively fallen outside the scope of this provision.

In the interests of consistency the Department supports the Board being given the power to refuse a non-mutual recognition applicant where he or she has been suspended indefinitely on account of professional misconduct or any basis relating to the person's physical or mental capacity to practise medicine.

Recommendation 4

That the Medical Practice Act be amended to give the Medical Board the power to refuse a non-mutual recognition applicant where he or she has been suspended indefinitely from an inter-state register on account of professional misconduct or any basis relating to the person's physical or mental capacity to practise medicine.

5.8 Medical students

The Act currently provides that a person is not entitled to undertake a course of medical study at a medical school in New South Wales accredited by the Australian Medical Council unless the person is registered with the Board as a medical student. No fees are payable. Once registered the only jurisdiction which the Medical Board has over a student is in relation to impairment.

In the Issues Paper several questions were canvassed on the issue of student registration. Should the Medical Board's jurisdiction over medical students in impairment matters be retained? Should the Medical Board have jurisdiction in disciplinary matters?

Under the Medical Practice Act impairment means any physical or mental condition or disorder which is likely to detrimentally affect the person's capacity to practise medicine and includes drunkenness or addiction to a deleterious drug. The impairment provisions enable the Medical Board to take pro-active steps to assist the student to deal with his or her impairment. This is an important power given that medical students are directly involved in the provision of care to the public whilst undertaking clinical placements.

Nearly all submissions received were supportive of the Medical Board continuing to have jurisdiction over medical students in impairment matters. It has been suggested however that further consideration should be given to the range of students who come within the definition of a "medical student". Currently students who are enrolled in a course at a medical school which involves non-clinical research or course work come within the scope of the provision. Given that these students are not providing direct patient care it may be more appropriate for the definition to be narrowed to those students who are undertaking a course through an accredited medical school which leads to a registrable medical qualification. In addition, it is understood that each year a substantial number of overseas students undertake an elective clinical term or terms within the hospital system. Given that these students have exposure to patients a consistent approach would seem to favour the Medical Board having jurisdiction over these medical students in impairment matters.

Very few submissions have advocated the Medical Board having jurisdiction in disciplinary matters. Medical students are already subject to disciplinary controls within universities. Consequently, if the Medical Board did acquire jurisdiction there would be scope for the two systems to conflict by imposing differing obligations. Further, given that the Medical Board is self funding such a measure would result in increased annual fees for medical practitioners and/or the introduction of annual fees for medical students (which currently are not levied).

The balance of the argument does not support the Medical Board having jurisdiction over medical students in disciplinary matters.

Recommendation 5

That:

- the Medical Board continue to have jurisdiction over medical students in impairment matters; and
- the definition of "medical student" in the Medical Practice Act be amended to more accurately cover those medical students who are directly involved in patient care.

6. REGISTRATION INQUIRIES

6.1 Scope of registration applications

The Medical Board must not register a person unless it is satisfied that an applicant is competent to practise. Schedule 1 to the Medical Practice Act deals with registration procedures and provides for the holding of inquiries into the eligibility of applicants for registration. A decision by the Board to refuse registration or impose a condition can be appealed to the Medical Tribunal.

The Issues Paper canvassed whether the Act should be amended to give the Board the power to conduct Schedule 1 inquiries in relation to:

- transition from internship/supervised training to general registration;
- transition from conditional/retired or non-practising registration to general registration; and
- all re-registration applications.

Submissions to the Issues Paper were very supportive of increasing the scope of Schedule 1 inquiries. This measure would enhance the ability of the Board to protect the public by enabling it to properly assess an applicant's competence to practise medicine.

Recommendation 6

That the Medical Practice Act should be amended to clarify that the Medical Board has the power to conduct inquiries into eligibility for:

- all re-registration applications;
- all applicants transferring from internship/supervised training to general registration; and
- all applicants transferring from conditional/retired or non-practising registration to general registration.

6.2 Power of the HCCC to intervene

The Director-General of the Department of Health may intervene at any inquiry before the Medical Board into an applicant's eligibility to be registered. Currently the Health Care Complaints Commission's power to intervene is limited to cases where a person has appealed against a decision of the Medical Board to the Medical Tribunal. The Commission has argued that it should have a role in the registration process that involves a right to appear at Board registration inquiries.

Some submissions have strenuously opposed the Commission having a power to intervene at these inquiries. For example, United Medical Protection in its submission cited the following reasons:

> *"First, the HCCC has its role limited by the Health Care Complaints Commissions Act. Its powers are only triggered upon receipt of a complaint. These powers are strictly defined by the Act and do not contemplate such intervention... Section 92 of that Act*

specifically states that the HCCC does not have power to set general standards of clinical practice."

The Medical Board has advised that most Schedule 1 inquiries are conducted into issues that are outside the usual jurisdiction of the Commission (eg whether an impaired student needs to have conditions placed on registration when applying for an internship); however, there may be circumstances where the Commission would be able to assist an inquiry. Accordingly, the Department advocates the Commission being notified of all inquiries (other than impairment inquiries) and being able to seek leave to appear at the discretion of the inquiry.

Recommendation 7

That the Medical Board notify the Health Care Complaints Commission of all registration inquiries (with the exception of those which concern impairment) and at the discretion of the inquiry be permitted to appear before the inquiry.

7. REQUIREMENTS FOR CONTINUING REGISTRATION

7.1 Introduction

One of the primary objectives of the Act is to provide patients with information about the ongoing competence of practitioners.

The Medical Board is prohibited from registering a person unless it is satisfied that the applicant is competent to practise medicine. To make this assessment the Medical Board relies heavily on the initial registration criteria, the complaints/disciplinary system and the practitioner's professional obligations to maintain his/her skills.

The Issues Paper canvassed a number of strategies for monitoring the continuing competence of practitioners:

- routine performance assessments;
- conferring on the Medical Board the power to assess practitioners on reasonable grounds;
- continuing medical education; and
- the development of a more comprehensive annual renewal process for practitioners.(See 8.2.8)

Many submissions argued that the current system for monitoring the competence of practitioners should be enhanced through the introduction of one or more of the strategies canvassed in the Issues Paper.

7.2 Routine performance assessments

One way of ensuring that practitioners maintain their skills and remain up to date with developments in their profession is through routine performance assessments. In cases where a practitioner's practice is thought to be sub-standard, the Board could direct a practitioner to undertake a specified training program.

Some submissions have argued that reliance on the complaints process for identifying practitioners who are not competent is inadequate and that routine performance assessments should be introduced. The Health Care Complaints Commission has endorsed a model which "*requires practitioners to provide evidence in relation to their current activities designed to maintain current knowledge and skills which can be used to substantiate their renewal of registration.*"[24] However, as an interim measure the Commission is supportive of the performance assessment model proposed by the Board (see below) and a more rigorous process for annual renewal of registration.

The introduction of routine performance assessments may be impractical in view of the diverse areas of practice of practitioners. It would result in additional costs to the profession and the community. The community would incur increased costs as the costs associated with an assessment system and its administration would be passed on by practitioners to patients as the Medical Board is self funding. There would be delays in the processing of registration renewals.

The Department does not support this particular option for the reasons given above.

7.3 Power to assess performance on reasonable grounds

The Issues Paper canvassed whether the Medical Board should be given additional powers to enable it to conduct performance assessments when there are reasonable grounds for doing so. Both the Medical Board and the Health Care Complaints Commission have identified that there is a group of practitioners whose overall level of knowledge, skill, judgment or care in the practice of medicine is below the standard which could reasonably be expected of a practitioner of an equivalent level of training and experience but who do not readily fit within either the current disciplinary or impairment systems.

Unlike the current disciplinary process which focuses on specific incidents that are documented in complaints, the performance assessment system seeks to address broad based problems with the practitioner's practice at an early stage through retraining and thereby minimising the risk to the public. The approach is educational and co-operative rather than adversarial.

These types of concerns have already resulted in the introduction of performance programs in Canada, Great Britain, New Zealand and the United States. Their experience suggests that the symptoms of a practitioner who is not performing satisfactorily include multiple complaints, minimal continuing education, clinical skills that are out of date, poor record keeping, inadequate sterilisation procedures and dirty rooms. The experience of British Columbia, where a performance assessment program exists, suggests that the physicians who benefited most from it were those who had not been certified by a College and those aged 55 and older.[25]

The Medical Board's research suggests that approximately 30 per cent of complaints could be more effectively handled under this system. The following case has been cited as an example of where there were major indicators of poor performance to which the Board could not adequately respond.

- An off duty policeman witnessed a major car accident and ran to a nearby surgery to seek assistance. The practitioner, Dr C was in solo practice and although there were no patients in the surgery at the time he refused to attend the emergency. A Professional Standards Committee was convened to consider the complaint of "failing to render urgent attention" (ie unsatisfactory professional conduct). The doctor initially put forward a defence that he was not well and not able to attend. In the course of listening to the doctor describe his practice the Committee became most concerned that the doctor's failure to attend was based on his fear that he may lack the skills to handle an emergency situation. Nevertheless, the particulars of the matter related to the doctor's failure to attend and could not be generalised to the question of poor performance. The doctor capitulated and admitted he should have assisted and would in future. The Committee had very little option beyond issuing a reprimand.

Most submissions on this issue have been very supportive of the introduction of a performance assessment system.

> *"The Commission supports the proposition that some complaints received by the Commission would be best dealt with by the Medical Board through the non-disciplinary process and further supports the Board's concept of the Performance Review Panel."*[26]
>
> *"It introduces a notification and assessment process which is consistent with the Medical Board's role in the protection of the public. The process of investigating only those who are brought to the attention of the Board because of concern about performance will meet the main concerns for public safety while at the same time identifying the highest risk doctors and thereby ensuring maximum efficacy for the process."*[27]

Some submissions have however given qualified support because the Issues Paper did not canvass specific methods for assessing the performance of practitioners and the final model which is being developed by the Medical Board has not been finalised.

The Medical Board in its submission to the Issues Paper has put forward a detailed proposal for managing practitioners who have demonstrably failed to perform at an adequate standard but do not readily fit within the disciplinary or impairment models. The two principles underpinning the proposal are that:

- it is to be educational and collaborative rather than adversarial and/or punitive; and
- the Colleges and other medical bodies play integral roles in the design and implementation of the process.

The key features of the proposal are:

- a notification to the Board is reviewed to determine whether it is dealt with under the performance, disciplinary or impairment system;
- the clinical practice of a practitioner to be dealt with under the performance system is assessed (e.g. inspection of records and premises where practice is inspected, interview, direct observation of the practitioner);
- a recommendation is made to a Panel which is to consist of at least two practitioners;
- the Panel can make a range of orders (e.g. imposition of conditions);
- there is a right of appeal to the Medical Tribunal;
- Colleges are to be involved in the assessment and re-training phases; and
- apart from the cost of the initial assessment which is to be met by the Medical Board, all other costs are to be met by the practitioner.

It is understood that the Medical Board has been discussing and is continuing to do so its proposal with all medical professional bodies. The Medical Board's submission states that it has received endorsement from all Colleges, the Australian Medical Association and the medical defence organisations. The Department as been informed that the Board will be seeking formal ratification from the Colleges which will be active participants in the process at the end of 1998.

As a matter of principle, the Department supports the introduction of a system for assessing the performance of practitioners who have broad based problems that warrant

early intervention in the interests of public health and safety. However, the model that is being developed by the Medical Board in which Colleges play an instrumental role has not been finalised nor ratified by the key stakeholders. Accordingly, it would appear to be premature for the Department to advocate a final position at this time.

Recommendation 8

That the Medical Board proposal for performance assessments be the subject of further consultation.

7.4 Continuing medical education

Continuing practitioner participation in continuing professional education is desirable and can be seen as an essential component of professionalism. The Issues Paper canvassed whether mandatory continuing education or a voluntary scheme established by the Board should be introduced.

There were several submissions which argued participation in continuing education should be a mandatory requirement for registration. Such a requirement, it is said, ensures that practitioners maintain their standards in an environment where there are rapid changes which practitioners must keep abreast of. The Issues Paper noted that such a requirement should only be introduced where there is a problem with professionals failing to maintain standards as there is little point in making participation in continuing education mandatory where professional associations and professionals already consistently recognise their professional responsibilities.

According to Medical Board figures 55 per cent of complaints received in 1996/97 concerned clinical competence. This would appear to suggest that a proportion of practitioners may benefit from a more structured approach to continuing medical education. Although Colleges do play an active role in continuing medical education it is important to note that not all practitioners are members of such organisations.

A substantial number of submissions support continuing medical education in principle but are opposed to it being made mandatory. By making continuing medical education mandatory for the purposes of registration, a barrier to registration is created as the cost of medical training programs would have to be borne by medical practitioners on an annual basis. Clearly programs will be of varying quality and usefulness for practitioners. Many submissions argued that continuing medical education should not be made mandatory because it is already conducted by Colleges. Other submissions noted that issues like lack of access to educational opportunities for rural/remote practitioners and cost may also be relevant.

As part of a more rigorous annual renewal of registration process the Department is proposing that practitioners should be required to make a declaration about continuing medical education activities they have undertaken in the previous 12 months.[28] By requiring practitioners to consider the amount of medical education they have undertaken, the profile of continuing medical education will be increased. Declarations will also give the Medical Board data on the types of practitioners who are receiving medical education, its standard and relevance to practice and the types of organisations which are delivering medical education.

This information will provide an improved basis for evaluating better whether the current system is adequate or if it could be improved.

The Department does not support continuing medical education being made a condition of registration at this time but considers that by requiring practitioners to make declarations on an annual basis on the amount of medical education they have participated in, awareness of the importance of medical education will be increased in the profession generally and the Medical Board will be well placed to formulate effective strategies for addressing any areas of concern that are identified.

8. DISCIPLINARY SYSTEM

8.1 Introduction

As noted at 2.2 complaints may be made to the Medical Board or the Health Care Complaints Commission. Submissions were sought on whether reforms to the current disciplinary system should be made to improve it and to eliminate unnecessary restrictions on competitive conduct.

Complaints and disciplinary systems play a central role in maintaining professional standards and protecting patients from harm. However, in enforcing such standards through disciplinary arrangements, such systems can potentially operate against patients where they impinge upon legitimate commercial and competitive conduct by medical practitioners. An example of this is the prohibition in the current Act on the use of qualifications unless they are recorded in the register held by the Medical Board. The practice of the Board has been to only record in the register those qualifications which are recognised by the National Specialist Qualifications Committee.

Submissions addressed the *benefits* arising from the existence of a statutory disciplinary system highlighting the ability to protect the public by taking action against incompetent or unethical practitioners in an effective manner.

The general view was that for a disciplinary system to be effective at monitoring and enforcing standards among the profession it must be independent, transparent, accountable to the public and fair to all parties.

Few submissions addressed the *costs* of disciplinary arrangements. Clearly there are costs for the HCCC, the Board and practitioners in conducting investigations and hearings. However, these costs are far outweighed by the benefits produced from removing incompetent or unethical practitioners from the register or imposing conditions on their registration, which in turn ensures that patients have information about those holding themselves out as medical practitioners.

No evidence was provided demonstrating that the current disciplinary system is inappropriately focussed on commercial conduct, and this is supported by the nature of complaints received by the Board to and the HCCC.

The Medical Practice Act contains a two tier disciplinary system. The definition of "unsatisfactory professional conduct" is attached at **Appendix C**. "Professional misconduct" is defined as unsatisfactory professional conduct of a sufficiently serious nature to justify suspension or deregistration of a practitioner. The grounds on which disciplinary action may be taken essentially relate to issues of competence and improper or unethical conduct.

No evidence has been presented to suggest that this provision has been used to inappropriately restrict commercial conduct. The complaints history of the Board highlights this point.

Alternatives to the disciplinary system include professional associations monitoring standards, or legal action at common law or under the *Trade Practices Act 1974 or the Fair Trading Act.* However, in both cases, neither system would achieve the protective objectives of the Act

because there is no ability to prevent practitioners from using the title "medical practitioner". Furthermore, legal action depends upon individuals being prepared to invest time and/or money in pursuing his or her cause of action.

8.2 Improving the disciplinary system

A range of matters pertaining to the operation of the disciplinary system were canvassed in the Issues Paper:

- grounds for making a complaint
- the definition of "unsatisfactory professional conduct"
- the definition of "professional misconduct";
- whether a Code of conduct should be introduced;
- medical record keeping practices;
- mandatory notification of cases of lack of competence and sexual misconduct;
- notification of criminal convictions and certain charges;
- information to be provided by registrants on renewal;
- the composition of Professional Standards Committees and the Medical Tribunal
- the conduct of proceedings before Professional Standards Committees and the Medical Tribunal
- disciplinary sanctions; and
- appeals

8.2.1 Grounds for making a complaint

Section 39 of the Medical Practice Act provides that complaints about a registered medical practitioner which touch upon any of the following may be made:

- criminal conviction;
- unsatisfactory professional conduct and professional misconduct;
- lack of competence;
- impairment; and
- character.

It is essential that the grounds for making a complaint complement the grounds for refusing registration which were discussed in Chapter 5. If they do not there will be anomalies because conduct will be treated differently depending upon whether it is being considered:

- in the course of an application for registration; or
- for the purposes of determining if disciplinary action should be taken against a person who is already registered.

Accordingly, in view of the recommendation that both criminal convictions and section 556As (ie both recorded and unrecorded convictions) constitute grounds for refusal of registration where the Medical Board is satisfied that the person has been rendered unfit in the public interest to practise medicine the Department supports the grounds of complaint being expanded to cover section 556As(or equivalent provisions).

Recommendation 9

That the grounds for complaint in the Medical Practice Act be amended to include not only convictions but instances where the charge has been proved but no conviction recorded.

8.2.2 Broadening the definition of unsatisfactory professional conduct

Submissions supported the retention of the two tiered definition noting that it drew a distinction between serious and less serious matters.

As the definition of "unsatisfactory professional conduct" provides the basis for disciplinary action, consideration needs to be given to whether the content of the definition adequately protects the public from incompetent and unethical practitioners and/or has an adverse impact on competition. No submissions directly addressed the issue of whether the current definition has an adverse impact on competition .

Two submissions argued that the definition is too broad and could result in a finding of "unsatisfactory professional conduct" in relatively trivial circumstances. They proposed that only behaviour which would attract the "severe disapproval of the medical practitioner's peers of good standing"should come within the definition of "unsatisfactory professional conduct" and "professional misconduct". It is said that without this safeguard "less than ideal" conduct could be deemed to lack adequate skill judgment or core or improper conduct.[29]

The Department does not support this proposal as it would retard the ability of the disciplinary system to protect the public by substantially narrowing the range of complaints that can be dealt with through the disciplinary process. The definition of "professional misconduct" is a simple and effective method for differentiating conduct which is extremely serious.

Many more submissions argued that the current definition is adequate in that it represents *"an excellent balance between protecting the rights and privileges of the doctors and at the same time protecting the interests of the patient*".[30]

The Issues Paper canvassed whether a number of amendments should be made to the categories that comprise the definition of "unsatisfactory professional conduct".

(i) Professional conduct falling below what may reasonably be expected of medical practitioner by the public or the profession

Most submissions were not supportive of this proposal. The most common reason cited was that in effect the current definition of "unsatisfactory professional conduct" already reflects the expectations of the public and the profession. Further, lay persons are involved at all levels of the disciplinary process.

(ii) Offences under various Acts of Parliament

The definition of "unsatisfactory professional conduct" includes convictions for a narrow

range of offences which touch upon the performance of medical treatment and the failure to disclose pecuniary interests.[31] The definition does not cover instances where a practitioner has been charged with one of the offences listed in the definition, the charge has been proven beyond a reasonable doubt but no conviction has been recorded pursuant to section 556A of the Crimes Act (or an equivalent provision).

The issue of unrecorded convictions has already been discussed in 5.6 in the context of whether the Board should be able to consider them for the purposes of whether a person has been rendered unfit in the public interest to practise medicine. It has also been noted in 8.2.1 that anomalies will result if the definition of "unsatisfactory professional conduct" (which is one of the grounds for lodging a complaint) is not consistent with the grounds for refusing registration.

In addition, it should also be noted that the offences which are provided for in the definition concern conduct occurring in the course of medical practice.

On balance the Department supports the definition of "unsatisfactory professional conduct" being broadened to include not only convictions but also findings of guilt where no conviction is recorded for one of the offences listed in the definition.

(iii) Sexual misconduct

A number of submissions were received on the question of whether sexual misconduct should constitute a separate category of unsatisfactory professional conduct.

Most submissions to the Issues Paper did not support this proposal on the basis that:

- recent case law[32] makes it clear that sexual misconduct falls within the definition of "unsatisfactory professional conduct"; and
- there are alternative ways of conveying to the profession that sexual misconduct will not be tolerated.(e.g. educational campaigns conducted by the Medical Board, professional associations and universities)

In view of recent cases where it has been made clear that sexual misconduct falls within the definition of "unsatisfactory professional conduct", the Department does not consider it necessary to create a separate category of unsatisfactory professional conduct for sexual misconduct. The Department does however support the initiatives taken by the Medical Board to inform the profession that sexual misconduct is a serious matter than can result in disciplinary action.

(iv) False qualifications

Under the current Act the use by a registered medical practitioner of qualifications in the practice of medicine which are not recorded in the register constitutes unsatisfactory professional conduct. The presumed rationale for the provision is that it ensures medical practitioners only use qualifications in medicine that are recognised by the Board. The Board as a matter of practice only includes in the register qualifications that are recognised by the National Specialist Qualifications Committee.

The Issues Paper sought submissions on the advantages and disadvantages of recording qualifications in the register and the prohibition on advertising qualifications

that are not recorded in the register.

Other submissions argued that the prohibition on using qualifications not recorded in the register should be removed on the ground that it is no longer meaningful and not in the public interest. The Medical Board in its submission argued that in view of the diversity of professional qualifications the task of preparing and policing a list of "acceptable" qualifications is extremely difficult. In addition, it can be argued that the prohibition is anti-competitive.

The Department is of the view that the power of the Board to record qualifications in the register should be retained. However, the prohibition on using qualifications not recorded in the register should be removed because it limits the information available to patients. Any harm can be minimised by general prohibitions on false, misleading and deceptive conduct under the Medical Practice Regulation 1998, the Trade Practices Act 1974 and the Fair Trading Act 1982. In serious cases where practitioners mislead the public, it may form grounds for a complaint of unsatisfactory professional conduct on the grounds that falsely claiming to hold qualifications may be considered "improper or unethical conduct".

(v) Over servicing/Improper conduct of a medical practice

The Issues Paper canvassed whether the definition should include conduct involving:

(a) providing a person with medical services of a kind that is excessive, unnecessary or not reasonably required for that person's well being; and

(b) influencing or attempting to influence the conduct of a medical practice in such a way that patient care may be compromised.

Very few submissions have addressed this issue. One submission noted that it was not necessary to cover in the Medical Practice Act matters likely to be raised under the Commonwealth Health Insurance Act.[33]

On the other hand, the provision would send a powerful message to the profession that over servicing is not only an issue for the Health Insurance Commission but is also relevant to whether a practitioner is an ethical and competent provider of medical services. It would also provide a more effective means of dealing with cases of over servicing.

One submission argued that the definition of "unsatisfactory professional conduct should include conduct where a practitioner "*knowingly associates with a service or produce which is advertised or provided in a manner capable of misleading patients or capable of brining the profession as a whole into disrepute*".[34] This was one of the recommendations which arose out of the Ministerial Committee of Inquiry into Impotency Treatment Services.[35] The Department is of the view that by prohibiting a person from providing medical services of a kind that is excessive, unnecessary or not reasonably required for that person's well being or conducting a medical practice in a way that patient care may be compromised, the definition of "unsatisfactory professional conduct" will adequately address any particular harm at which the recommendation is aimed.

The Department acknowledges that in some circumstances a medical practitioner may

be required by his or her employer to provide medical services in such a way that he or she is providing a person with medical services of a kind that is excessive, unnecessary or not reasonably required for that person's well being or conducting a medical practice in such a way that patient care may be compromised. Employers that are not registered medical practitioners are outside the scope of the disciplinary system which is only concerned with the conduct of medical practitioners. This particular issue is discussed in Chapter 10.

(vi) Conflict of interest

The definition of "unsatisfactory professional conduct" currently includes conduct which results in conviction for any of the offences under the Private Hospitals and Day Procedures Centres and Nursing Homes Acts which relate to disclosure of pecuniary interests to patients.

The Issues Paper canvassed whether the scope of the conflict of interest provision should be strengthened. Conflicts of interest can arise in a number of situations and are not limited to the offences currently listed in the Medical Practice Act. There may be circumstances where a practitioner wishes to refer his or her patient to an institution or provide services in which he or she has a financial interest. By imposing an obligation on the practitioner to advise the patient that he or she has a financial interest in those services the patient is able to sake a more informed decision about whether to get a second opinion.

A number of submissions argued that failure to disclose a conflict of interest should constitute unsatisfactory professional conduct.

The Medical Board in its submission supported the inclusion of improper conflict of interest as a form of unsatisfactory professional conduct and noted that the definition in the Australian Medical Association Code of Ethics may be useful. It states

> "*Do not refer patients to institutions or services in which you have a financial interest, without full disclosure of such interest*".

On balance, the Department supports the definition of "unsatisfactory professional conduct" being amended to incorporate the concept of conflict of interest. Patients are at a disadvantage due to their limited ability to make an assessment of the need for medical services or the type of services required. Patients rely heavily on the advice of their practitioners. Armed with information on whether a practitioner has a financial interest in the service being recommended the patient is able to make a better informed decision.

(vii) Failure to respond to the Medical Board without reasonable cause

The Issues Paper canvassed whether the Medical Board should have the power to compel the subject of a complaint to respond. Although many submissions were silent on this issue, more submissions than not supported the Medical Board having such a power.

Both the Health Care Complaints Commission and the Medical Board have in their submissions suggested that failure by the subject of a complaint to respond to a request from the Medical Board for information without reasonable excuse should constitute "unsatisfactory professional conduct". The Medical Board has advised that a significant number of complaints have been unnecessarily delayed and taken further than their gravity warranted because of the failure of the practitioner to respond.

The Australian Medical Association has expressed the strong view that the Medical Board should not be given additional powers in this area.

> "*... the AMA is of the view that it is not the position of the Board to act as the authority for another organisation, with its own legislative authority.... Perhaps this issue should be looked at more closely by the Health Care Complaints Commission, but the AMA's view is that it is certainly not the role of the Medical Board.*"[36]

Concerns have been expressed to the Department about delays associated with the investigation of complaints by the Health Care Complaints Commission. Section 29 of the Health Care Complaints Act states that the investigation of a complaint is to be conducted as expeditiously as the proper investigation of the complaint permits. Some of the recommendations which arose from that review may further reduce the investigation time frame.

Three inter-state medical registration boards already have the power to compel a practitioner to respond to inquiries.

In the interests of assisting the Medical Board to discharge its responsibilities in a timely and efficient manner, the Department supports the Medical Board having the power to compel the subject of a complaint to respond to a request for information within a reasonable time frame. Failure to respond to a request without reasonable cause would breach the Medical Practice Act and therefore constitute "unsatisfactory professional conduct".

Recommendation 10

That the definition of "unsatisfactory professional conduct" in the Medical Practice Act should be amended to include:

- both convictions and cases where a finding of guilt is made but no conviction recorded for the specified offences under the Mental Health Act, Children (Care and Protection) Act, Guardianship Act, Private Hospitals and Day Procedure Centres Act, Nursing Homes Act and Health Insurance Act ;
- failure to disclose a conflict of interest in a service;
- conduct which involves:
  (a) providing a person with medical services of a kind that is excessive, unnecessary or not reasonably required for that person's well being; or
  (b) influencing or attempting to influence the conduct of a medical practice in such a way that patient care may be compromised;
- failure to respond to a Board request for information without reasonable excuse.

That the prohibition on the use of qualifications not recorded in the register be deleted from the definition of "unsatisfactory professional conduct" in the Medical Practice Act .

8.2.3 Definition of "professional misconduct"

The Medical Practice Act defines "professional misconduct" as "unsatisfactory professional conduct" of a sufficiently serious nature to justify suspension of the practitioner from practising medicine or the removal of the practitioner's name from the Register.

Two submissions have advocated two quite different amendments being made to the definition of "professional misconduct".

One submission has argued that the definition of "professional misconduct" is not appropriate because it gives rise to a presumption that professional misconduct should result in suspension or deregistration.

The Department does not support this amendment. The current provision draws a clear distinction between less serious and serious matters. It is considered that the proposed amendments would erode the meaningfulness of this distinction which is fundamental to the two tier disciplinary process in which less serious matters can be dealt with in a non-adversarial forum.(ie Professional Standards Committee) Serious matters which could possibly lead to de-registration are accorded a formal hearing before a Medical Tribunal.

Another submission has suggested that the definition of "professional misconduct" should be changed from conduct of a sufficiently serious nature to justify suspension ... or removal of the practitioner's name from the Register" to "conduct of a sufficiently serious nature **which may** justify suspension or removal of the practitioner's name from the Register. As has already been noted above, a finding of "professional misconduct" will not automatically result in suspension or deregistration. The Department does not consider that this proposal would in substance alter the current definition of "professional misconduct" and accordingly it is not supported.

8.2.4 Codes of Conduct

In the Issues Paper the Department sought comments on the desirability of introducing codes of professional conduct. Some health professional registration Acts confer on the relevant registration authorities that administer them the power to establish codes of professional conduct which should be observed by registered practitioners in carrying out their professional practice. Codes of conduct have been given a statutory basis to assist the relevant health professional registration board ensure that registered practitioners are competent to practise. The codes established by the various boards cover a range of issues including but not limited to standards of conduct, professionalism, privacy and confidentiality, research and relations with other members of their profession.

Codes of professional conduct can play an important role in protecting the public from harm by establishing standards to be observed by practitioners in the course of their professional practice. Such codes can assist registration boards in determining whether practitioners have adopted appropriate standards. Similarly, they can be used by disciplinary bodies to assist in defining standards of acceptable practice. Most importantly they serve as a guide for practitioners as to the expected standard of conduct or practice.

However, codes can be used to restrict competition. Where they are recognised in legislation, they can restrict competition by altering the behaviour of individual practitioners and can impose compliance costs on members to the profession. To this extent, the review needs to consider whether inclusion of a provision to enable Codes to be developed is consistent with the requirements of the Competition Principles Agreement. Obviously, whether such a Code has such an impact will depend on the content of the Code itself.

In the absence of Codes, the standards that are expected of medical practitioners are derived from the definition of unsatisfactory professional conduct and the common law. The Board is able to provide further assistance in this regard through its ability to issue policy statements to the profession. To date the Board has issued policies on a number of areas including sexual misconduct. It can be argued that Codes would be seen to be more proactive by establishing clear standards to be observed by practitioners.

While the need for standards could be addressed by the profession itself through professional associations or other advisory bodies (eg the National Health and Medical Research Council) it can be difficult for the practitioner to determine exactly what is the appropriate standard to be observed. This is particularly evident where there are a range of conflicting guidelines on particular issues. A Code can provide a single reference point for both patients and practitioners.

Of greater concern is the fact that codes developed by professional associations may give undue emphasis to protecting certain forms of conduct by the profession and may not be consistent with the public interest. In particular, the deeming of matters as "unprofessional conduct" by an association may have an adverse impact on legitimate commercial conduct (eg restrictions on advertising). Practitioners may feel obliged to observe such standards even though they are not legally binding.

The benefits and costs of a Code can only be determined where the precise content of the Code is known. While the concerns that Codes can restrict competition or can impose unnecessary compliance costs on practitioners are noted, in the absence of a legislative

code, standards could be set by other bodies which may result in greater restrictions on competition and compliance costs for practitioner.

Submissions to the Issues Paper were divided on the issue of whether Codes of Professional Conduct should be introduced. Submissions against the introduction have argued:

- The current ability of the Board to provide guidance to the profession by issuing policy statements, a newsletter and special mailings is efficient.
- If conduct is not proscribed in a code practitioners may assume that it is acceptable.
- "... *codes have the potential to ensure any anti-competitive practices which would result in higher process for consumers... The AMA notes the current acts which have established Codes of Conduct and sees no relativity whatsoever between the paramedical groups covered by those acts and the medical profession.*"[37]
- "*The AMA and other professional bodies have Codes of Conduct which are adequate... It is unlikely that an Act of Parliament could devise a Code of Conduct which would surpass one devised by the AMA.*"[38]

Submissions in favour of the introduction of Codes have raised the following issues.

- A Code is important because it sets out the rules or standards of conduct to be observed by a practitioner when carrying out the practice of medicine and has educative value for health care consumers and for members of the profession.
- Codes will assist the Board to ensure that practitioners are competent to practise within their levels of skill and training.
- Codes would educate consumers and the profession.
- Codes should be approved by an appropriate independent body.
- "*The Commission supports the desirability of professions publishing Codes of professional Conduct for the educative value to consumers and the profession and for the benefit in declaring acceptable professional conduct.*"[39]
- '*It is acknowledged that the introduction of a code may lead to reduced competition and potentially higher prices for consumers, but we believe that this cost would be offset by the potential benefits of a reduced incidence of malpractice and negligence.*"[40]

On balance, the Department considers that codes are a valuable tool for directing practitioners on the standards to be adopted. Similarly, they can be used by disciplinary bodies to assist in defining standards of acceptable practice. Codes of conduct can also be of benefit to consumers. The Department proposes that the Act be amended to provide scope for codes to be made.

A range of options were canvassed in the Issues Paper including whether the Code should be subject to the approval of the Minister, Parliament, the Department and/or any other body.

To ensure that any codes of conduct for medical practitioners do not sanction anti-competitive conduct or contain trivial matters, and serves the interests of patients, the Department supports codes being made by regulation under the Act, following consultation with the Board. As a result the Regulation/Code could proceed through the Regulatory Impact Statement process which involves public consultation and a full assessment of the respective advantages and disadvantages of its provisions. As it has been recommended that Codes be made by Regulation, a breach will clearly form grounds for complaint.

Recommendation 11

That the Medical Practice Act be amended to enable Codes of Conduct to be made by Regulation under the Act following consultation with the Board.

8.2.5 Medical record keeping practices

The current Act provides that regulations may make provision requiring medical practitioners and corporations providing medical services to make and keep specified records. The Medical Practice Regulation 1998 introduced requirements on the form, content and storage of medical records. Failure to comply with the regulation constitutes "unsatisfactory professional conduct". The rationale for the introduction of the provisions was to facilitate optimal patient care for which sound record keeping practices are necessary.

The provisions were introduced to ensure that proper standards in medical record keeping are observed. Poor communication and/or a poor standard of record keeping are consistently central issues in medical complaints and litigation. Accurate patient records can facilitate high quality patient care and will be of enormous assistance to both health professionals and complainants in determining the cause of an adverse event.

Such a system may result in compliance costs for the practitioner. These however must be balanced against the benefits associated with proper medical record keeping practices which are identified above. There was widespread support for the regulation of medical record keeping practices when the Medical Practice Regulation 1998 was introduced in September 1998.

Most submissions emphasised that sound medical record keeping practices are a vital part of good patient care and are a professional responsibility. The lack of adequate records (and in some instances no records at all) hinders patient care.[41] The benefits to the public and the medical profession of comprehensive, uniform records should not be under-estimated.[42]

The Department supports the continued regulation of medical record practices under the Medical Practice Act.

8.2.6 Mandatory notification in cases of a lack of competence and sexual misconduct

In the Issues Paper the question was canvassed as to whether medical practitioners should be under a statutory obligation to report cases of lack of competence and sexual misconduct. Submissions both in favour of and opposed to mandatory notification have been received.

Submissions in favour of a system of mandatory notification argue practitioners have an inherent responsibility to protect the public, there is potential for medical practitioners to harm their patients, and patients are frequently unable to assert their rights

One submission quoted from a report of the Task Force on Sexual Abuse of Patients commissioned by the College of Physicians and Surgeons of Ontario:

> "Patients seek the help of doctors when they are vulnerable -when they are sick, when they are needy, when they are uncertain about their physical or emotional health. The physicians has the knowledge, the skills and the expertise the patient needs to heal. The patient often suspends both judgment and personal power idealising the doctor in order to feel secure."[12]

Submissions opposed to a system of mandatory notification have raised a number of practical issues.

- Making notification mandatory would be counterproductive in that it would be unlikely to lead to a significantly increased rate of notification but would be likely to deter people from making notifications and/or lead to evasive behaviour on the part of practitioners at risk.

- Effective enforcement of such a requirement would be difficult . For example, it would be necessary to establish that a practitioner was aware of a fellow practitioner's lack of competence.

- There are other methods available for increasing notifications which would be more effective. Programs conducted by the Medical Board, professional associations and universities which educate practitioners about the complaint process and identifies those practices which are not acceptable would be of assistance in this regard. For example, it is understood that the British General Medical Council has released a publication titled "Good Medical Practice" which says it is every practitioner's duty to "*protect patients when you (sic) believe that a doctor's or other colleague's health, conduct or performance is a threat to them ... the safety of patients must come first at all times.*"

Whilst the Department does not support the introduction of mandatory notification of cases of lack of competence and sexual misconduct, primarily because of the difficulties in meaningfully enforcing such a provision, non-statutory approaches which encourage practitioners should be pursued by the Medical Board.

Recommendation 12

That the Medical Board should review its strategies for encouraging practitioners to notify it when they obtain information which raises issues about a practitioner's competence or sexual misconduct.

8.2.7 Notification of criminal convictions and charges of a serious nature that relate to conduct occurring in the course of practice

The criminal justice system can provide information which is relevant to whether a person is fit to practise medicine. The Issues Paper canvassed whether a positive obligation should be placed on practitioners to notify the Medical Board in the event that they are:

- convicted of a criminal offence (which includes recorded and unrecorded convictions); or
- charged with an offence of a serious nature that relates to conduct occurring in the course of practice.

(i) Criminal convictions

Section 71 of the Medical Practice Act already requires courts to notify the Medical Board if they are convicted of an offence (with the exception of several minor offences which are prescribed in the Medical Practice Regulation 1998). It is proposed that practitioners be under a positive obligation to notify the Medical Board if they are convicted of an offence which is of a type notifiable by courts. The definition of an offence would include cases where an offence is proven but no conviction is recorded.[44] Failure to comply would be a breach of the Act and as such would come within the definition of "unsatisfactory professional conduct" and provide prima facie grounds for disciplinary action.

It is important to emphasise that under section 15 of the Medical Practice Act registration may only be refused where a person has been convicted of an offence and the Board is of the opinion that the conviction renders the person unfit in the public interest to practise medicine.

There is already a statutory obligation on Courts to notify convictions sustained by medical practitioners. The proposed system of "self-notification" will provide an additional means for obtaining relevant information in a timely manner. It will also emphasise to practitioners the potential seriousness with which criminal convictions should be regarded.

The majority of submissions to the Issues Paper have been supportive of practitioners being required to "self report" recorded convictions to the Board.

Recommendation 13

That the Medical Practice Act be amended to impose a positive obligation on practitioners to notify the Medical Board if they are convicted of an offence (irrespective of whether it is recorded or not) unless it is an offence of a type that is not required to be reported to the Medical Board.

(ii) Charges of a serious nature that relate to conduct occurring in the course of practice

The Issues Paper canvassed whether a limited range of charges should be reportable to the Medical Board; that is, should charges of a serious nature which relate to

conduct occurring in the course of practice be reportable?

Why should such charges be reportable?

> "*The circumstances may be relevant to the practitioner's ability to practise and they may impact on the 'good character' requirement for practitioners and thus an obligation to notify is central to the protection function of the Board.*"[45]

The Department has not proposed that the charges per se would constitute the basis for disciplinary action. Rather, the charge and the circumstances surrounding it can be relevant to a practitioner's overall ability to practise and to questions of character. On notification of a charge there would be several options open to it. In very serious cases the Board would be able to suspend the practitioner's registration or impose conditions on his or her registration for a limited time if satisfied that such action is necessary to "protect the life or the physical or mental health of any person".[46] Other options available would be to consider whether the charge warrants the practitioner being dealt with under the impairment system or immediate referral to the Health Care Complaints Commission for investigation and prosecution or whether professional disciplinary action should await the outcome of the criminal trial.

The introduction of a system which requires practitioners to self report charges is not without precedent. Under the Health Services Act visiting practitioners appointed by a public health organisation who have been charged or convicted of a serious sex or violence offence are already under a positive obligation to report that information to the chief executive officer of the organisation. The term "serious sex or violence offence" is defined to mean an offence involving sexual activity, acts of indecency, physical violence or the threat of physical violence that would be punishable by imprisonment for 12 months or more.[47]

Approximately half of all submissions to the Issues paper addressed the issue of reporting charges. Of those, just over half were supportive of the proposal on the ground that a charge may disclose information relevant to the protective function of the Medical Board. Submissions that opposed the proposal have suggested that it would compromise the practitioner's defence in any criminal proceedings.

The purpose of disciplinary proceedings is "*to maintain proper ethical and professional standards, primarily for the protection of the public, but also for the protection of the profession*".[48] A criminal court is not concerned with issues of professional standards. Its task is to ascertain whether the prosecution is able to prove beyond a reasonable doubt that the accused is guilty of the particular charges that have been laid. The differing functions of disciplinary and criminal proceedings is a recurring theme in this paper. This was noted in the discussion of section 556As (ie where a person has been proven guilty but no conviction recorded) in 5.6 but is considered in greater depth in 8.2.10(iii) where the sequence of criminal and disciplinary proceedings is discussed. In view of the differing roles of the disciplinary and criminal justice systems, the fact that a person can be subjected to the two types of proceedings in relation to the same conduct does not constitute double jeopardy.

In the interests of enabling the Medical Board to carry out its protective function, the Department is recommending that all medical practitioners should be obliged to inform

the Medical Board if they are charged with a "serious sex or violence offence" where the allegations relate to conduct occurring in the course of practice. A "serious sex or violence offence" means an offence involving sexual activity, acts of indecency, physical violence or the threat of physical violence that would be punishable by imprisonment for 12 months or more.

Recommendation 14

That the Medical Practice Act be amended to oblige a medical practitioner to notify the Medical Board within seven days if charged with a "serious sex or violence offence" where the allegations relate to conduct occurring in the course of practice. A "serious sex or violence offence" means an offence involving sexual activity, acts of indecency, physical violence or the threat of physical violence that would be punishable by imprisonment for 12 months or more.

8.2.8 Information to be provided on renewal

The Issues Paper canvassed whether the process for renewing registration should be more rigorous. Currently the Act requires applications to be accompanied by a fee. Should additional information be provided to the Medical Board to enable it to assess whether the practitioner continues to be competent to practise medicine and be of good character. Clearly the Medical Board can only take action to protect the public on information received. Relevant information may come from a range of sources and is not limited to complaints.

The Department supports a more comprehensive process for renewing registration to enable the Board to be able to adequately assess whether a registered practitioner continues to be competent to practise medicine and of good character and therefore render renewal of registration a meaningful process, particularly for the public. Accordingly, the registration renewal form should include declarations on the following:

- criminal convictions (recorded and unrecorded);
- charges for serious sex or violence offences where the allegations relate to conduct occurring in the course of practice;
- significant illness for the purpose of identifying whether there may be issues of impairment; and
- continuing medical education activities.[49]

Recommendation 15

That the Medical Practice Act be amended to require applicants for registration to make declarations on:

- criminal convictions (recorded and unrecorded);
- charges for serious sex or violence offences where the allegations relate to conduct occurring in the course of practice;
- significant illness for the purpose of identifying whether there may be issues of impairment; and
- continuing medical education activities.

8.2.9 Composition of Professional Standards Committees and the Medical Tribunal

The Medical Practice Act contains a three tier disciplinary system involving the Medical Board, Professional Standards Committees and the Medical Tribunal. An effective disciplinary system plays a central role in securing the underlying objective of the Medical Practice Act which is to protect the public from incompetent and unethical practitioners. For the system to be effective it must be independent, transparent, accountable to the public and fair to all parties.

A number of specific issues pertaining to the composition of Professional Standards Committees and the Medical Tribunal were canvassed in the Issues Paper. That is:

(i) the establishment of a panel of lay persons to sit on Professional Standards Committees and the Medical Tribunal who are appointed by the Minister;
(ii) chairpersons of Professional Standards Committees; and
(iii) whether Board members should b permitted to sit on Professional Standards Committees and the Medical Tribunal.

(i) Lay persons on Professional Standards Committees and the Medical Tribunal

A number of submissions have been complimentary of the contribution that lay persons make on these bodies. Specific issues raised in submissions include:

- There should be a transparent process for the selection and appointment of the lay members in accordance with published guidelines. The Minister should seek nominations for selection from a range of stake holders.[50]

- The proposal for the establishment of a panel of lay persons who are appointed by the Minister for three year terms would enable the suitability and availability of members to be reviewed on a regular basis and provide the opportunity for new lay persons to be appointed.

- The Health Care Complaints Commission has suggested that the terminology "lay persons" should be replaced with "public persons" in order to "*better reflect the representational role of these members on behalf of the community...*"[51]

The Medical Practice Act currently provides that a lay person for the purposes of

Professional Standards Committees and the Medical Tribunal is a person other than a medical practitioner who is appointed from a panel nominated by the Minister. The Department does not support any narrowing of the range of persons who meet the definition of "lay person". Further, the role of lay persons is not one of direct representation of the community, but rather to provide a perspective as a member that is other than part of the medical profession.

(ii) Board membership on Professional Standards Committees and the Medical Tribunal

Submissions on the issue of whether Medical Board members should be precluded from sitting on Professional Standards Committees and the Medical Tribunal are divided. Some submissions have gone further to argue that all members of Professional Standards Committees and the Medical Tribunal should be drawn from a panel which has been approved by a third party like the Minister for Health.

For a disciplinary system to be effective it must be independent and its processes transparent. It is against these criteria that the proposal must be assessed.

A number of arguments have been made in support of the continued involvement of Board members in Professional Standards Committee and Medical Tribunal hearings.

- The two disciplinary bodies are quite independent of the Medical Board. Only members of the relevant Committee are aware of individual cases and they are precluded from sitting on Professional Standards Committees.

- The Board believes that it is important for it to maintain a degree of contact and familiarity with the proceedings of Professional Standards Committees and the Medical Tribunal so that it has a direct feedback mechanism and can identify trends and issues.

A number of submissions have put forward a contrary view that Professional Standards Committees and the Medical Tribunal would be seen by the profession to be more impartial if members of the Medical Board were precluded from sitting on them and membership was drawn from a panel nominated by the Minister for Health. It can also be argued that Board membership of disciplinary bodies is by no means the only way in which the former can monitor trends and issues pertaining to the latter. This could be done in range of ways both formal and informal.

(iii) Chairpersons of Professional Standards Committees

The Issues Paper also sought comments on whether chairpersons of Professional Standards Committees should have any particular qualifications and/or experience. Professional Standards Committees are intended to be relatively informal peer review panels. To date while most Professional Standards Committees are chaired by one of the medical members lay members, with skills at chairing meetings or inquiries have been used. Professional Standards Committees should be conducted in a fair and efficient manner. In those cases involving difficult procedural issues it is particularly important for the Chairperson to have some awareness of the requirements of natural justice.

Accordingly, the Department is of the view that the most appropriate member of the Committee should be picked to be the Chairperson irrespective of whether they have any particular qualifications or experience. The Department also supports a proposal put forward in one of the submissions for members of Professional Standards Committees and the Medical Tribunal to receive training in procedural fairness and the administration of inquiries.[52]

Recommendation 16

That the Medical Practice Act be amended to provide that members of Professional Standards Committees and the Medical Tribunal should be drawn from a panel of persons appointed by the Minister for Health.

That the Medical Board arrange training in procedural fairness and the administration of inquiries for members of Professional Standards Committees and the Medical Tribunal.

8.2.10 Conduct of proceedings before Professional Standards Committees and the Medical Tribunal

As has already been stated the objective of the Medical Practice Act is to protect the public from incompetent and unethical practitioners. The disciplinary system should underpin the public protection function. For disciplinary proceedings to be effective they must be conducted in a manner which is independent, transparent and fair to all parties. The Issues Paper canvassed a number of specific matters on the conduct of disciplinary proceedings which were raised with the Department.

(i) Legal representation before Professional Standards Committees

Under the Medical Practice Act legal representation is permitted before the Medical Tribunal but not before hearings of Professional Standards Committees. The rationale given for this provision in the Second Reading Speech for the Medical Practice Bill was to "*ensure that the hearings retain their informal character*".

Several submissions argued that legal representation should be permitted in view of the range of sanctions which a Professional Standards Committee may invoke (e.g. a fine of up to $5,500, ordering that a practitioner complete further education) and that the practitioner is at a disadvantage because the Health Care Complaints Commission's hearing officer is often an experienced advocate.

Many more submissions supported the contrary view that legal representation before Professional Standards Committees would be detrimental to the overall process. The following reasons were cited.

- Professional standards committee hearings would look less like inquiries by the practitioner's peers but become adversarial and legalistic. Hearings would need to be chaired by a legally qualified person. The aim of having a relatively informal hearing into professional issues could be undermined by resort to legal

argument and the whole purpose of the two-tier structure would be defeated as more and more cases would have to be referred to the Medical Tribunal.

- Practitioners appearing before Professional Standards Committees would incur legal expenses.

- The proceedings would be lengthier and there would be delays in the hearing of matters.

- There are appeal rights to the Medical Tribunal where legal representation is permitted.

- Hearings of Professional Standards Committees follow the inquisitorial system where Committee members are responsible for questioning witnesses. As a result the hearings officers of the Health Care Complaints Commission do not adopt the traditional prosecutorial role.

- The Health Care Complaints Commission in its submission quoted from a letter from the President of the Medical Board, Professor John Horvath which advised that the employment of hearing officers had

> *"been a singular success ... advantageous to all concerned with the Professional Standards Committee processes, as the level of professionalism has enabled the Committees to get on with the substance of the inquiry, rather than being distracted by procedural and technical issues which had been more common with less experienced presenters."*

On balance, the Department supports the continued prohibition on legal representation before Professional Standards Committees.

One submission was received which advocated representation at the Professional Standards Committee level by a person other than a legal practitioner.[53] Under section 177 of the Medical Practice Act a Committee may grant leave for an advisor (other than a legal practitioner) to address the Committee or appear at the inquiry. The Committee must ensure that the practitioner is afforded procedural fairness. In view of this requirement, the likelihood of "representation" as of right resulting in inquiries becoming more adversarial and the existence of a right of appeal to the Medical Tribunal, the Department does not support practitioners being entitled to representation by an advisor before Professional Standards Committee hearings.

(ii) Standard of proof

Several submissions were received in support of the adoption of the criminal standard of proof in disciplinary proceedings. Currently the disciplinary body must satisfy itself on the balance of probabilities that the practitioner committed the conduct in question. The standard is not a static one. Rather, the more serious the charge the higher the degree to which the disciplinary body must satisfy itself that the subject matter of the complaint is proved. For example, in disciplinary cases where a practitioner's livelihood is in jeopardy a high standard of proof is applied. In criminal proceedings the

guilt of an accused person must be proved beyond a reasonable doubt.

Submissions have emphasised that this proposal cannot be assessed without giving due consideration to the purpose behind the two types of proceedings.

- Criminal proceedings are inherently punitive in nature and involve the State seeking to remove fundamental liberties and rights of one of its citizens. Proof beyond reasonable doubt is required in such proceedings because of the paramount importance which the law places upon ensuring that innocent persons are not convicted and punished.[54]

- A criminal court is not concerned with issues like competence. Its task is to ascertain whether the prosecution is able to prove beyond a reasonable doubt that the accused is guilty of the particular charges that have been laid.

- The purpose of disciplinary proceedings is "*to maintain proper ethical and professional standards, primarily for the protection of the public, but also for the protection of the public*".[55]

- To require a degree of certainty indispensable to a criminal conviction in professional disciplinary cases would clearly entail placing the privileges enjoyed by the medical profession above the protection of the public from incompetent and unethical practitioner.[56]

The Department is of the view that the adoption of the criminal standard of proof (ie beyond a reasonable doubt) would be inconsistent with the objective of the Medical Practice Act which is the protection of the public and accordingly it is not supported.

(iii) Sequence of disciplinary and criminal proceedings

A course of conduct may give rise to both disciplinary and criminal proceedings. Section 56 of the Medical Practice Act provides that current civil or criminal proceedings relating to the subject matter of the complaint do not prevent disciplinary proceedings from being pursued It has been suggested that in such cases disciplinary proceedings should not take place until criminal proceedings have been finalised.

Submissions advocating changes to section 56 of the current Act have made the following points.

- Criminal and disciplinary proceedings are markedly different in nature with different standards of proof. The protection of the public from incompetent or unethical practitioners requires that disciplinary hearings not be delayed for the conduct of any other proceedings.

- Section 56 merely provides a discretion to the Professional Standards Committee or the Medical Tribunal to continue with an inquiry when there are civil or criminal proceedings on the same subject matter pending. In Edelsten v Richmond[57] the Court said:

> "*The discretion given to the tribunal involves balancing the public interest*

in the observance of the right to silence..."

- Professional Standards Committees and the Medical Tribunal are best placed to determine in any particular case whether the public interest requires the complaint be heard prior to the conclusion of related proceedings.[58]

- Another case cited in a submission[59] is Ibrahim v Walton[60] where the Court said:

> *"... in relation to complaints against a medical practitioner, there are matters other than his interest or the public interest in the right to silence to be considered, and those include the interest of the public in the proper performance by medical practitioners of the undoubted privileges and powers which they have in relation to their patients; and in the protection of members of the public who are patients from any abuse of those powers or privileges. In some cases it is obvious that the public interest in protecting patients should be given priority to that of the person complained about who is also subject to the criminal proceedings."*

Several submissions have argued that the following sequence of hearings must be adhered to: criminal hearing, disciplinary hearing and then the civil hearing. The rationale given is that a practitioner's criminal trial will be prejudiced if he or she has to outline his or her defence in a disciplinary body prior to the criminal action.[61]

The discretion held by Professional Standards Committees and the Medical Tribunal to conduct inquiries notwithstanding that criminal or civil proceedings relating to the same subject matter are on foot is not unfettered but involves the balancing of the public interest in protecting patients and the public interest in the observance of the right to silence. The Department does not support the erosion of this discretion.

(iv) Admission of evidence

Nether a Professional Standards Committee nor the Medical Tribunal are bound to observe the rules of law governing the admission of evidence. Each may inform itself of any matter in such a manner as it sees fit. The Issues Paper canvassed whether the current rules for conducting Medical Tribunal hearings are unfair. Submissions were invited to cited specific examples of unfairness.

Persons who come before the Medical Tribunal are entitled to a fair hearing. Submissions that argued the current system is fair have made the following points:

- evidence can only be admitted in proceedings before the Tribunal if it is "rationally probative" of a fact in issue in the proceedings;[62]
- the Chairperson of the Tribunal is a District Court Judge who is well placed to ensure that Tribunal proceedings are conducted in a fair manner;
- in practice, the substantive rules of evidence governing the admission of evidence are generally followed by the Tribunal but technical legal requirements relating to form and the like may be dispensed with;
- any suggestion that "*hearsay evidence may be given inappropriate weight is unsustainable. The primary circumstance where hearsay evidence is admitted*

in proceedings before the Medical Tribunal is where a patient makes contemporaneous complaints to relatives and/or friends concerning the conduct of a practitioner, most usually following a physical examination by the practitioner. Such evidence of recent complaint is of course admissible in any legal proceedings where the rules of evidence are strictly applied as one of the well established exceptions to the hearsay rule";[63] and

- other quasi-judicial bodies such as the Administrative Appeals Tribunal which has only recently been established is not bound by the rules of evidence.

Submissions which favour reform in this area have not addressed specific examples of unfairness.

On balance, after giving due regard to the protective nature of the jurisdiction, the Department does not support any amendments being made to the way in which proceedings before Professional Standards Committees and the Medical Tribunal are conducted.

8.2.11 Disciplinary sanctions

The Medical Practice Act contains a broad range of sanctions which should facilitate the achievement of the Act's underlying objectives.

(i) Imposition of conditions on registration which adversely affect a third party

Both Professional Standards Committees and the Medical Tribunal have the power to impose conditions on a practitioner's registration. For example, a condition could be imposed that a practitioner may only treat children in the presence of a chaperone.

> "*Overly restrictive or impractical restrictions can greatly disrupt the efficient and effective functioning of a hospital and therefore pose a threat to patient care.*"[64]

The Department is aware of a number of instances of conditions being imposed where the public hospital concerned or the Department, in the case of conditions imposed on the public health system generally, has not been notified of the decision or given an opportunity to appear before the Committee or Tribunal to provide advice as to the practicality of conditions proposed. The Issues Paper sought submissions on the role of third parties on whom a burden is imposed through the imposition of conditions on registration.

Although third parties cannot be compelled to comply with orders by these disciplinary bodies, for the most part public sector bodies do make great efforts to facilitate their implementation notwithstanding issues of cost or impracticality. The Board's view is that "*if conditions cannot feasibly be met by a hospital, then the doctor is unable to practise medicine safely, and is effectively unemployable.*"[65]

The Department acknowledges that it is the responsibility of Professional Standards Committees and the Medical Tribunal to make orders or impose conditions which

are consistent with the protective charter of the Medical Practice Act. However, as noted the conditions that a disciplinary body is proposing to make may be impractical to implement and/or impose an appreciable cost burden on a third party. In these circumstances, to ensure that the disciplinary body is fully informed, prior to making a decision, any third parties that may be placed under an appreciable burden by proposed orders should be given an opportunity to be heard by the disciplinary body. Ultimately it must remain a matter for the third party as to whether they are able to facilitate implementation of an order. In the case of a proposed order relating to the public health system generally, (eg that the registrant only work in the public system) the Director-General of the Department should be notified as the relevant third party.

Recommendation 17

That the Medical Practice Act be amended to provide that:

- if a Professional Standards Committee or the Medical Tribunal is proposing to make an order which will place an appreciable burden on a third party, prior to making the order the third party will be given an opportunity to be heard on the proposed order; and
- a third party which is placed under an appreciable burden by a decision of a Professional Standards Committee or the Medical Tribunal will be provided with a copy of the decision within seven days of it being made.

It will remain a matter for the third party as to whether it is able to implement the order.

(ii) Counselling

"Counselling" is a term which is used in different parts of the Act. In addition to it being an outcome of an impairment process and an order made by a Professional Standards Committee and a Medical Tribunal, the Board has the power in respect of a complaint it has received to direct the practitioner to attend counselling. A practitioner who fails to attend counselling without reasonable cause is taken to lack physical and mental capacity to practise medicine.

Most submissions have been positive of the role that counselling has played since its introduction. The Department does not consider any amendments to the provision are warranted but would encourage the Medical Board to play an active role in assisting parties to a complaint to understand the process.

(iii) Emergency powers of the Medical Board

The Medical Board has powers to suspend and impose conditions on registration where it is satisfied that such action is necessary for the purpose of protecting the life or the physical or mental health of any person. Since the introduction of these powers hearings have been held on approximately ten occasions to deal with an urgent matter that could not await the finalisation of an investigation and eventual hearing by a Professional Standards Committee or Medical Tribunal.

The Medical Practice Act does not provide any guidance on the conduct of

proceedings for the exercise of emergency powers. Other problems with these powers which were identified in the Issues Paper include:

- the timing of the various actions;
- the failure to include reference to an Impaired Registrants Panel as an outcome;
- the interaction with time frames under the Health Care Complaints Act; and
- the lack of a mechanism to review conditions pending a hearing.

An overwhelming numbers of submissions that addressed this issue supported the retention of the emergency powers and their review to overcome some of the problems that were identified in the Issues Paper.

> "*The AMA also acknowledges that there are strong public policy reasons for the Board having the power to take urgent action for the protection of the public in appropriate cases and agrees that the four dot points included under paragraph 8.9.4 [ie the issues identified above] detailing some of the problems should be addressed*".[66]

The Department supports the retention of the emergency powers on the ground that they are an important tool for protecting the public in cases where immediate action is warranted. However, the Department supports the powers being reviewed to address the shortcomings that have been identified with the current provisions.

Recommendation 18

That in the interests of protecting the public, the emergency powers under the Medical Practice Act should be retained but reviewed to address:

- the timing of the various actions;
- the failure to include reference to an Impaired Registrants Panel as an outcome;
- the interaction with time frames under the Health Care Complaints Act; and
- the lack of a mechanism to review conditions pending a hearing.

8.2.12 Appeals

Decisions of the Medical Board and Professional Standards Committees can be appealed to the Medical Tribunal and are dealt with by way of a rehearing with fresh evidence. The Medical Tribunal is a quasi-judicial body which is chaired by a senior judicial officer. Appeals from decisions of the Medical Tribunal are made to the Supreme Court and are limited to decisions on points of law. The Issues Paper canvassed several proposals for reform in this area.

(I) Scope of Supreme Court appeals

It has been suggested that appeals from decisions of the Medical Tribunal to the Supreme Court should be by way of rehearing. The Medical Tribunal consists of one Judge of the District Court, two registered medical practitioners and one lay person.

Submissions that have argued there should be no extension to the current provisions in relation to the jurisdiction of the Supreme Court have put forward the following reasons;

- the reason for the constitution of an expert body like the Medical Tribunal is so that it can bring its own expert resources to the determination of often complex factual issues pertaining to medical science;[67]
- the Medical Tribunal is an expert tribunal with a legal chairperson;
- the argument that the systems under the Legal Profession Act (where appeals to the Supreme Court are by way of a rehearing) and the Medical Practice Act are analogous fails to acknowledge that the Legal Profession Act deals with issues concerning the conduct of members of the legal profession who have specific duties towards the Court and that the Supreme Court functions in a sense as an expert Tribunal in these matters; and
- any extension to the scope of the Supreme Court's jurisdiction could result in delays in the hearing of matters and, as once heard, the matters would be lengthier and the legal costs greater.

Submissions in favour of extending the jurisdiction have made the following points.

> *"Full confidence can only be achieved if there are full appeal rights from hearings before the Medical Tribunal to the Court of Appeal... Appeal rights on questions of fact are a safeguard against incorrect decisions and strengthen any system of justice."*[68]

On balance, the Department does not support any of the proposals canvassed on the grounds that the Department does not consider the scope of the current appeal rights to be unfair and that the proposals would increase costs and delays

(ii) **Standing of persons who can appeal against a decision of a Professional Standards Committee**

Appeals against decisions of a Professional Standards Committee can be made by a registered practitioner about whom a complaint has been referred to a Committee or the complainant. The term "complainant" has been interpreted by the courts to mean the person whose complaint was the subject of the Professional Standards Committee inquiry and not the original complainant to the Medical Board or the Health Care Complaints Commission. The Issues Paper canvassed whether the original complainant who provided the information which formed the basis for disciplinary proceedings should have a right of appeal.

The Health Care Complaints Commission is responsible for both the investigation and prosecution of complaints before disciplinary bodies. Public protection is facilitated by the interlinking of the Health Care Complaints and Medical Practice Acts under which there are formal consultative processes. It is understood that the Health Care Complaints Commission has a review committee to examine concerns of original complainants who are unhappy with the outcome of investigations and that the Medical Board frequently reviews matters to ensure that the initial action taken has been appropriate.

Submissions overwhelmingly opposed original complainants having rights of appeal against decisions of Professional Standards Committees. Allowing original complainants to occupy such a role would be contrary to the statutory functions of the Health Care Complaints Commission. Section 80(1)(c) of the Health Care Complaints Act states that the Commission's function is:

> "*to make complaints concerning the professional conduct of health practitioners and to prosecute those complaints before the appropriate bodies, including registration authorities, professional standards committees and tribunals*".

The Department does not support any amendments being made to the Medical Practice Act to permit original complainants to appeal against decisions of Professional Standards Committees.

(iii) Appeals against determinations of the Chairperson of the Medical Tribunal

Currently, under section 63 a person in respect of whom the Chairperson of the Medical Tribunal has made a determination that he or she does not have sufficient physical or mental capacity to practise medicine does not have a right of appeal to the Supreme Court. This is out of step with analogous cases (ie a person about whom a complaint has been referred to the Tribunal) where a right of appeal to the Supreme Court does exist against a decision of the Tribunal on a point of law or the exercise of a power under Part 4 of Division 4.

Nearly all submissions have been supportive of an appeal right to the Supreme Court being introduced in circumstances where a decision has been made under section 63(3).

Recommendation 19

That section 63 of the Medical Practice Act be amended to confer a right of appeal to the Supreme Court.

(iv) Scope of review applications

Under section 92 a person may apply for review of orders of a Professional Standards Committee, the Chairperson or a Deputy Chairperson of the Medical Tribunal, the Medical Tribunal or the Supreme Court. The review body is the Medical Tribunal unless the order being reviewed requires that it be reviewed by the Medical Board. As a result of several court cases it is now possible for applicants to revisit the original findings which resulted in deregistration. This could potentially involve a rehearing and may prolong the length and increase the costs of inquiries.

It has been suggested that there may be scope for seeking to define these limits so as to minimise misconceived attempts to broaden review applications to generalised inquiries into the original complaint which led to the deregistration or imposition of

conditions.

Prior to the introduction of the concept of "review" in 1987, under the former Medical Practitioners Act 1938 a practitioner whose name was removed from the register could apply to the disciplinary tribunal to be registered, after the expiry of any time which had been fixed preventing a re-application. In such applications the disciplinary tribunal followed the principles expressed by the Court of Appeal in dealing with applications for restoration by legal practitioners, namely that the findings of the initial Tribunal had to be accepted and that an applicant should not seek to go behind those findings nor seek to discredit them.[69]

Accordingly, it can be argued that the introduction of the term "review" was not intended to permit for the first time challenges to earlier findings of the Tribunal but to permit a later Tribunal to change or lift orders if changed circumstances warranted such a course. This would appear to be at odds with the result of the Rohatgi[70] decision where the Court of Appeal determined that the word "review" had a wide meaning capable of permitting challenges to findings made by earlier Tribunals.

One submission has identified several practical problems with the Rohatgi interpretation.

- In circumstances where a review body considers on evidence placed before it that a former practitioner was not guilty of professional misconduct, the review body would be powerless to set aside or quash a finding of professional misconduct. The powers of a review body which are set out in section 94 would only permit an order to be made for reinstatement.

- If as a result of the review an error was shown in the original Tribunal's judgment the public interest would require that the complaints be re-heard. However, the review Tribunal has no such power.[71]

Although the Department supports limits being imposed on the scope of review proceedings under section 92 it is acknowledged that such limits may in exceptional circumstances cause injustice. For example, re-consideration of initial findings may be warranted where a crucial witness has retracted his or her evidence.

The Department recommends that the scope of review applications (under section 92) be narrowed to preclude a person from challenging findings made by earlier Tribunals and to confer a right of appeal to the Supreme Court in circumstances where a substantial miscarriage of justice would arise from the discovery of fresh evidence.

Recommendation 20

That the Medical Practice Act be amended to narrow the scope of review applications to preclude a person from challenging findings made by earlier Tribunals and to confer a right of appeal to the Supreme Court in circumstances where a substantial miscarriage of justice would arise from the discovery of fresh evidence.

8.3 Removal from the register

The Medical Board is currently required to remove the name of a practitioner at his or her own request. This can present difficulties under mutual recognition as the register will show that the practitioner's name was removed at his or her own request notwithstanding that disciplinary action has been taken.

A number of submissions have been received which support limits being imposed on the power of a practitioner to compel the Medical Board to remove his or her name from the register in circumstances where health or disciplinary proceedings have been contemplated or are in progress. This would ensure that in the case of mutual recognition applicants the information upon which those applications are assessed is more accurate.

The Medical Practice Act already provides that a complaint about a registered medical practitioner may be made and dealt with even though the practitioner has ceased to be registered. Several submissions have argued that the proposal would impose continuing financial, legal and ethical obligations on a practitioner for no benefit to the public.

On balance, the Department does not support the introduction of measures which would fetter a person's right to have his or her name removed from the register.

9. IMPAIRMENT

9.1 Introduction

The Medical Practice Act contains a non-disciplinary system for managing impaired practitioners and medical students. The definition of impairment makes it quite clear that a condition will render a person impaired in circumstances where it detrimentally affects or is likely to detrimentally affect the person's physical or mental capacity to practise medicine. In certain circumstances the impairment process enables the Medical Board to take action before the practitioner/student's condition puts the public at risk. Specific benefits of the system which have been identified include:

- the non-punitive nature of the system encourages practitioners to self report or report others before patients are injured; and
- benefits for patients because they have an assurance that practitioners have sufficient physical and mental capacity to practise medicine.

One submission raised concerns about the application of the impairment process to persons with physical disabilities and in particular those with permanent non-progressive physical disabilities. The tremendous range of conditions which affect, or have the potential to detrimentally affect, a person's physical or mental capacity to practise medicine and the requirements of medical practice demand that the Medical Board have a broad discretion in this area in the interests of public health and safety

The Issues Paper canvassed a number of proposals for improving the impairment process.

9.2 Mandatory reporting of impairment

Should medical practitioners and health institutions be compelled to report practitioners and students who are suspected of being impaired?

Submissions in favour of mandatory reporting of impairment have argued that it is essential for the adequate and effective protection of the public.

Numerous submissions have argued that reporting should not be mandatory. The following reasons have been cited.

- To date the impairment program has been approached in a co-operative manner. There is a concern that this approach which has facilitated the making of notifications would be jeopardised if mandatory notification was introduced.

- The introduction of a system of mandatory notification may not result in an increased number of notifications as impaired practitioners may be more likely to cover up their condition and not self report. To date a significant number of impaired practitioners with insight into their problems have of their own accord informed the Board of their impairment.

- Effective enforcement of mandatory notification may be difficult as it would be necessary to establish that the practitioner was aware that his or her colleague was

impaired.

- Non-statutory approaches which publicise the impairment program and encourage practitioners to make notifications may be more effective.

It is noted with interest that a recent Victorian study on practitioners impaired by opioid abuse found that community pharmacists were the primary source of notifications, followed by inspections of pharmacy records by Departmental officers.[72]

On balance, the Department does not support the introduction of a statutory obligation which compels medical practitioners and health institutions to report practitioners and students who are impaired. The Department does however support the Medical Board's activities in this area to publicise the impairment program.

9.3 Impaired practitioner initiated requests for variation or removal of conditions on registration

Currently, the Medical Practice Act provides that a practitioner who has been suspended or had a condition imposed on his or her registration as a result of the impairment process is entitled to have the protective measures lifted at his or her request. It has been suggested that a request for removal or variations of conditions be referred to the Impaired Registrants Panel for a recommendation which would be provided to the Medical Board for a determination.

Not all practitioners who are put through the impairment program have insight into their impairment. The current requirement that protective measures be lifted at the practitioner's request raises serious issues of concern in these cases. Many submissions have supported the introduction of a system which gives the practitioner the opportunity to present arguments as to why there should be a variation of conditions, with proper consideration being given to that request. on the ground that it will help to protect the public. To do otherwise, it has been said may put the public at risk by impaired practitioners returning to practice without restrictions.[73]

The Department supports the proposed system with the proviso that it should be accompanied by a right of appeal to the Medical Tribunal

Recommendation 21

That the Medical Practice Act be amended to provide that a practitioner who has agreed to have conditions imposed on his or her registration may only have them lifted with the agreement of the Medical Board which will receive a recommendation from an Impaired Registrants Panel, and with an accompanying right of appeal from the Medical Board's decision to the Medical Tribunal.

9.4 Power to direct medical examinations

The Medical Practice Act currently contains no power to direct a practitioner to undergo a

medical examination unless a complaint has been lodged under Part 4 (ie disciplinary proceedings). The Medical Board has the power to direct a medical student who is the subject of a matter referred or proposed to be referred to an Impaired Registrants Panel to undergo a medical examination. The Issues Paper canvassed whether the Medical Board should have a parallel power to compel medical practitioners to undergo medical examinations.

Numerous submissions supported the Medical Board having a parallel power to direct that a medical practitioner undergo a medical examination. The same issues of public protection it is argued arise irrespective of whether a person is a medical student or a medical practitioner.

The Department supports the Medical Board having the power to direct a medical practitioner to undergo a medical examination in circumstances where a practitioner has been or is proposed to be referred to an Impaired Registrants Panel. This is subject to the condition that a practitioner must not be directed to undergo a medical examination unless it is reasonable to require the examination given the nature of the notification. Failure to attend a medical examination without reasonable cause should constitute lack of sufficient physical and mental capacity to practise medicine. These amendments will give the Medical Board uniform powers to act irrespective of whether a complaint or notification has been received.

The Issues Paper also canvassed whether a broader power to direct a medical practitioner to undergo a medical examination should be included in circumstances where it might be helpful to determine if a complaint should be made or whether the practitioner should be referred to an Impaired Registrants Panel. The need for such an extensive power has not been supported by any evidence to the review. The Department considers that the existing power to direct a practitioner to undergo a medical examination where a complaint has been lodged and the proposed amendments in relation to practitioners about whom there are impairment concerns will be adequate.

Recommendation 22

That the Medical Practice Act be amended to give the Medical Board the power to direct a medical practitioner who is the subject of a matter referred or proposed to be referred to an Impaired Registrants Panel to undergo a medical examination.

9.5 Disclosure of conditions by impaired practitioners

The Issues Paper considered the question of whether practitioners should be compelled to disclose conditions that have been imposed on them as part of the impairment process. It is understood that notification of the practitioner's employer is a common outcome of the impairment process. The Medical Board takes the view that it should be responsible for informing employers of any conditions imposed. It is understood that orders are generally made in such a way that they encompass whoever the employer may be. For example, the doctor may only work in a position approved by the Board and that the employer shall be provided with a copy of the orders.

Many submissions have argued that in the interests of enabling employers to play a role in ensuring that the practitioner is providing safe and appropriate care, the employer should be informed of any conditions that have been imposed

> "*It is essential that impaired practitioners who have agreed to conditions being imposed on their registration disclose such conditions to their employer so that their employer can adequately assess their skills and competence and place them in an appropriate role.*"

Submissions have not focused on who should be responsible for informing an employer - the Medical Board or the practitioner.

The Department considers that the Medical Board should continue to be primarily responsible for informing a practitioner's employer where impairment related conditions have been imposed.

10. CORPORATIONS ENGAGED IN THE PROVISION OF MEDICAL SERVICES

An issue which emerged from consultation on the Issues Paper was that unlike medical practitioners who are subject to a complex web of obligations, the Medical Practice Act does not regulate corporations providing medical services.[74]

Corporate medicine has become increasingly widespread with practitioners in private practice no longer confined to operating as sole practitioners or in partnership. There has been a proliferation of medical centres and specialised clinics where medical practitioners are retained as employees.

The "Report of the Ministerial Committee of Inquiry into Impotency Treatment Services in N.S.W." raised serious issues of concern about a number of clinic practices and their potential to be contrary to the interests of patients. Some of the practices identified include:

- short and ineffective consultation with treatment by injections and minimal after-care to patients;
- potential for abuse of patients with significant psychological vulnerability due to the targeting of the condition through widespread advertising;.
- high costs for patients (eg clinics charging over ten times the esumated wholesale costs for injections and for syringes) and large financial gains for practitioners (eg medical practitioners being paid a fixed per centage of their gross takings which were made up of the sales of medication and Medicare charges);
- the manner of preparation and the contents of each dosage may not be disclosed to patients and may be inappropriately labelled; and
- practitioners ~~have~~ minimal specialist experience or training in the area of treatment.

As was noted in 8.2.2 there may be circumstances where an employer places pressure on a medical practitioner to provide medical services that are excessive, unnecessary or not reasonably required for a person's well being or such that patient care may be compromised. Specifically, a practitioner's continued employment or remuneration may be contingent on the practitioner following particular prescribing or treatment patterns.

Clearly, employers that are not medical practitioners are outside the scope of the disciplinary system which is only concerned with the conduct of medical practitioners. It can be argued that it is inequitable for an employer who influenced or attempted to influence a practitioner to engage in the offensive conduct to be beyond the reach of the law.

In New South Wales private hospitals and day procedure centres are required to be licensed. An applicant for a day procedure centre must satisfy a number of criteria including that he or she is a fit and proper person.

Recommendation 23

That the Department undertake further consultation on whether legislative amendment is required to adequately address improper or unethical practices by corporations engaged in providing medical services and, if so, the form of such legislation.

11. REGULATION OF CONDUCT AND MARKET INFORMATION

11.1 Advertising

The current Act contains a regulation making power over advertising. The restrictions on advertising in the Medical Practice Regulation 1998 are closely modelled on consumer protection legislation (ie the Trade Practices and Fair Trading Acts). The Regulation prohibits the advertisement of medical services which:

> "*(a) is false misleading or deceptive, or*
> *(b) creates an unjustified expectation of beneficial treatment, or*
> *(c) promotes the unnecessary or inappropriate use of medical services.*"

The prohibition applies to both corporations providing medical services and to individuals. Corporations advertising medical services are required to nominate a medical practitioner who is responsible for any advertising. The maximum penalty is $27,500. In addition, it is important to note that any breach of the regulation constitutes unsatisfactory professional conduct.

The Issues Paper sought submissions on whether the regulation making power should be deleted from the Medical Practice Act. If the power was deleted advertising would be controlled by the Trade Practices and Fair Trading Acts which prohibit misleading and deceptive conduct. It is noted with interest that as a result of recent amendments to the Trade Practices Act there is now scope for the introduction of enforceable industry codes of practice.

Restrictions on advertising can exacerbate the fundamental disparities in market information by denying consumers access to information about the availability, quality and price of services provided by competing practitioners. Restrictions can eliminate or constrain normal forms of competitive behaviour. Obviously the extent to which restrictions will impact on competition will depend on the precise terms of the regulation. It should be noted that the restrictions in the Medical Practice Regulation are very closely modeled on consumer protection legislation (ie the Trade Practices and Fair Trading Acts).

The Australian Competition and Consumer Commission in its submission to the review made the following points.

- Although advertising can contribute to the ability of consumers to make informed choices, the Commission does not *"support or condone an 'anything goes' approach to advertising in the medical sector"* nor advocate the dissemination of "*information that is inaccurate, misleading or deceptive. For example, the Commission would be concerned if medical practitioners incorrectly advertised that a certain procedure would provide results that are in fact unproven. This type of information does not promote competition and nor does it benefit patients*".

- The Commission's concerns in this area are focused on restrictions on advertising that extend beyond consumer protection legislation.

> *"[I]f medical professionals can demonstrate that additional restrictions on*

> *advertising are necessary to prevent undue risks to consumer welfare, and are therefore in the public interest, then they may have a case for the reintroduction of some (limited) restrictions. However a demonstrated case needs to be made for each example of concern."*[75]

Most submissions to the Issues Paper supported the retention of the power to regulate advertising under the Medical Practice Act.

Submissions in favour of the retention of the power to regulate advertising raised the following points.

- The Commission expressed the view that consumer protection legislation does not adequately protect the public and that advertising is not merely about the dissemination of information but is also:

  > *"inherently linked to the promotion of sales of a particular product or service, and this may be through the dissemination of information (or whatever quality or accuracy) or through the mere promotion in the public arena of the existence of a service or product without providing any information regarding its characteristics or uses."*[76]

- Standard of care issues are not considered in any prosecution of a complaint regarding misleading or deceptive advertising.[77]

- Consumer protection legislation is generally inaccessible to most health care consumers.

- As advertising becomes more popular and competition becomes stronger (particularly in areas like cosmetic surgery and laser eye surgery) there is a temptation to make claims for a procedure which are unjustified or do not present a balanced picture of a procedure.[78]

- Removal of the power to regulate advertising could have an adverse impact on the WorkCover scheme as it could allow medical practitioners to actively tout for business in the area of workers compensation and result in cost increases for the scheme. Removal of restrictions on advertising by lawyers had a significant cost impact on the scheme. [79]

- In an environment where there is a heavy dependence on government funding, the removal of the power to regulate advertising must result in more advertising which seeks to increase demand for services in one area which will have a negative overall impact on the total amount of funds available for other areas which may be less glamorous or marketable (eg treatment of major psychiatric illnesses).[80]

- *"Information asymmetry between consumers and providers of medical services renders consumers less able to assess claims made by health care providers. Education of consumers to overcome this information asymmetry is not a realistic option given the range and complexity of health services. NCOSS also considers it to be in the public interest to reduce the extent of over servicing or provision of*

inappropriate services".[81]

- *"False and misleading advertising by medical practitioners cannot be divorced from the delivery of health care. Medical advertising inherently occurs within the context of medical treatment and affects (or has the potential to affect) the health of a consumer. Maintaining high standards of medical advertising should therefore remain linked to monitoring professional health standards."*[82]

- The Medical Practice Act contains a broad range of sanctions which range from counselling to deregistration. The penalties which are provided for under the Fair Trading and Trade Practices Acts are numerous but do not include the power to order deregistration of a practitioner.

- *"The disciplinary bodies established under the MPA have strong representation by medical practitioners. This is appropriate where public health issues are under examination. This Department considers the conduct of health practitioners in relation to advertising and other matters is likely to have a public health dimension. Accordingly, medical bodies are better positioned to assess the health risks associated with such conduct, and continued regulation of medical advertising by medical bodies is supported."*[83]

A substantially smaller number of submissions advocated the dropping of the power to regulate advertising under the Medical Practice Act. The following points were raised.

- The Medical Practice Regulation duplicates consumer protection legislation which adequately protects the public.

- Restrictions on advertising are not rightly within the province of the Medical Practice Act and can be interpreted as entering an anti-competitive arena. An appropriate consumer information campaign could accompany the removal of the Board's jurisdiction in this area.[84]

- *"Given that complaints are rarely received by consumers, and more likely to be received from competitors, the Medical Board's involvement in business to business competition issues is not appropriate and suggests that it already plays little part in actual consumer protection."*[85]

- *"Removing advertising restrictions from the Act may encourage practitioners to more widely advertise their services and spend time and effort on advertising that provides consumers with the knowledge required to select a location, range of services and style of practice that suits their needs."*[86]

- The issue of professional standards which the Medical Board has an active role in maintaining and monitoring (through the registration, disciplinary and proposed performance assessment systems) is much broader in scope than the issue of advertising. Placing restrictions on advertising will not necessarily impact on the maintenance of professional standards.

On balance, the Department supports the Medical Board continuing to have a role in the area of advertising for the following reasons.

- The maintenance of high standards of advertising is fundamentally linked to high professional standards which is in the public interest. It can be said that medical advertising is one aspect of the overall issue of medical treatment. It is noted that breach of the advertising regulation is "unsatisfactory professional conduct" under the Act.

- The restrictions in the Medical Practice Regulation 1998 are closely modelled on consumer protection legislation and do not unduly restrict competition in the area of advertising. Their existence however sends a powerful message to practitioners that advertising is a professional matter which is of interest to the Board in view of its public protection function. In addition the range of sanctions available in a disciplinary context are more comprehensive than those under consumer protection legislation and include deregistration and the imposition of conditions on registration.

- Removal of the power to regulate advertising would mean that in circumstances where evidence was available of advertising that was false, misleading or deceptive and there was direct evidence of an adverse patient outcome that warranted disciplinary action, the matter would have to be dealt with in two different forums. In addition, the advertising issue would involve an assessment of the veracity of claims made. The Medical Board is well placed to undertake this task.

- The Medical Practice Regulation prohibits the advertising of medical services which "promote the unnecessary or inappropriate use of medical services". Without this restriction in place there would be greater scope for resources to be used unnecessarily, potentially at the expense of more beneficial uses.

The Medical Practice Act provides that a corporation that wishes to advertise medical services is required to nominate to the Board a medical practitioner who is to be responsible for advertising. Both that individual and the corporation can be proceeded against for any breach of the advertising requirements. Two submissions argued that persons eligible for this position should not be confined to medical practitioners. The Department notes however that as advertising is a professional matter, it is only appropriate that a medical practitioner against whom disciplinary action can be taken should be held accountable for the quality and content of the advertising of medical services.

11.2 Access to medical records

Another issue identified for consideration in the Issues Paper was whether the Medical Practice Act should be amended to give patients a right to access their medical records. Submissions were divided on the issue of whether a statutory right of access should be included in the Act. The Issues Paper noted that as a general rule patients in public hospitals, private hospitals, day procedure centres and nursing homes may already access their medical records.

Submissions from consumer groups expressed a particular interest in this issue. In addition to a right of access to a patient's own record, many advocated consumers being provided with information on what records exist about them, how they can be accessed, the process for correcting errors in a record and where they can go to have a practitioner's decision to refuse access to a record reviewed.

Only one submission from a professional body was supportive of patients having a right of access. The Royal Australian and New Zealand College of Psychiatrists expressed the view that patient access is a good idea but that sensitive aspects of a record should remain confidential in certain circumstances such as where access would put the safety of third parties at risk.

Most professional bodies did not support patients having a right of access to their medical records. Listed below are some of the reasons given.

- Access may be inappropriately used by a legal practitioner to build a case against a medical practitioner (ie fishing expedition).
- In some cases patients will need counselling and advice on the contents of notes and unrestricted access would not ensure that these support mechanisms are in place.
- With psychological and emotional problems unrestricted access could be harmful (eg child sexual abuse cases).
- Notes are an aide memoir only and remain the practitioner's intellectual property.

Although the inclusion of a right of access in the Medical Practice Act would ensure consistency of approach between the different sectors in which medical practitioners treat patients, the Department is of the view that the issue of access to records should be dealt with in a consistent manner for all professions. This is more appropriately considered separately from any review of legislation covering a particular profession.

11.3 Recovery of fees by medical practitioners

The Medical Practice Act currently provides that proceedings cannot be commenced for the recovery of fees for professional services until three months have expired since the bill was served personally or by post on the person to be charged with the amount. This provision would inhibit a registered medical practitioner's ability to recover the amount concerned in circumstances where there was evidence that the person charged would leave the jurisdiction before the expiry of the three months. No other health professional registration Acts in New South Wales contain restrictions on when a practitioner may commence proceedings for unpaid fees.

No submissions were able to identify a reason for the retention of the restriction on the recovery of fees. A number of submissions argued that the recovery of fees is a strictly commercial issue that is not relevant to professional standards and accordingly should not be dealt with in the Medical Practice Act. The only comparable provision (in the context of registered health professionals) which has been identified is section 12A(3) of the Dentists Act 1934 which was not carried over into the Dentists Act 1989

The Department supports the removal of the restrictions on when a practitioner is able to recover fees for services provided.

Recommendation 24

That the Medical Practice Act be amended to remove the restrictions on when practitioners may initiate proceedings to recover fees for services provided.

11.4 Mandatory disclosure of fees

The issue of whether the Medical Practice Act should be amended to compel practitioners to disclose their scale of fees to patients prior to commencing treatment was canvassed in the Issues Paper.

Several consumer groups have in submissions expressed the view that practitioners should provide as much information as is relevant to a consumer in relation to their treatment and care. An estimate of all costs associated with treatment is essential information for consumers and should be required to be provided in advance of treatment.[87]

Several submissions have put forward the contrary view.

> *"Mandatory disclosure of fees prior to a service would often be impossible due to various situations or complications incurred in the practice of medicine. Making disclosure mandatory would be likely to increase the level of proposed fees in order to cover contingencies. The Board's responsibility should be to protect the public from unsatisfactory practitioners, not to direct practitioners in the manner in which they run their practices."*[88]

One submission noted that a patient's clinical condition may be such that he or she is not in a position to comprehend a disclosure about fees before receiving treatment. That is a patient may be unconscious and in need of urgent medical attention in circumstances where the only health facility available is a private one.

The Code of Ethics of the Australian Medical Association is informative as it states that:

> *"Where possible, ensure that your patient is aware of your fees. Be prepared to discuss fees with your patient."*

It is also understood that medical practitioners who have been disqualified by the Health Insurance Commission are obliged to tell their patients that no Medicare benefit will be payable in respect of any services rendered.

Whilst the Department supports the concept of practitioners providing information to patients on the cost of any proposed care, it is appreciated that there may be practical difficulties with enforcing a duty to provide full fee disclosure to patients prior to the commencement of treatment and that this is not the only strategy for achieving the desired outcome. For example, this is an issue which could be addressed in a Code of Conduct which encourages practitioners to disclose their fees or through a publicity campaign directed at consumers which encourages them to be more proactive about such matters.

11.5 Access to information on the register

To date there have been few requests from consumers for information on the register. It is understood that the Medical Board has been responding positively to requests for the following types of information: names, qualifications that have given rise to an entitlement to registration, additional qualifications that are recorded in the register and general registration status. The Issues Paper canvassed whether other types of information like conditions imposed as a disciplinary or non-disciplinary process should be publicly available.

Before turning to discuss submissions on this issue, it should be noted that the Medical Board is bound by the Freedom of Information Act 1989. This means that there is a presumption in favour of the Board giving access to documents unless they fall within one of the categories of exempt documents which are set out in the Freedom of Information Act.

Submissions on the issue of consumer access to information on the register were divided with most professional bodies arguing that there should be no increase in the level of information which is made available to consumers.

Numerous consumer groups have advocated that with the exception of a practitioner's residential address, all other information should be accessible to the public.

> "*NCOSS finds it extraordinary that consumers do not at present have access to full information about a practitioner's history of disciplinary actions and their outcomes, or current conditions placed upon their registration and any evidence of non-compliance. NCOSS notes that competitive markets are premised upon full information being made available to consumers, and strongly argued that this barrier to consumers accessing information cannot be justified.*"

The Medical Board in its submission has expressed the view that:

> "*... conditions on registration should be available to members of the public in request, in keeping with the Board's public protection function. However, it does note that some conditions imposed as a result of impairment disclose confidential issues in relation to a practitioner's health which should not be of relevance to a member of the public. Although requests for information concerning conditions are very rarely received from members of the public, granting a statutory right to this information might be detrimental to the impairment program, and therefore in the longer term, to the public.*"

As has been noted above, both consumers and practitioners already have a right to seek access to information held by the Medical Board under the Freedom of Information Act. In this context and in the interests of balancing the public interest in consumers being able to access information on practitioners and any detriment to the impairment program which may be caused by impairment conditions being made available, the Department supports information on the orders of all disciplinary and impairment proceedings with the exception of impairment related conditions which have been recommended by an Impaired

Registrants Panel being readily publicly available.

Recommendation 25

That the Medical Practice Act be amended to clarify that orders of all disciplinary and impairment proceedings with the exception of impairment related conditions which have been recommended by an Impaired Registrants Panel should be publicly available.

12. RESTRICTIONS WHICH IMPACT ON THE PRACTICE OF UNREGISTERED PRACTITIONERS

12.1 Introduction

Unregistered persons are prohibited under the Medical Practice Act from holding themselves out to be registered medical practitioners. In addition, there are three other restrictions which impact directly on the practice of unregistered persons and can be viewed as anti-competitive.[89] Essentially, these restrictions prevent unregistered persons from:

- recovering fees for medical or surgical services they have provided;
- holding themselves out as qualified, willing or able to cure a range of specified diseases (eg AIDS, HIV, cancer, epilepsy); and
- providing cancer treatments for certain purposes.

Most submissions grouped the three restrictions together arguing that notwithstanding their anti-competitive effect, there are paramount considerations of public health which dictate the retention of the provisions. A number of submissions have even advocated the scope of the restrictions being increased.

Before turning to each of these restrictions it is important to note the broader regulatory environment in which these activities occur. As discussed previously, consumer protection legislation prohibits any provider of a service from engaging in false and misleading conduct. In addition, it should be noted that:

- the Health Care Complaints Commission has the power to investigate complaints about unregistered practitioners;
- the Poisons and Therapeutic Goods legislation limits access to certain drugs to medical practitioners; and
- the Public Health Regulation 1991 provides that unregistered persons (with the exception of dentists) must not carry out any procedures which penetrate the skin unless certain requirements the object of which is to avoid infection are met.

12.2 Recovery of fees

This restriction prevents unregistered persons from initiating legal proceedings to recover fees for medical and surgical services. The Department has identified a number of concerns with this restriction.

- The Medical Practice Act already prohibits unregistered persons from holding themselves out to be medical practitioners.

- The provision does not prohibit unregistered persons from charging for medical and surgical services per se but prohibits them from initiating legal proceedings to recover fees for services rendered.

- The scope of the provision would appear to be somewhat imprecise as the terms "medical and surgical" are not defined in the Act.

No submissions have identified with any precision how this restriction protects the public. On balance, the Department supports the removal of this restriction from the Medical Practice Act.

12.3 Prohibition on advertising cures for a range of diseases and treating cancer

Whilst there is a prohibition in the Act on advertising cures for a range of diseases, it does not preclude unregistered persons from treating people with one of the specified diseases but simply prohibits them from advertising that they can cure a person so afflicted. The majority of these diseases can be classified as ones for which there is no generally accepted cure.(eg HIV, AIDS, epilepsy) It is interesting to note that the prohibition does not apply to medical practitioners.

There is also a provision in the Act which is more restrictive than the prohibition on advertising cures for certain diseases. This provision prohibits an unregistered person from giving a person a substance which it is claimed is likely to prevent cancer or have curative or alleviating powers in the treatment of cancer.

This restriction seems to purport to exclude unregistered practitioners from providing treatment to people with cancer. Several submissions have noted that alternative practitioners can be of benefit to those who are suffering from cancer.(eg naturopaths, herbalists, aromatherapists, acupuncturists) Again, this restriction impedes the development of new and innovative services which may be of assistance to patients with the specified conditions and limits consumer choice.

The rationale for the provisions according to the Australian Medical Association is

> "*One must accept that the diseases/conditions mentioned within the Act at the moment would involve perhaps the most vulnerable group of patients in the community. Their vulnerability must be protected at law from unscrupulous purveyors of "quick cures". The AMA would strongly promote that the current section be extended to preclude unregistered persons from treating patients for one of the specified diseases mentioned within the Act.*"

The Medical Board in its submission has expressed a different view.

> "*... it was inappropriate for it [the Board] to attempt to police the activities of unregistered persons offering to provide health care, provided that they do not purport to be registered medical practitioners when they do so. It [the Board] did not believe there is any justification for expanding its jurisdiction in relation to alternative therapy.*
>
> *Its [the Board] experience in seeking to enforce the provisions of section 108 and 109 has been singularly unsuccessful, even where serious consequences including death have resulted from the unregistered person's activities.* This has been due to a number of factors, including evidentiary *and burden of proof issues arising when matters are pursued in the local courts.*"

Several submissions have argued that the current restrictions prevent the development of new and innovative services which may be of assistance to patients with the specified conditions.

If the restrictions were removed, the following regulatory framework would apply.

- Consumer protection legislation would continue to prohibit claims about a product or service which are misleading and deceptive.
- All unregistered practitioners would continue to be prohibited from holding themselves out to be medical practitioners.
- The Health Care Complaints Commission would be able to investigate the activities of unregistered practitioners.
- Controls on access to certain drugs under Poisons and Therapeutic Goods legislation and in the area of skin penetration under the Public Health Regulation would continue to apply.

On balance, the Department considers that the current restrictions do not provide more effective protection for consumers than that offered by the above regulatory framework. The provisions are difficult to enforce and represent a piecemeal approach to the regulation of unregistered practitioners. The Department therefore recommends their removal.

The Department is currently considering the issue of the development of an effective framework for minimum standards for the conduct and safety of alternative practitioners under the auspices of the Australian Health Ministers Council. A number of factors are informing that process including the Council of Australian Governments "Principles and Guidelines for National Standard Setting and Regulatory Action by Ministerial Councils and Standard-Setting Bodies".

Recommendation 26

That the current restrictions:
(i) on recovering fees for medical or surgical services;
(ii) advertising cures for a range of diseases; and
(iii) providing cancer treatments,
be removed from the Medical Practice Act.

13. ADMINISTRATION OF THE MEDICAL PRACTICE ACT

13.1 Application of the Anti-Discrimination Act

The Committee which reviewed practices for the employment of medical practitioners in the NSW Health System has proposed that

> "*To acknowledge the social and cultural diversity of New South Wales, the State's Medical Practice Act should be amended to require the NSW Medical Board, and any other bodies operating under the Act, to conform in their policies and processes with the requirements of the New South Wales Anti-Discrimination Act.*"

There is available the view that the Anti-Discrimination Act already applies to the policies of the Medical Board which is the only administrative body established under the Medical Practice Act.[90] The Department proposes that this recommendation be the subject of further consultation with interested groups.

13.2 Ministerial direction

The Committee which reviewed practices for the employment of medical practitioners in the NSW Health System has proposed that:

> "*[T]he New South Wales Minister for Health should be given legislative power to direct the Board on matters of policy, but this power should not include issuing directions on matters pertaining to the registration of individual medical practitioners or the setting of medical standards.*"

In relation to the proposal for the Minister for Health to have a statutory power to direct the Board on matters of policy, it should be noted that this type of control in a health professional registration Act is not unprecedented. Under the Nurses Act 1991, the Nurses Registration Board is subject to the direction and control of the Minister. The Department recommends that this proposal be the subject of further consultation with interested stakeholders.

13.3 Confidentiality and protection from disclosure

Currently, the only documents which cannot be compelled to be produced to a court in civil proceedings are reports made by an Impaired Registrants Panel to the Medical Board. The Issues Paper canvassed whether there is adequate protection from disclosure for other documentation in civil proceedings.

Under section 30 of the Health Care Complaints Act 1993 expert reports obtained as part of the investigation of a complaint may only be used in disciplinary or related proceedings under a health registration Act and in other legal proceedings where the person who gave the report, the complainant and the person against whom the complaint is made agree.

In the interests of protecting "*the supply of expert reports and the candour with which opinions are expressed*"[91] , the Department supports all medical reports which have been prepared at the request of the Board or pursuant to an order of a Professional Standards Committee or the Medical Tribunal being afforded the same protections which are currently

afforded to reports made by Impaired Registrants Panels.

Recommendation 27

That the Medical Practice Act be amended to give all medical reports which have been prepared at the request of the Board or pursuant to an order of a Professional Standards Committee or the Medical Tribunal the same protections which are currently given to reports of Impaired Registrants Panels.

13.4 Composition of the Medical Board

The Medical Practice Act provides that there are to be 18 members on the Medical Board of which:

- 1 is a medical practitioner who is an officer of the Department of Health or the public health system;
- 1 barrister or solicitor;
- 2 medical practitioners nominated by the N.S.W. Branch of the Australian Medical Association;
- 1 medical practitioner nominated by the Ethnic Affairs Commission;
- 1 medical practitioner jointly nominated by Sydney, N.S.W. and Newcastle Universities;
- 8 medical practitioners are nominated by Colleges; and
- 4 persons nominated by the Minister not less than 2 of whom are to be persons who are conversant with the interests of patients as consumers of medical services.

It is understood that the Board has worked very hard to ensure that all Board members understand that they have been nominated by their respective organisation but do not represent them. That is, Board members must act in the interests of the Board.

Submissions on the composition of the Board have suggested the following changes:

- the Royal Australian College of Medical Administrators should be removed; and
- the number of nominees of the Australian Medical Association should be reduced from two.[92]

Other suggestions for improving the composition of the Board that have been made include student representation and greater community representation.

Given the current size of the Board, the Department is of the view that it should not be increased and any change in composition should be accommodated within the overall size of the Board. The Department supports an increase in the number of members conversant with consumer interests and recommends consideration be given to all four persons nominated by the Minister being conversant with consumer interests.

The Committee which reviewed practices for the employment of medical practitioners in the NSW Health System has proposed the following amendments to the composition of the Medical Board.

- The registered medical practitioner nominated by the Ethnic Affairs Commission should be replaced with the Chair of the Ethnic Affairs Commission or his/her nominee.

- The President of the Anti-Discrimination Board or his/her nominee should have a position on the Board.[93]

- Minister should nominate one representative of overseas trained doctors.

The Department recommends that further consultation be undertaken with interested stakeholders on the Committee's proposals.

13.5 Terms of Board members

The Medical Practice Act provides that a person may not hold office as a Board member for consecutive terms totaling more than 12 years. Comments were sought on whether the current arrangement achieves the right balance of retaining expertise and adding new members who can bring fresh views to Board deliberations. Although very few submissions addressed this issue, those that did tended to favour a reduction in the number of years a person may serve from 12 to 8 years on the ground that it would "freshen the views of the organisation".[94]

On balance, the Department considers that by reducing the number of years a person may serve from 12 to 8 years, the Board's ability to benefit from fresh perspectives that new members can bring to an organisation would be enhanced but at the same time provide sufficient scope for the retention of the corporate memory of the organisation. Accordingly, the Department supports this proposal.

Recommendation 28

That the Medical Practice Act be amended to provide that a person may not hold office as a member of the Board for consecutive terms totalling more than eight years.

13.6 Appointment of President and Deputy-President

Currently the President and the Deputy President of the Board are selected by the Minister and appointed by the Governor. The Issues Paper canvassed whether the two positions should be elected by Board members.

Very few submissions have addressed this issue. Given the concern which has been raised that an election may result in factionalism within the Board and inappropriate campaigning and that no submissions have identified how this proposal will further protect the public, it is not supported by the Department.

The Committee which reviewed the practices for the employment of medical practitioners in the NSW Health System has proposed that the Medical Board should have:

> *"An independent chairperson, to ensure consistency of approach and total independence. Ideally, the person should not be a member of any decision making*

body in the medical profession associated with education, registration, assessment and the medica workforce. Consideration should be given to a member of the judiciary being the chairperson."

As this proposal has not been the subject of consultation, the Department recommends that it be the subject of further discussion with interested groups.

13.7 Fines

The Issues Paper canvassed whether the Medical Board should have the power to withhold registration where fines are overdue.

Very few submissions addressed this issue. Those that did focused on the fact that the Medical Board is not without redress when practitioners fail to pay their fines by the due date. The Medical Board is able to initiate proceedings for the monies owing.

The Department does not support giving the Medical Board the power to withhold registration when fines are overdue.

13.8 Offences by corporations

The Medical Practice Act provides that where a corporation contravenes a provision of the Act or regulation each person who is a director of the corporation or person concerned in the management of the corporation is taken to have contravened the same provision if the *"person knowingly authorised or permitted the contravention"*.[95]

It has been suggested to the Department that it is very difficult to prosecute a director or person concerned in the management of a corporation because a court must be satisfied that the person "knowingly authorised or permitted the contravention". A different approach has been taken to the concept of corporate responsibility in the Tobacco Advertising Prohibition Act 1991. That Act provides that when a body corporate commits an offence every director and person who takes part in the management of the body corporate is taken to have committed the same offence unless he or she proves that:

- the offence was committed without his or her consent or connivance; and
- he or she exercised all such due diligence to prevent the commission of that offence as he or she ought to have exercised, having regard to the nature of his or her functions in that capacity and to all the circumstances.

The Department supports the provision in the Medical Practice Act concerning offences by corporations being amended to make it consistent with the Tobacco Advertising Prohibition Act 1991 to ensure that directors and those involved in the management of corporations can be held accountable for contraventions of the Medical Practice Act and the regulation.

Recommendation 29

That the Medical Practice Act be amended to provide that when a body corporate commits an offence, every director and person who takes part in the management of a body corporate is taken to have committed the same offence unless he or she proves that:

- the offence was committed without his or her consent of connivance; and
- he or she exercised all such due diligence to prevent the commission of that offence as he or she ought to have exercised, having regard to the nature of his or her functions in that capacity and to all the circumstances.

13.9 Staff of the Board

The Medical Practice Act currently provides that the Board may with the concurrence of the Health Administration Corporation (which is the Director-General of the Department of Health) fix the salaries, wages, allowances and conditions of employment of the Board's staff in so far as they are not fixed by or under another Act or law.

The Medical Board is one of the three registration boards that operate independently of the Health Administration Corporation which employs the staff of the remaining health professional registration boards. The other two registration boards which operate independently are the Dental and Pharmacy Boards. They are similarly required to obtain the concurrence of the Corporation to fix salaries and conditions of employment.

The Department considers that in view of the fact that the Medical Board is a public sector organisation there is a public interest in the Health Administration Corporation continuing to play a role in determining the salaries and conditions of Board staff.

14. OTHER ISSUES

14.1 Post Graduate Medical Council

The Post Graduate Medical Council was established in 1988 by the then Minister for Health. Its objective is to ensure that medical graduates meet agreed minimum standards of safety, clinical skill and professional competence over the first two years of their postgraduate medical training. Specifically, it is responsible for intern and junior medical resident education and training, accrediting training positions for junior doctors and for the allocation of interns to training posts with public hospitals in NSW. It is understood that the Post Graduate Medical Council is principally funded by the Department of Health.

The Health Administration Act provides that the Minister for Health may have constituted such councils, committees and advisory bodies as he or she may consider appropriate. The Minister is responsible for determining the terms of reference and the membership of such bodies.

The Department considers that this mechanism under the Health Administration Act provides sufficient scope for recognising the activities of the Post Graduate Medical Council.

14.2 Professional indemnity insurance

A number of submissions have acknowledged that although professional indemnity insurance if made a condition of registration would be anti-competitive, there would be significant public benefits as consumers would be able to obtain compensation for injury caused by a practitioner.[96]

This Department is currently considering in conjunction with the Attorney-General's Department a range of issues concerning health professional indemnity.

14.3 Deregistration of certain foreign practitioners

There are provisions in the Medical Practice Act which enabled the Medical Board to conduct an audit of the register in 1993 to remove from the names of certain overseas trained practitioners who had not shown a commitment to live and practise in Australia for prescribed periods ending in 1992. It is important to note that deregistration was based on a failure to practise in Australia and was not based on competence. The Medical Board has advised that it will not be auditing its register again.

The only practitioners to whom the provisions continue to apply are those who would have been deregistered because they prima facie met the requirements for deregistration but whose registration had already lapsed due to the non-payment of fees at the time the Medical Board did its audit. That is, the names of these practitioners were not on the register at the time of the audit in 1993 and therefore could not be removed.

With the passage of time since the audit, the Department considers the likelihood of practitioners seeking to re-register after so many years is remote and accordingly the provisions should be deleted.

Recommendation 30

That Part 3 of Schedule 5 of the Medical Practice Act be deleted.

14.4 National Board

Several submissions have suggested that there should be a national board for registering medical practitioners. In a climate where practitioners are becoming increasingly mobile, the Department can see some benefit in a consistent approach being taken in registration matters throughout the country. Any progressing of a national board would need to take place at a Commonwealth/State level and it is arguable that the development of mutual recognition over recent years achieves this consistency.

FOOTNOTES

1.N.S.W. Department of Health, Profile of the Medical Workforce in N.S.W., 1996.

2.Submission - N.S.W. Medical Board

3.Submission - Australian Association of Surgeons

4.Appendix C, Issues Paper on the Medical Practice Act 1992, September 1998

5.See 2.3

6.Submission - New South Wales Medical Board

7.Submission - Health Care Complaints Commission

8.Submission - Australian Competition and Consumer Commission

9.Submission - Australian Competition and Consumer Commission

10.Submission - Royal Australasian College of Physicians

11.Submission - N.S.W. Medical Board

12.Submission - Health Care Complaints Commission

13.Submission - N.S.W. Medical Board

14.Submission - Health Care Complaints Commission

15.Submission - N.S.W. Medical Board

16.Submission - N.S.W. Medical Board

17.Submission - Royal Australasian College of Physicians

18.Submission - N.S.W. Medical Board

19.Submission - Health Care Complaints Commission

20.Submission - United Medical Protection

21.Submission - Royal Australasian College of Surgeons

22.Submission - Health Care Complaints Commission

23.Section 15 of the Medical Practice Act

24.Submission - Health Care Complaints Commission

25.V. Waymouth, Deputy Registrar, College of Physicians and Surgeon of British Columbia

26.Submission - Health Care Complaints Commission

27.Submission - NSW Medical Board

28.See also 8.2.8

29.Submissions - United Medical Protection and Royal Australasian College of Surgeons

30.Submission - Australian Medical Association

31.Mental Health Act (performance of special medical treatment), Children (Care and Protection) Act (performance of special medical treatment), Guardianship Act (performance of special medical treatment), Private Hospitals and Day Procedure Centres Act (disclosure of pecuniary interests), Nursing Homes Act (disclosure of pecuniary interests) and Health Insurance Act (disclosure of pecuniary interests)

32.See Health Care Complaints Commission v Litchfield

33.Submission - Australian Association of Surgeon

34.Submission - Health Care Complaints Commission

35.1998 Report of the Ministerial Committee of Inquiry into Impotency Treatment Services in N.S.W.

36.Submission - Australian Medical Association

37.Submission - Australian Medical Association

38.Submission - Australian Association of Surgeons

39.Submission - Health Care Complaints Commission

40.Submission - Council on the Ageing

41.Dr J Vinen, Head, Department of Emergency Medicine, Royal North Shore Hospital

42.Mr B Mewes, Pharmaceutical Services Branch

43.Submission - Health Care Complaints Commission

44.The issue of recorded and unrecorded convictions is discussed in 5.6

45.Submission - Council on the Ageing

46.Section 66, Medical Practice Act 1992

47.Section 99, Health Services Act 1997

48.Health Care Complaints Commission v Bruce Litchfield, Clyne v NSW Bar Association (1960) 104 CLR 186, NSW Bar Association v Evatt (1968) 117 CLR 177

49.See 7.4

50.Submission - Health Care Complaints Commission

51.Submission - Health Care Complaints Commission

52.Submission - United Medical Protection

53.Submission - United Medical Protection

54.Submission - Health Care Complaints Commission

55.Health Care Complaints Commission v Bruce Litchfield, Clyne v NSW Bar Association (1960) 104 CLR 186, NSW Bar Association v Evatt (1968) 117 CLR 177

56.Submission - Health Care Complaints Commission

57.(1987) 11 NSWLR 51 at 61

58.Submission - Health Care Complaints Commission

59.Submission - Health Care Complaints Commission

60.Unreported, 23 April 1991

61.Submission - United Medical Protection

62.Bowen-James v Walton, NSW CA, unreported, 5 August 1991

63.Submission - Health Care Complaints Commission

64.Submission -Northern Rivers Area Health Service

65.Submission - NSW Medical Board

66.Submission - Australian Medical Association

67.Submission - Health Care Complaints Commission

68.Submission - United Medical Protection

69.Ex part Evatt; Re N.S.W. Bar Association (1969) 71 SR 158

70.Rohatgi v Health Care Complaints Commission, Court of Appeal, unreported, 26 July 1996

71.Submission - Health Care Complaints Commission

72.Medical Journal of Australia Vol 169, 1998

73.Submission - Royal Australian and New Zealand College of Psychiatrists

74.The only regulation of corporations in the Medical Practice Act is in the area of advertising and medical record keeping.

75.Submission - Australian Competition and Consumer Commission

76.Submission - Health Care Complaints Commission

77.Submission - Health Care Complaints Commission

78.Submission - Australian Plaintiff Lawyers Association

79.Submission - WorkCover

80.Submission - Royal Australasian College of Physicians

81.Submission - NCOSS

82.Submission - Department of Fair Trading

83.Submission - Department of Fair Trading

84.Submission - Royal Australian and New Zealand College of Psychiatrists

85.Submission - Pacific Medical Centres Pty Limited

86.Submission - Pacific Medical Centres Pty Limited

87.Submission - Health Care Complaints Commission

88.Submission - Australian Association of Surgeons

89.These restrictions do not apply to ambulance officers or other registered health professionals.

90.Although the Medical Practice Act also the Medical Tribunal and Professional Standards Committees those are disciplinary bodies of a quasi judicial nature. The Medical Board is responsible for formulating policies and considering applications for registration.

91.Second Reading Speech for the Health Care Complaints Bill, 28 October 1993

92.Submission - Health Care Complaints Commission

93.Submission - Ethnic Affairs Commission

94.Submission - New South Wales College of Nursing

95.Section 187, Medical Practice Act

96.Submission - NCOSS