

Bioethical issues

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EMBRACING THE NEW PROFESSIONALISM: SELF-REGULATION, MANDATORY REPORTING AND THEIR DISCONTENTS

In response to perceived failures in medical self-regulation in Australia, first in two States (for doctors) and now under the National Registration and Accreditation Scheme (for all health practitioners), mandatory reporting of peer status or practice that poses risks to patients has been introduced. Yet now, in response to the lobbying of State and federal health ministers by the medical profession, mainly in relation to the impairment provisions, this is to be reviewed. This column argues that claims concerning the negative consequences for practitioners of mandatory reporting are illogical and lack supporting evidence. There is, however, evidence that the medical profession does not consistently act in accordance with its professed positions in the area of physician impairment and departure from accepted clinical standards. The call for a review of mandatory reporting reflects an outdated model of regulation that does not align with increasing calls for a "new professionalism". In its own interests, but primarily in the interests of patients, the medical profession should embrace new attitudes and practices that will at first appear to threaten the privilege of self-regulation, but on proper scrutiny will be seen as necessary to retain it.

INTRODUCTION

In one of *Aesop's Fables*, the blasting wind fails to remove the passing traveller's coat, while the patient sun has it off within minutes, and with little apparent effort. Brute force is no competition for gentle persuasion.¹ Like the traveller, the Australian polity recently refused to risk further exposure to errant and impaired doctors, despite efforts of members of the profession, particularly the Australian Medical Association (AMA), to prevent the introduction of mandatory reporting of practice that threatens patient safety. The legal regime was embraced as part of the National Registration and Accreditation Scheme for health professionals (the National Scheme), implemented from 1 July 2010.

In November 2010, a mere five months after their introduction, it was announced that the mandatory reporting requirements of the National Scheme were to be reviewed by an independent body commissioned by the Australian Health Ministers Advisory Council (AHMAC), at the behest of State and federal health ministers.² This appears to have been motivated mainly by claims from the profession that mandatory reporting causes impaired doctors to avoid seeking medical care for fear of being reported.³ The president of the federal AMA stated that it was the long-term view of the association that the issues health practitioners become aware of in the course of providing health services to other practitioners or medical students should be exempt from mandatory reporting. He said:

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¹ University of Massachusetts at Amherst, *Aesop's Fables: The Wind and the Sun*, <http://www.umass.edu/aesop/fable.php?n=31> viewed 28 October 2010.

² Brettingham-Moore C, "Mandatory Reporting Laws to be Reviewed", *Medical Observer* (15 November 2010), <http://www.medicalobserver.com.au/news/mandatory-reporting-laws-to-be-reviewed> viewed 15 November 2010.

³ Australian Medical Association (Qld), "Health Professionals' Right to Confidential Health Treatment", *Media Release* (11 November 2010), <http://www.amaq.com.au/index.php?action=view&view=82939> viewed 20 November 2010.

The AMA has been concerned about the potential impact that mandatory reporting will have on the medical workforce, particularly because the current requirements to report are very broad. All State and Territory AMAs have lobbied State and Territory Governments to include mandatory reporting exemptions for treating doctors in the national registration scheme. The Parliament of Western Australia has understood the issue and has included the exemption in its State law. The other jurisdictions must now also make the amendments quickly so that the national scheme remains truly national. Doctors' health advisory services are reporting that, since mandatory reporting laws came into effect under the national registration scheme on 1 July 2010, the number of doctors seeking treatment has been falling. These reports reinforce the AMA's concerns that mandatory reporting laws will deter doctors from seeking health care when they need it.⁴

The outcome of the AHMAC review will have significant implications for health practitioners and patients. This column analyses some of the claims and counterclaims that the review should take into account. These go to the relationships between internal and external regulation of the health professions, and the authority and power of the professions. It argues that mandatory reporting was an inevitable political response to failures by the health professions (chiefly medicine) to adequately self-regulate, and that lobbying by the health professions (again, chiefly medicine) to wind back mandatory reporting provisions are supported by neither good arguments nor good evidence. It offers some alternative suggestions for the professions' approach to self-regulation in this area.

MANDATORY REPORTING: GESTATION AND BIRTH

The idea and practice of a fully self-regulated medical profession have been weakening for the past 200 years, but in the past three to four decades the process has accelerated. Against a broad background of recent social change that includes a general erosion of traditional authorities, the increasing availability of education, and broad rights claims (including health rights), the autonomy of the medical profession and the authority of the clinician have been steadily, albeit far from completely, eroded. Social attitudes, legislation and the common law have responded to dissatisfaction with medical paternalism, rank-closing and resistance to change.⁵ These developments were reinforced by the widely publicised failures of clinical competence and self-regulatory responses such as the New Zealand cervical cancer case,⁶ the Bristol Infirmary case,⁷ and an unfortunate Australian series of "whistle-blowing sagas",⁸ among others. For Australia, the cases of doctors Reeves and Patel (as indicated below) signalled the tipping point for public and political tolerance of self-regulatory failure. Yet by the 2000s, self-regulation remained a significant enough element of overall medical regulation to make the proposed introduction of mandatory reporting laws appear as another threat to the profession's independence, in the eyes of the AMA and individual commentators.

Reporting of substandard or potentially harmful practice by medical peers has been mandated in a minority of States in the United States of America for varying times.⁹ New Zealand moved towards a mandatory reporting model in the early 2000s, following recommendations by the Cull Inquiry, which found, among other things, that doctors had a general tendency not to report their colleagues whose performance was substandard.¹⁰ Reform was strongly resisted by the New Zealand Medical Association (NZMA), among other bodies, and this resulted in making reporting discretionary, rather

⁴ Australian Medical Association, *Good First Step But Health Ministers Must Do More on Mandatory Reporting Laws* (12 November 2010), <http://www.ama.com.au/node/6200> viewed 16 November 2010.

⁵ Freckelton I, *Regulating Health Practitioners* (Federation Press, Sydney, 2006).

⁶ Cartwright S, *The Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters 1988* (Government Printing Office, Auckland, 1988), <http://www.moh.govt.nz/moh.nsf/indexmhl/cartwright-inquiry> viewed 15 November 2010.

⁷ Bristol Royal Infirmary Inquiry, *Final Report* (2001), http://www.bristol-inquiry.org.uk/final_report/index.htm viewed 15 November 2010.

⁸ Faunce T and Bolsin S, "Three Australian Whistle-blowing Sagas: Lessons for Internal and External Regulation" (2004) 181 MJA 44.

⁹ Arnold P, "Mandatory Reporting of Professional Incompetence" (2008) 189 MJA 132.

¹⁰ Cull H QC, *Review of Processes Concerning Adverse Medical Events* (March 2001) (Cull Inquiry) pp 15, 75-76, <http://www.moh.govt.nz/moh.nsf/0/9565e9869641cd26cc256a1d0074172b?OpenDocument> viewed 15 November 2010.

than mandatory, under the *Health Practitioners Competence Assurance Act 2003* (NZ), which applies to all health practitioners, not just doctors.¹¹ Interestingly, unlike the current situation in Australia, the NZMA did not oppose the mandatory reporting of impaired practitioners during its lobbying in relation to the proposed Act. It was also argued at the time that the combination of the new legislation and New Zealand's *Code of Health and Disability Services Consumers' Rights*¹² meant that there would, in practice, be a legal obligation on medical practitioners to report colleagues who practise below an acceptable standard.¹³

New South Wales¹⁴ and Queensland¹⁵ legislated in 2008 and 2009 respectively to introduce mandatory reporting by medical practitioners, of peers they believed to have practised unprofessionally or incompetently. These statutes were prompted in the short term by the cases of Graham Reeves and Jayant Patel, and the reports of inquiries¹⁶ into their activities.¹⁷ But they were soon made redundant by the legislation, enacted in Queensland,¹⁸ that governs the introduction of the National Scheme for most health practitioners across Australia.¹⁹

Under the *Health Practitioner Regulation National Law Act 2009* (Qld) (the National Law), notifiable conduct by a practitioner, which must be reported to the Medical Board of Australia by another practitioner (of any health profession, not just that of the first practitioner) who has formed a reasonable belief that it has occurred, means the first practitioner has

- (a) practised the practitioner's profession while intoxicated by alcohol or drugs; or
- (b) engaged in sexual misconduct in connection with the practice of the practitioner's profession; or
- (c) placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or
- (d) placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.²⁰

¹¹ Jackson K and Parker M, "Full Steam Ahead on the SS 'External Regulator'? Mandatory Reporting, Professional Independence, Self-regulation and Patient Harm" in "Bioethical Issues" (2009) 17 JLM 29 at 30-33.

¹² New Zealand Health and Disability Commissioner, *The Code of Rights*, <http://www.hdc.org.nz/the-act--code/the-code-of-rights> viewed 29 November 2010.

¹³ Coates J, "Removal of the Mandatory Reporting Provisions – Only a Pyrrhic Victory?" (2002) 115 NZMJ 187.

¹⁴ *Medical Practice Amendment Act 2008* (NSW).

¹⁵ *Health and Other Legislation Amendment Act 2009* (Qld).

¹⁶ Garling P SC, *First Report of the Special Commission of Inquiry – Inquiry into the Circumstances of the Appointment of Graeme Reeves by the Former Southern Area Health Service* (31 July 2008) (Garling Report), http://www.healthactionplan.nsw.gov.au/files/garling-report/FirstGarling_Report.pdf viewed 15 November 2010; Queensland Public Hospitals Commission of Inquiry, *Final Report* (2005) (Davies Report), <http://www.qphci.qld.gov.au/default.htm> viewed 15 November 2010.

¹⁷ Jackson and Parker, n 11 at 33-40.

¹⁸ *Health Practitioner Regulation National Law Act 2009* (Qld).

¹⁹ Arrangements in New South Wales for the implementation of the National Registration Scheme are different from the other States. The *Health Practitioner Regulation (Adoption of National Law) Act 2009* (NSW) gives effect in New South Wales to the scheme, and the *Health Practitioner Regulation Amendment Act 2010* (NSW) amends various statutes to complement the scheme. It provides for the Health Care Complaints Commission to retain its role and functions, particularly the investigation and prosecution of serious complaints about health practitioners. National Boards, including the Medical Board of Australia, act as co-regulators with the Health Care Complaints Commission in handling complaints. The current New South Wales definitions for "unsatisfactory professional conduct" and "professional misconduct" will remain applicable, and these differ from definitions used under the National Law. In New South Wales, "unsatisfactory professional conduct" is "any conduct that demonstrates that the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience". "Professional misconduct" is defined 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". See New South Wales Government, Health Care Complaints Commission, *The National Registration Scheme for Health Practitioners* (2010), <http://www.hccc.nsw.gov.au/Information/Information-For-Health-Providers/National-Registration-Scheme/default.aspx> viewed 26 November 2010. See generally Freckleton I, "Regulation of Health Practitioners: National Reform in Australia" (2010) 18 JLM 207 (Editorial).

²⁰ *Health Practitioner Regulation National Law Act 2009* (Qld), s 140.

The risk of *substantial* harm posed by a practitioner's impairment, and the risk of harm posed by a practitioner's *significant* departure from accepted professional standards, are key concepts in considerations for and against mandatory reporting. While the National Law governs all traditionally regulated health professions, the focus in what follows here is on medicine, since this profession has been the most vocal in opposing mandatory reporting, before and after the legislation was enacted.²¹

MANDATORY REPORTING AND ITS DISCONTENTS

No individual or group likes to accept blame when things go wrong. But societies have demonstrated that they are prepared to extend privileges to groups only if they abide by the terms of the contract established with the polity. For example, in the mid-19th century, when the American Medical Association was founded, physicians had to offer to establish and maintain high standards of competence and conduct in order to regain their high social status, which had fallen into significant disrepute during the first half of the century.²² It was not surprising that the State governments of New South Wales and Queensland enacted mandatory reporting legislation in response to perceptions that the medical profession was not prepared to act in response to gross incompetence and misconduct in the cases of Reeves and Patel. While other individuals and government bureaucracies were also criticised for failing the public in these instances, self-regulation must be seen as having failed, if even such gross irregularities as demonstrated in these cases are ignored.

Consultation in relation to the draft National Law helped streamline its final provisions. The importance of distinguishing between illness/disability and impairment, with the latter implying the existence of a risk to patients,²³ was not emphasised in the draft,²⁴ but the impairment-harm link was included in the Act, as necessary to trigger a report. At the 2009 Forum of the Medical Indemnity Industry Association of Australia, the association's submission to exempt medical practitioners working for indemnity groups from mandatory reporting was confirmed.²⁵ At the same forum, it was submitted that doctors with health problems would be driven away from seeking health care by the failure to exempt treating doctors from mandatory reporting of their patients. The exemption was not included in the National Law, but the notification trigger in cases of impairment was made a "risk of *substantial* harm" (emphasis added).

Subsequent to the commencement of the National Scheme, there has been further agitation for the treating doctor exemption, on the basis that the number of doctors seeking help from doctors' health advisory services has fallen from previous levels, and claims that "doctors most in need of help are now far less likely to present themselves for treatment".²⁶ At a recent Royal Australian College of General Practitioners conference, a medical indemnity organisation representative was reported to have labelled the mandatory reporting laws a disgrace, because doctors' health was put at risk by their deterrent effect.²⁷ As noted above, the AMA also reports that since mandatory reporting laws came into effect, the number of doctors seeking treatment has been falling, and has claimed a deterrent causal link between mandatory reporting and this decline.

In terms of the practice standards component of notifiable conduct, consistent lobbying had strengthened the trigger for reporting under the New South Wales legislation to a "*flagrant* departure

²¹ For a recent article on mandatory reporting written from the perspective of nursing practice see Kochardy M, "Impairing the Practice of Nursing: Implications of Mandatory Notification on Overseas-trained Nurses in Australia" (2010) 17 JLM 708.

²² Jonsen A, *A Short History of Medical Ethics* (Oxford University Press, Oxford, 2000) pp 63-79.

²³ Reid A, "Overview: The Experience of the New South Wales Medical Board" (2002) 177 MJA S25.

²⁴ Breen K, "National Registration Legislative Proposals Need More Work and More Time" (2009) 191 MJA 464.

²⁵ Medical Indemnity Industry Association of Australia, "MIIAA Forum 2009" (2009) 15 *Newsletter* 2, <http://www.miaa.com.au/files/f/897/MIIAA%20September%202009%20Newsletter.pdf> viewed 16 November 2010.

²⁶ Phelps K, "Mandatory Reporting Erodes Doctors' Rights", *Medical Observer* (2010), <http://www.medicalobserver.com.au/blog/194> viewed 16 November 2010.

²⁷ East M, "Doctors' Health at Risk with New Laws" (22 October 2010) *Australian Doctor* 4.

from accepted standards of professional practice",²⁸ and the trigger in Queensland to practice that "significantly departs from accepted standards of the profession"²⁹ (emphases added). In the current author's view, these were reasonable qualifications of the draft provisions in the two States; without them, a flood of notifications might have been expected. The National Law also requires "a significant departure from accepted professional standards" as the notification trigger (emphasis added).

But some pre-July 2010 lobbying argued that the professional standards requirements were not necessary at all. This stronger position was based such claims as the "profession has a high level of integrity",³⁰ and "existing codes of professional conduct applicable to the medical profession throughout Australia, are perfectly robust and functional".³¹ This mirrored claims made to resist the previous legislative moves in New South Wales and Queensland. For example, the AMA in Queensland had argued that the legislation was unnecessary because of existing ethical obligations, and the lack of evidence that legal compulsion would improve reporting.³² And since July 2010, it has been suggested that the mandatory reporting regime may promote "vexatious reporting by doctors with an axe to grind against a colleague".³³

MANDATORY REPORTING: IGNORANCE, SELECTIVE INTERPRETATION, OBFUSCATION?

What sense can we make of these various claims? What do they tell us about the relationships between internal regulation (self-regulation) and external regulation (in this case, the National Law) of the medical profession? Specifically, is mandatory reporting an unreasonable incursion on self-regulation and an affront to an honourable profession? Is it fair that a small number of high-profile cases has apparently led to governments legislating in this way? Is "reactive" legislation causing doctors to present themselves for treatment of health problems less frequently, with consequent increased risks to their health? Is the legislation unnecessary in light of the existence of "robust" internal ethical and professional standards and codes which serve the same purpose, but without the opprobrium attaching to an external reporting and identification process?

The fundamental, agreed criterion of both internal and external regulation in the areas of impairment, conduct and clinical competence is the assurance of patient safety and welfare. At least in their published materials, medical associations and colleges profess this primary value. The Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia*, states that "Doctors have a duty to make the care of patients their first concern and to practise medicine safely and effectively".³⁴ All claims about mandatory reporting should use this criterion as a reference point.

While a number of suggestions and submissions led to improvements in the final version of the National Law, that final version should be considered carefully, together with the explanatory material that accompanies it, in order to make further sensible commentary. The claim that the mandatory reporting requirements have brought about a reduction in self-referrals to doctors' advisory services may well be true. But what does this claim rest on? It is difficult to accept that it rests on an accurate reading of the impairment provision, supported by the explanatory guidelines. Given that the impairment provision states that for the impairment to be notifiable, it must have "placed the public at risk of substantial harm in the practitioner's practice of the profession", the vast majority of doctors' maladies, as under existing ethical obligations, will remain unnotifiable. The *Guidelines for*

²⁸ *Medical Practice Amendment Act 2008* (NSW) (repealed), s 71A.

²⁹ *Medical Practitioners Act 2001* (Qld) (repealed), s 166(6)(a)-(d).

³⁰ Stott K, "Health Practitioner Regulation National Law 2009" (2009) 113 *Australian Health and Medical Law*, <http://www5.cch.com.au/amed/amed113.html> viewed 16 November 2010.

³¹ Bird S, quoted by Stott, n 30.

³² Brand D, "Working Towards an Outcome for Your Profession" (December 2008) *Doctor Q* 7.

³³ Phelps, n 26.

³⁴ Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* at [1.4], <http://www.medicalboard.gov.au/Codes-and-Guidelines.aspx> viewed 16 November 2010.

Mandatory Notifications state:

"Substantial harm" has its ordinary meaning; that is, considerable harm such as a failure to correctly or appropriately diagnose or treat because of the impairment. For example, a practitioner who has an illness which causes cognitive impairment so he or she cannot practise effectively would require a mandatory notification.³⁵

What this suggests is that if doctors are being deterred from presenting for health care by the mandatory reporting laws, it is because they are largely ignorant of the wording and the intention of the provisions. It is interesting to note that the medical indemnity organisation representative who labelled the mandatory reporting laws a disgrace because doctors' health was put at risk by their deterrent effect, also indicated that the problem was more of perception than reality, because doctors feared automatically triggering a mandatory report if they sought help from another doctor for a perceived impairment.³⁶ If a doctor is treating a colleague for a condition that places the public at risk of substantial harm, the principles of self-regulation – the privilege defended as sufficient for patient safety as far as reporting impaired or incompetent colleagues goes – would surely demand that the treated doctor be known to the regulatory authority, and managed by the relevant committee discharging that element of the self-regulation function. Any doctor whose impairment does pose a substantial risk, or – in the absence of that doctor's insight – any treating doctor who considers that a substantial risk exists, should surely feel *ethically* compelled to self-report/report the matter to the board. Hence, no doctor whose impairment does not pose a substantial risk should feel deterred from seeking medical help on the grounds of public identification and damage to reputation. And doctors treating other doctors who are compliant with treatment, in many cases, will legitimately form the view that continuing practice poses no risk of substantial patient harm, and hence will not be obliged to report. The statutory regime demands no more than what a robust, profession-governed, self-regulatory process should require, and what existing ethical codes do require. The consequences for impaired doctors who are reported under the new legislation are no different from those when reporting was "merely" an ethical requirement – being placed on an impaired practitioners' register and being supported, managed and monitored, often in continuing practice. If impaired doctors and their treating doctors feel deterred by mandatory reporting laws, we are entitled to conclude that there was, and continues to be, significant non-compliance in relation to the ethical obligations that were depended on in arguments against mandatory reporting.

In response to this state of affairs, the Medical Board of Australia has recently reminded medical practitioners that an impairment or poor health *in itself* is not sufficient grounds to trigger a mandatory report, and that those with an impairment who cease practice voluntarily, before it affects practice, do not need to be reported,³⁷ as they are no longer in a position to place the public at risk of substantial harm. Following this reminder, we should expect the number of doctors contacting health advisory services to return towards previous levels, as long as doctors read important messages sent to them by the Medical Board. If they do not return to previous levels, the public can reasonably infer that, at an individual level, doctors are not aware of or are not prepared to act in accordance with, their responsibilities as imposed by both internal and external mechanisms, and/or that at an organisational level, the medical profession has not adequately promulgated the details and implications of the impairment provisions.

It is contended that somewhat similar principles apply to the resistance to the accepted professional standards provision, on the grounds that professional codes and practices are sufficiently robust and functional to fulfil the purpose of protecting patient safety. If the prominent cases such as Reeves, Patel and others were not prevented by self-regulation, we can reasonably infer that other, less serious and less prominent cases, albeit still significant in terms of patient harm, are also not being prevented, or even detected and reported after the event, via existing self-regulation processes. The

³⁵ Medical Board of Australia, *Guidelines for Mandatory Notifications*, p 3, <http://www.medicalboard.gov.au/Codes-and-Guidelines.aspx> viewed 16 November 2010.

³⁶ East, n 27.

³⁷ Medical Board of Australia, "Mandatory Reporting" (2010) 1 *Update* 8.

new provision states that notifiable conduct is that which places the public at risk of harm because the practitioner has departed significantly from accepted professional standards. In this case, the explanatory guidelines for mandatory notifications state that "significant" means "important", or "of consequence", and that a significant departure is one which is serious and would be obvious to any reasonable practitioner, although the risk of harm need not be substantial.³⁸ The guidelines go on to say:

This provision is not meant to trigger notifications based on different professional standards within a health profession, provided the standards are accepted within the health profession; that is, by a reasonable proportion of practitioners. For example, if one practitioner uses a different standard to another practitioner, but both are accepted standards within the particular health profession, this would not qualify as a case of notifiable conduct.³⁹

If patient safety and welfare constitute the crucial, agreed purpose of notification, then claims about the medical profession having a high level of integrity and existing ethical processes being sufficiently robust and functional so as to not require additional legal reporting obligations, must bear significant weight. The problem is that these are no more than assertions; they are not based on any evidence at all. We have no way of knowing how many instances of significant departure from accepted standards go unreported, and hence we do not know how robust the self-regulatory process is in ensuring patient safety, to the extent that this kind of process can assist to do this within the broad range of safety assurance processes.

However, we do know that:

- doctors consider that they are responsible for the actions of their colleagues (supporting the injunctions of their professional codes), and that they believe they should act in response to a colleague's failure to achieve professional standards;⁴⁰
- there is at least some qualitative evidence for a difference in rate of incident reporting on the part of nurses compared with doctors;⁴¹
- in a large survey of United States physicians, 64% agreed with the professional commitment to report colleagues who are significantly impaired or otherwise incompetent to practise, 69% were prepared to deal with impaired physicians in their own practice, and 64% said they were prepared to deal with incompetent colleagues; of the 17% who had direct knowledge of an incompetent colleague, 67% actually reported the colleague to the relevant authority;⁴² and
- in another large United States study (3,504 participants), while 96% of respondents agreed that physicians should report impaired or incompetent colleagues to relevant authorities, 45% of those who had encountered such colleagues had not reported them.⁴³

Hence, while professional ethical codes require reporting, and commentators – in resisting mandatory reporting – claim that professional self-regulation is working in this area, there is evidence that while physicians agree with professional norms, they do not always behave in conformity to these norms. Consequently, we have at least some evidence that self-regulation in the area of reporting impairment and incompetence to relevant authorities is not working adequately, and could certainly not be termed robust.

³⁸ Medical Board of Australia, n 35, p 4.

³⁹ Medical Board of Australia, n 35, p 4.

⁴⁰ Raniga S, Hider P, Spriggs D and Ardagh M, "Attitudes of Hospital Medical Practitioners to the Mandatory Reporting of Professional Misconduct" (2005) 118(1227) NZMJ.

⁴¹ Kingston M, Evans S, Smith B and Berry J, "Attitudes of Doctors and Nurses Toward Incident Reporting: A Qualitative Analysis" (2004) 181 MJA 36.

⁴² DesRoches C, Rao S, Fromson J, Birnbaum R, Iezzoni L, Vogeli C and Campbell E, "Physicians' Perceptions, Preparedness for Reporting, and Experiences Related to Impaired and Incompetent Colleagues" (2010) 304 JAMA 187.

⁴³ Campbell E, Regan S, Gruen R, Ferris T, Rao S, Cleary P and Blumenthal D, "Professionalism in Medicine: Results of a National Survey of Physicians" (2007) 147 *Annals of Internal Medicine* 809.

It is argued, of course, that reporting by individual peers of their colleagues is by no means the only mechanism for identifying those physicians whose clinical standards are unacceptable.⁴⁴ Clinical monitoring and improvement services,⁴⁵ continuing educational requirements,⁴⁶ incident reporting and root cause analysis,⁴⁷ quality assurance mechanisms, and others, are important strategies, contributed to by the profession but also by health departments and other players, that have been developed in response to the increasing complexity of health care systems in which individual practitioners operate. The existence of these quality monitoring and improvement mechanisms, however, should not render individual reporting unnecessary. They are also deficient to the extent that they, too, failed to intervene in the prominent cases mentioned here, that consequently caught public attention. There is also a danger that they can be used to *exclude* a role for individual responsibility, on the basis that the complexity of systems renders individual responsibility irrelevant. This trend is one response to the shift away from the traditional culture of individual blame to one that takes more account of systemic complexity.⁴⁸ There is general agreement that the previous culture of "blaming and shaming" had negative consequences. But accountability is not confined to systems, and we should avoid conveniently rationalising all instances of individual responsibility and accountability via concepts like complexity and the unpredictable emergence of new phenomena from complex systems.⁴⁹ The important document addressing the new professionalism, "Medical Professionalism in the New Millennium: A Physician Charter", retains the importance of individual responsibilities under the subheading "Commitment to Professional Responsibilities":

As members of a profession, physicians are expected to work collaboratively to maximize patient care, be respectful of one another, and participate in the processes of self-regulation, including remediation and discipline of members who have failed to meet professional standards. The profession should also define and organize the educational and standard-setting process for current and future members. Physicians have both individual and collective obligations to participate in these processes. These obligations include engaging in internal assessment and accepting external scrutiny of all aspects of their professional performance.⁵⁰

REASSERTING PROFESSIONALISM IN MEDICINE

The broad social changes indicated at the beginning of this column, together with individual instances of failure in clinical standards and adequate self-regulatory responses, have spawned a large literature on professionalism in medicine over recent decades, some of which is more defensive of traditional professional values, but some of which accepts the social changes and professional failures as legitimately fuelling increasingly insistent community demands for improvements in self-regulation, but also for greater external regulation.⁵¹ Traditionalists will have been somewhat surprised and disappointed with concessionary statements from within their own professional ranks, such as the

⁴⁴ Wynia M, "The Role of Professionalism and Self-regulation in Detecting Impaired or Incompetent Physicians" (2010) 304 JAMA 210.

⁴⁵ For example, Queensland Health operates a Clinician Performance Support Service (CLiPSS) for clinicians who require remediation in areas of concern. See http://www.health.qld.gov.au/clipss/html/supp_plan.asp viewed 18 November 2010.

⁴⁶ Australia's specialist colleges require members of the specialty to undertake continuing education to either remain in good standing as college fellows or, in the case of general practitioners, to remain on the vocational register, which attracts the higher of two possible Medicare rebates for patients. See <http://www.racgp.org.au/QACPD> viewed 18 November 2010.

⁴⁷ Root cause analysis is "a systematic process that allows for the identification and management of underlying factors and system vulnerabilities that contributed towards the occurrence of an incident". See <http://www.health.qld.gov.au/patientsafety/im/webpages/whatisrca.asp> viewed 18 November 2010.

⁴⁸ See eg Leape L, Woods D, Hatlie M, Kizer K, Schroeder S and Lundberg G, "Promoting Patient Safety by Preventing Medical Error" (1998) 280 JAMA 1444.

⁴⁹ For explanation of the role of complexity in health systems, see eg Carayon P and Wood K, "Patient Safety – The Role of Human Factors and Systems Engineering" (2010) 153 *Studies in Health Technology and Informatics* 23; Leischow S, Best A, Trochim W, Clark P, Gallagher R, Marcus S and Matthews E, "Systems Thinking to Improve the Public's Health" (2008) 35 *American Journal of Preventive Medicine* S196.

⁵⁰ Medical Professionalism Project, "Medical Professionalism in the New Millennium: A Physician Charter" (2002) 177 MJA 263.

⁵¹ Irvine D, "Everyone is Entitled to a Good Doctor" (2007) 186 MJA 256.

following:

The failings of self-regulation have been familiar, long before the recent high profile cases. At some stage in their professional lives, most doctors will have come across others whose failings have been tolerated and covered up by their colleagues. *Supporting doctors, protecting patients*, the consultation document from the Department of Health (DoH) for England, summarises the damning evidence on under-performing doctors.⁵²

And:

We have no one to blame but ourselves for the problems we now face. As a profession, and as groups within the profession, we have responded pusillanimously to each attack on our professionalism. It is vital for us to act now to reaffirm it and to restore what has been eroded away.⁵³

And:

The obvious question is why a profession with so many conscientious people could act so defensively. How does this behaviour fit with a profession committed to putting patients' interests first? One explanation lies in the 19th century cultural mindset of unfettered professional autonomy that, deep down in the profession's collective psyche, lingers on even today. This assumes that, once doctors are fully trained, for the rest of their professional lives they are then entitled to exercise wide discretion as to how they practise medicine, how thoroughly they keep themselves up-to-date, how they relate to patients and colleagues, and what standard of practice they personally consider acceptable.⁵⁴

How should a profession, that no doubt remains wedded to the values and practice of self-regulation, now act so as "to restore what has been eroded away"? Concessionary statements like these suggest that the time has well passed when it still *appeared* likely that huffing and puffing about the robustness of the profession's ethical accountability was sufficient. The paradoxical position, as argued recently,⁵⁵ is that what remains of the self-regulation function will be best preserved by the open embrace of *external* processes like mandatory reporting that are currently being brought to bear, as an expression of the profession's willingness (to use a colloquialism derived from psychotherapeutic practice) to "own its own shit", and move on.

Defensive postures, such as the claim that the legislation will cause practitioners to hide their impairments and professional issues, driving the issues underground and increasing risks,⁵⁶ do little else than transparently cling to the "cultural mindset of unfettered professional autonomy". As argued above, impairments should be self-reported and those that risk substantial patient harm should be reported by others if the impaired doctor lacks the insight to do this.⁵⁷ And it is impossible to hide professional standards issues, because if you continue to practise incompetently the incompetence will not be hidden, and the only alternative is practising competently, when it will no longer be relevant. But those who continue to practise incompetently are hardly likely to self-report for improvement, and the alternative nets for capturing these doctors have inevitable holes.

⁵² Jewell D, "Supporting Doctors, or the Beginning of the End for Self-regulation?" (2000) 50 *British Journal of General Practice* 4.

⁵³ Bagshaw P, Begg E, Moller P, Nicholls G, Toop L and Winterbourne C, "Reaffirming Professionalism in Medicine" (2001) 114 *NZMJ* 347.

⁵⁴ Irvine, n 51 at 257.

⁵⁵ Jackson and Parker, n 11 at 43-44. See also Parker M, "Normative Lessons: Codes of Conduct, Self-regulation and the Law" (2010) 192 *MJA* 658 at 659.

⁵⁶ Royal Australian College of General Practitioners, *Response to the Australian Health Workforce Ministerial Council's Communiqué of 8 May 2009 Regarding Proposed National Registration Arrangements and Proposed Accreditation arrangements* (15 May 2009), http://www.racgp.org.au/Content/ContentFolders/Reportsubmissionsandoutcomes/RACGP_response_to_AHWMC_Communique_2009-05-18.pdf viewed 18 November 2010.

⁵⁷ Freckleton J and Molloy P, "The Health of Health Practitioners: Remedial Programs, Regulation and the Spectre of the Law" (2007) 15 *JLM* 366.

THE FUTURE

Our professional codes have certainly required the reporting of problem practitioners. The AMA's *Code of Ethics* (2004) advises doctors to "report suspected unethical or unprofessional conduct by a colleague to the appropriate peer review body".⁵⁸ Until the State boards were disbanded at the end of June 2010, they published similar statements. For example, the Medical Board of Queensland stated:

In order to protect your patients and the public, you should identify to an appropriate authority, medical or other health practitioners whose health, conduct or performance is a threat to the public. If you are not sure what to do, ask an experienced colleague or contact the Medical Board or your medical defence organisation for advice.⁵⁹

But it is not sufficient to assert that professional self-regulation is doing a good job, merely on the basis of what codes of ethics have to say on the matter of obligations in response to poor performance or conduct. The profession as an autonomous profession must demonstrate that it deserves the community's continuing trust, particularly in relation to keeping its own house in order, through evidence and action. As many have now already argued, this means a new kind of professionalism,⁶⁰ that is outward looking rather than defensive. This column concludes with some suggestions and challenges in keeping with this reform in approach to medical self-regulation. The underlying assumption here is that the life of what Davies has termed 19th and 20th century "light touch" regulation has come to an end; the medical profession needs to accept that this is so and act accordingly. Davies captures these now-outmoded ideas in the following:

Decisions were made through informal discussion, control of fellow professionals was distasteful, and the assumption was that only an exceptional few would stray from the fold. The Merrison Commission on the regulation of the medical profession endorsed this approach as late as the mid 1970s. In a different political climate, however, with a more demanding public, with more diverse professionals, with organisational rather than solo practice the norm for many, with a state wanting to guarantee standards and a press alert to poor performance, the limits of light touch regulation have become all too apparent.⁶¹

She goes on to suggest:

Research on the regulation of the health care workforce needs to deepen understanding of how old ideas about professional self-regulation can be modified and developed to serve both the professions and the public ... Different disciplines can contribute to this, as can independent research agencies and the regulatory bodies themselves.⁶²

Here, then, are some new ideas:

1. The medical profession, and in particular the AMA, should endorse mandatory reporting, in recognition of the profession's past failings and the close alignment between the requirements of mandatory reporting and the profession's assertions about its ethical obligations to take responsibility for members who practise at inadequate standards. It should make submissions to this effect to the forthcoming AHMAC review, should this proceed. It should accept that, as argued here, the logic concerning the deterrent effect of mandatory reporting on the seeking of health care by doctors is flawed, and cease deploying this alleged deterrent effect defensively and deceptively.
2. The profession should consider encouraging stronger deterrent penalties for unprofessional conduct, and more demanding re-education strategies, eg, for those practitioners found to have departed significantly from accepted clinical standards. If the profession were to lead the arguments for and the development of new strategies, rather than be led towards greater

⁵⁸ Australian Medical Association, *Code of Ethics* (2004, editorially rev 2006), s 2.1.d, <http://www.ama.com.au/codeofethics> viewed 18 November 2010.

⁵⁹ Medical Board of Queensland, *Good Medical Practice*, s 2.9.1 (no longer available online).

⁶⁰ Irvine D, "Time for Hard Decisions on Patient-centred Professionalism" (2004) 181 MJA 271.

⁶¹ Davies C, "Regulating the Health Care Workforce: Next Steps for Research" (2004) 9 *Journal of Health Services Research Policy* (S1) 55.

⁶² Davies, n 61.

accountability measures such as revalidation, as might currently be predicted, it would demonstrate the serious primary commitment to patient welfare and safety that the community expects to see it espouse and practise.

3. The most prominent recent cases of poor practice and inadequate professional response have been brought to light by whistle-blowers and the press. As Rothman argues, the medical profession should encourage and protect whistle-blowers, particularly within its own ranks.⁶³ This historically novel position would, again, not just help those patients at risk or support those who have already been harmed, but also convince others that the profession is more serious about that primary responsibility than its own welfare.
4. Recent developments in undergraduate medical education in the area of medical ethics, law and professionalism should be strengthened. As Rothman also suggests, as well as teaching the theory of professionalism, this includes fostering the skills necessary to promote and protect it.⁶⁴ Included here are the skills required to advocate for patients, resist hierarchical bullying, eliminate rank-closing and take appropriate action in relation to poorly performing peers. In Australia, this implies joint efforts between medical schools to strengthen curriculum, assessment and research.⁶⁵
5. A vigorous research agenda is required to underpin all these endeavours. Research in the area of professionalism in medicine and the health professions is in its infancy. This ought not be left to the universities, but be led by partnerships between academic researchers, the profession (colleges, the AMA etc), consumer groups and the regulator (now the Medical Board of Australia). Linkage projects involving these players will be important in bringing about cultural change. It will be important to determine the attitudes and practices of members of the profession and of the public in the areas of impairment and clinical standards and the reporting of inadequate health care practice and unprofessional conduct. But it will be crucial to critically appraise these attitudes and practices in relation to the reference point of patient welfare and safety. Research on the links between behaviour and achievement at the undergraduate level and the same parameters at the level of professional practice is also crucial.⁶⁶

CONCLUSION

It will be unfortunate if the inquiry into mandatory reporting is not alerted to the failure of sections of the profession to become fully aware of the details and implications of the mandatory reporting provisions, and the role this is likely to be playing in perceptions about mandatory reporting's apparent deterrent effect on doctors seeking medical help. It will also be unfortunate if the inquiry is persuaded that the provisions should be weakened as a result of assurances that the profession can be trusted to adequately manage breaches of its clinical and professional standards. The era of "light touch" regulation has passed, and the medical profession must cease resorting to outdated arguments and non-evidence-based claims, if it wishes to retain those elements of self-regulation that remain and that modern polities will be willing to concede. It must cease huffing and puffing and throwing its weight around, and begin to engage in better informed and more coherent efforts to illuminate its primary task – ensuring the welfare and safety of patients.

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⁶³ Rothman D, "Medical Professionalism – Focusing on the Real Issues" (2000) 342 NEJM 1284.

⁶⁴ Rothman, n 63.

⁶⁵ Parker M, Turner J, McGurgan P, Emmerton L, McAllister L and Wilkinson D, "The Hard Problem: Assessing Medical Students' Professional Attitudes and Behaviour" (2010) 193 MJA 662.

⁶⁶ This kind of research has been undertaken in the United States. See eg Papadakis M, Hodgson C, Teherani A and Koatsu N, "Unprofessional Behaviour in Medical School is Associated with Subsequent Disciplinary Action by a State Medical Board" (2004) 79 *Academic Medicine* 244.