

**AMA Submission  
to the  
Senate Community Affairs Committee  
on the exposure draft of the  
Health Practitioner Regulation National Law**

**for the**

**Inquiry into the  
National Registration and Accreditation Scheme  
for doctors  
and other health workers**

**July 2009**

## **Introduction**

The Australian Medical Association is the peak representative body of the medical profession. The AMA represents doctors in training, general practitioners, specialists and clinical academics across the spectrum of salaried doctors and private practitioners across Australia.

The AMA appreciates the opportunity to provide comments on the exposure draft of the Health Practitioner Regulation National Law (the draft Bill) released by the Australian Health Workforce Ministerial Council on 12 June 2009.

We are very pleased to see that a number of issues raised by the AMA in its submissions to Government have been addressed in the draft bill. These are set out in Attachment A.

The key issue for the AMA has been, and continues to be, the independence of accreditation of medical education and training. We acknowledge, and are pleased, that the Ministerial Council has forfeited the power to approve accreditation standards as provided for in the Intergovernmental Agreement (the IGA). We also note some Health Ministers will be forfeiting existing jurisdictional powers. However, we remain concerned that there is little clarity in the draft Bill about the circumstances in which the Ministerial Council will give the national board policy directions on accreditation standards. We believe the Bill must contain additional provisions that:

- Define the circumstances when the Ministerial Council can issue policy directions on accreditation standards; and
- Provide mechanisms for transparency and accountability of these directions.

In the first section of this submission, we have set out our understanding of how the accreditation process is dealt with in Bill B and our recommendations for how this process could be further improved through specific amendments to the Bill.

In the second section of this submission we have outlined a range of other important issues that will need to be clarified and reflected, where necessary, in revisions to the Bill. Most of these issues go to the functional operation and administration of the scheme and will require further clarification, resolution and in some cases amendment to the Bill.

One of these issues relates to the role of the Public Interest Assessor, a concept which has been introduced at a very late stage of the implementation. As such there has been very little explanation about how the role and functions of the Public Interest Assessor will work in practice. The additional operational costs that this entity will impose on the scheme should not be borne by the health professions in their registration fees.

Finally, we note that individual State and Territory AMAs may provide their own input in respect of specific implementation issues, particularly around registration processes, complaints handling arrangements and the public interest assessor.

## **1. Independence of Accreditation**

In respect of accreditation, we are pleased to see that there are now substantial differences between the IGA and the draft Bill. Given these changes it is important that we set out here our understanding of how the new arrangements will operate for the medical profession:

- The only accreditation standards that will operate for the medical profession from 1 July 2010 are the existing standards that have been recommended by the Australian Medical Council (AMC);
- The existing accreditation standards for the medical profession will be automatically adopted without approval by the Ministerial Council or the Medical Board of Australia (the Medical Board);
- Changes to the adopted accreditation standards can only be developed and recommended by the accrediting body (the AMC for the first three years) and then be approved by the medical board. If the medical board rejects the changes, the AMC can publicise the details;
- There is no capacity for the Ministerial Council or the medical board to impose, write or change accreditation standards;
- The Ministerial Council is able to give policy direction to the medical board in respect of accreditation standards in certain circumstances set out in clause 10(4) but, as outlined above, the practical effect of these directions is limited given that changes to the accreditation standards must be recommended by the AMC; and
- Only the accrediting body (the AMC) can accredit individual courses, with the medical board having quite a separate role of approving a course for registration after it has been accredited by the AMC.

It is in respect of the second last dot point that we remain concerned that the Ministerial Council will have some broad power to influence accreditation standards for medical education and training. This is because there is not enough clarity or transparency of the Ministerial Council's use of the mechanisms in clauses 10(3)(d) and 10(4).

While the capacity of the Ministerial Council to issue policy directions is limited, in order to provide further certainty, we strongly consider the draft Bill should include additional provisions to:

- A. provide more specific codification in the Bill of the parameters for how and when any Ministerial Council directions are made in relation to accreditation standards under clauses 10(3)(d) and 10(4), including:
  1. defining "substantive and negative impact" in subclause 10(4);
  2. requiring the Ministerial Council to apply a public interest test that considers, amongst other things, the potential impact on the quality and safety of patient care;
  3. requiring the Ministerial Council to consult with the relevant Learned Medical College and faculties on best practice;
- B. require that Ministerial Council decisions to issue the medical board a policy direction under clauses 10(3)(d) and 10(4) be unanimous;

- C. provide for more transparency of policy directions made under clauses 10(3)(d) and 10(4) by:
1. requiring directions to set out:
    - i. the findings on material questions of fact;
    - ii. references to the evidence or other material on which those findings were based; and
    - iii. give the reasons for the decision to issue the policy direction;
  2. requiring Ministerial Council directions to the medical board made under clauses 10(3)(d) and 10(4) to be provided in writing to peak medical organisations and Learned Medical College and faculties, and to be published on National Agency's website, within seven working days of the direction being issued;
- D. provide additional accountability for Ministerial Council directions made under clauses 10(3)(d) and 10(4) through the inclusion of specific provisions for reviewing any such directions.

The AMA also seeks a guarantee that the AMC will be the external accrediting body for the medical profession, and that it will have an ongoing role, beyond an initial three-year period, as the external accrediting body for medical education and training. To date, Ministerial Council communiqués have only stated that it is expected the AMC will be the external accrediting body for the medical profession. We are concerned that the Ministerial Council may seek to influence accreditation processes by appointing, and presumably revoking appointments of, external accreditation entities under clause 60. The medical profession has a high regard for the operation and activity of the AMC. There is no reason why the AMC should not be appointed as the external accrediting body for a period substantially longer than three years.

In a similar vein, given that national boards can establish accreditation committees under clause 62, it would secure the independence of the accreditation process if the national boards, and not the Ministerial Council, were fully responsible for ongoing appointments of external accreditation entities.

Given that there are substantial aspects of clause 10 to be clarified and improved, through the incorporation of the changes listed above, the draft Bill should be recirculated publicly before the final Bill is introduced into the Queensland Parliament.

## **2. Other important issues that require clarification and/or changes to the draft Bill**

### **Process for handling future amendments to legislation**

- The AMA opposes the clauses in the draft Bill that provide for future amendments to the Act to be only through the Queensland Parliament. As we read the clauses with the relevant provisions of the IGA, there is no requirement for Parliaments in the other jurisdictions to have the opportunity to consider the amendments. Further, there is no provision requiring future amendments to the legislation to be developed in consultation with stakeholders. The AMA asks that Government

provide further advice setting out the process for the development of and consultation on future amendments to primary and subordinate legislation.

### **Public interest assessor**

- The Public Interest Assessor (the PIA) is a newly introduced entity to the proposed scheme. There has been little or no information provided to fully explain how the role of the PIA will operate in practice. Government should provide this information before the final Bill is introduced in the Queensland Parliament. Further, the office of the PIA will require additional funding, which should be fully met by Government and not from the registration fees of registrants.

### **Accreditation standards**

- The AMA asks that the draft Bill include the definition of *accreditation standard* provided by the existing national accreditation agencies for the health professions.

### **Mandatory reporting**

- The definition of *reportable conduct* requires further consultation with the health professions. In effect, the relevant provisions in the draft Bill represent new mandatory reporting requirements across the health professions, as well as for the medical profession who are subject to existing state/territory laws. The draft definition in the Bill has a very broad application and there are considerable risks that health professionals will over-report, or not know when to report. We support suggestions by other health profession groups for educative scenarios to be provided to registrants so they have some certainty of what would be considered in scope as reportable conduct, before case law is established.
- The AMA notes the medical defence organisations will provide full and detailed submissions on the mandatory reporting requirements and asks that these submissions be given full and careful consideration.
- Spouses, treating doctors and other professionals such as the doctors' advisory health service, should be included in the exemptions to the mandatory reporting requirements in clause 156.
- Further, the draft Bill should expressly preclude medical practitioners who participate in quality assurance activities in accordance with the Commonwealth *Health Insurance Act 1973* from any requirement to report reportable conduct identified during those activities.

### **Registration**

- There must be appropriate supporting codes and guidelines developed by the medical board, in consultation with the profession to provide reasonable guidance to medical practitioners and the public as to appropriate standards of conduct and competency. Any such codes and guidelines must be developed with the advice and support of the relevant profession.
- The draft Bill requires amendment to clarify that only medical practitioners who meet the requirements in clauses 75 and 76 are eligible for specialist registration and therefore entitled to use the title *medical specialist*. Clause 133 should be

amended to remove the provision that permits a person who holds limited registration to use the title *medical specialist*.

- The AMA notes that clause 90 provides for limited registration for not more than two years, and clause 91 states that limited registration may not be renewed or restored. Officials have provided verbal advice that people with limited registration will be able to re-apply for registration at the end of the two-year period. This needs to be made clear in the draft Bill.
- We consider that a two-year period for limited registration for area of need, before a new application is required to be made, is reasonable. However, two years may be too short for people in post-graduate practice who hold limited registration (for example interns) to cover issues such as pregnancy or illness.
- As stated above, the operational costs of the Public Interest Assessor should not be met from registrants' fees – this function was not part of the original scheme and was not requested by the medical profession.
- Finally, we remain concerned that the costs of the scheme will significantly increase registration fees. Governments must cover the additional costs of the scheme in so far as it exceeds existing registration fees.

### **Complaints**

- The AMA notes the flexibility provided in the draft Bill for each state and territory to adopt its own processes to handle complaints about health professionals. We anticipate there will be significant input from individual state and territory government, professional and public interest entities about the degree to which preferred state-based arrangements can be accommodated by the draft Bill.
- We also understand that the medical defence organisations will also make detailed submissions in respect of the complaints handling processes, and ask that their views be carefully considered. It is very important that the rights of health professionals to a fair hearing are preserved and balanced within the framework that also seeks to provide members of the public with appropriate complaints handling arrangements.
- As already stated, the role and functions of the Public Interest Assessor needs to be more fully explained to the health professions.

### **Board**

- We note that the membership of the national boards will comprise at least one member from the smaller participating jurisdictions. This may be an issue of concern for members of the health professions in those smaller jurisdictions who may consider their interests will not be adequately represented at the National level. Over time, there is a real risk that registration and complaints handling functions for registrants in smaller jurisdictions may be carried out outside the jurisdiction. There could be implications for patient safety if local issues are unable to be taken into account because there is no local knowledge.

- The profession will have more confidence in the medical board and the state boards if the profession is involved in the nomination process for board members.
- The AMA notes that there will be health profession agreements between the National Agency and the national boards in respect of the resources provided to the boards to carry out their functions. However, we are concerned about what will happen when agreements cannot be reached between the National Agency and the boards. In these circumstances the Ministerial Council should give precedence to the position of the board when providing directions on how the dispute is to be resolved under clause 24(2).
- Further, the Bill should contain explicit provisions that permit the national boards to employ staff to enable the boards to carry out their functions. The AMA opposes arrangements whereby staff of the medical board and the state boards will be employed by the National Agency on behalf of the board under arrangements determined by the National Agency.
- Clause 280 provides protection from personal liability for certain persons involved in the exercise of functions under the law. This provision should be clarified to ensure that this protection is also provided to medical practitioners, who may be Learned Medical College fellows, involved in the assessment of international medical graduates, or carry out performance assessments on behalf of the medical board.

#### **Provision of information about registrants**

- Clause 265 requires further clarification about the extent of information about registrants that can be disclosed to other Commonwealth and State entities. This clause effectively extends the existing arrangements for sharing information about registered medical practitioners between various government bodies beyond what is currently allowed, without setting out specific circumstances and reasons for doing so.

#### **Advertising**

- The draft Bill does not reflect some important issues that are dealt with in medical registration Acts at the moment. We suggest that, in respect of advertising, consideration be given to including the following requirements being imposed in respect of advertisements of registered health professionals:
  - i. advertisements should only contain factual material. They should be honest and accurate and should be informative rather than persuasive, providing patients with information regarding the appropriateness and availability of (doctor's) services;
  - ii. advertisements should not exploit patients' vulnerability or lack of (medical) knowledge;
  - iii. advertisements must not promote a service that the advertiser knows or ought reasonably to know will, or is likely to, harm a person to whom it is provided;
  - iv. advertisements should not claim or imply that one practitioner is superior to another or denigrate other practitioners or services.

**Protection of use of title**

A national health profession registration and accreditation scheme has a responsibility to the public to ensure non-medical health professionals, or other people, do not hold themselves out as medical practitioners. There will be instances where non-medical health professionals possess a doctorate and the relevant health profession board recognises certain doctorates as a qualification for registration by that board. To ensure that the public is not misled by non-medical health professionals who hold a doctorate, the draft Bill should include a provision that requires the use of the title ‘doctor’ by these health professionals to be accompanied by information that they are not medical.

In addition, we are also concerned about the use of the term physician and surgeon and believe that serious consideration should be given to including specific protections in the Bill for these titles as well.

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## **Previous issues of concern to the AMA addressed in the draft Bill**

### **Approval processes**

- The Ministerial Council will approve registration standards (including scopes of practice) but only if the standards are recommended by the national boards;
- The Ministerial Council will approve the list of specialities but only on advice from Boards which in turn must have regard to advice from the AMC or a specialist medical college;
- The national boards will approve other standards. The national boards can only approve accreditation standards developed and submitted to it by the accrediting authority;
- The existing AMC accreditation standards will be automatically adopted under the scheme without the need for approval by the Ministerial Council or the medical board;
- Neither the medical board nor the Ministerial Council can unilaterally write or change existing accreditation standards;
- National boards are required to consult with other affected boards and advise the Ministerial Council of their views about a matter that may reasonably be expected to be of interest to another national board (for example when proposing to change the scope of practice of their respective health profession).

### **Professional representation on Boards**

- The medical board membership will comprise at least half and up to 2/3rds medical practitioners;
- A practising medical practitioner must be the chair of the medical board.

### **State flexibility**

- National boards can establish State/territory boards (committees);
- If a State Board of the National Board is established, members will be appointed by the jurisdiction Minister;
- Complaints handling arrangements are flexible to accommodate State/territory preferences;
- At least one representative from each of the large and one representative from the small States and Territories will be on the medical board, with no limit in the Bill to number of Board members in total. However, in practice it may mean that not all jurisdictions will be represented on the medical board.

### **Role of national agency vs. role of national board**

- The National Agency is not involved in registration or accreditation decisions or other activities of the national boards, unless a board allows it;
- The National Agency cannot usurp the national boards in relation to decisions about the resources of the national boards;
- The National Agency will provide services to the national boards under a mutually agreed service agreement;

- The National Agency will administer separate budget allocations and maintain separate bank accounts for each national board;
- Funds can only be paid out of a board's account if it is consistent with the agreed Board budget or if the board approves the expenditure;

#### **Legal representation for registrants**

- Explicit right in the draft Bill for attendance of a legal representative at hearings of professional standards panels or health panels.

#### **Specialist registration and area of need**

- Specialist registration only for qualified doctors as assessed by the medical board (i.e. those with agreed recognised qualifications or substantially equivalent qualifications);
- While individual Ministers can still determine areas of need, there is an explicit provision protecting the right of boards not to register registrants merely because they are going into an area of need.

#### **Mandatory reporting**

- Mandatory reporting not required by professional indemnity employees or those involved in legal proceedings;
- If a practitioner does not report in circumstances set out in the draft Bill, it will not be considered an offence, but rather unprofessional conduct for which disciplinary rather than legal action will be undertaken;

#### **Miscellaneous issues previously proposed which we objected to**

- Registrants are not required to provide workforce data to gain or retain registration;
- No automatic MBS/PBS entitlement upon registration;
- No further reference to “continuing competence requirements”;
- No further reference to “practice requirements”;
- Doctors endorsed to practice in the area of acupuncture will be able to use the title “acupuncturist”;
- It will be an offence for any health professional to recklessly use the title “specialist”.

#### **Student registration**

- Will be mandatory but will be arranged between the educational institution and the Board;
- Only relevant offences (indictable offences and impairment) by students will be dealt with by the medical board.