Medical Board of South Australia

Our ref: 273/09

30 April 2009

The Secretary
Senate Community Affairs Committee
PO Box 6100
Parliament House
Canberra ACT 2600

By Email: community.affairs.sen@aph.gov.au

Dear Sir or Madam

I enclose a submission[1] to the Senate Inquiry into the National Registration and Accreditation Scheme for Doctors and Other Health Workers. This has been prepared by the community members of the Medical Board of South Australia and has the Board's full support.

Our Board has been concerned for some time that there continues to be a perception amongst the public that the Medical Profession in Australia self regulates and that its processes are not transparent.

As this submission points out *inter alia* this is not the case. Medical regulatory agencies around the world have increased lay membership over the last two decades. The experience has been overwhelmingly positive along the lines outlined in this submission.

One of the tasks of the new Scheme will be to correct this misapprehension. Community members have the same fiduciary responsibility as other members to protect the safety and dignity of the general public in their dealings with the profession. For that reason it is crucial that they do not represent specific constituencies and that their selection and appointment processes are open and transparent.

Yours sincerely

DR TREVOR MUDGE
PRESIDENT
MEDICAL BOARD OF SOUTH AUSTRALIA

Enc[1] MBSA Community Members Submission

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Dear Sir or Madam

Submission on behalf of the Medical Board of South Australia (MBSA)

MBSA has made detailed submissions to each of the consultation papers delivered by the National Registration and Accreditation Implementation Project. I attach for the information of the Senate Inquiry a copy of these papers[1-6]. I particularly draw the committee's attention to submissions made in response to the proposed registration arrangements, complaints handling and specialist registration.

In addition to the above, MBSA has sought a submission from our community representatives and those of other State and Territory medical boards. A copy of this is also attached[7] for your consideration. This has value as it contains the perspective of 'expert' consumers presently involved in regulation of medical practitioners.

Whilst we apologise for the significant detail provided in the attached documents, some of which is outside your terms, it is important for the Inquiry to appreciate the total effect of the proposed model. Consequently, general comment only is made below. However, MBSA would be happy to provide an oral submission to the Senate Committee on specific matters if required.

Terms of Reference Questions

a. the impact of the scheme on state and territory health services

In many ways the full impact is unknown. The central issue will be independence of the standard setting for granting of registration. The boards as they currently exist are statutory bodies with necessary separation from political influence. It is absolutely vital that the independence of registration decisions in relation to health practitioners is maintained.

Similarly, it is equally vital that decisions in relation to the standards of accreditation are also independent of political influence. Control of standards of professional training and education must remain with the professions. Whilst acting in accordance with government policy and legislation, accreditation agencies should not be able to be unduly influenced by government who may seek to alter (lower) standards in response to short term workforce priorities.

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The independence of accreditation is also a fundamental key requirement of the World Federation of Medical Education and Accreditation standards which when met provide international credibility to the medical courses and programmes completed by practitioners. This permits international recognition of medical qualifications for registration purposes and allows Australian trained doctors to practise internationally.

Whilst it is envisaged that there will be increased portability of medical practitioners, on current regulation data this will only affect approximately 10% of the medical workforce. This is the approximate percentage who hold registration in more than a single State or Territory. Most practitioners practise in a single State and mobility issues are therefore not relevant.

b. the impact of the scheme on patient care and safety

Australia enjoys a very high international reputation in relation to medical education and regulation. The impact of any dilution in standards of medical education, training and registration requirements has significant potential to increase public exposure to risks resulting from health care delivery. Examples of this are contained with the submission with the obvious example being Dr Jayent Patel, currently facing criminal charges in Queensland. Whilst there was oversight in relation to a restriction on his overseas registration by the Medical Council of Queensland, far greater harm resulted from the lack of internal governance in the health sector, in part driven by workforce and financial considerations above patient safety considerations, allowing Dr Patel to practise unrestricted and above his registration for some considerable time.

Another effect of the national model is the 'single desk' approach to regulation. This has the inevitable effect the risk of error being exposed nationally. Currently practitioners must transfer under mutual recognition legislation. This allows individual boards to independently assess applicants. This process has uncovered errors in other States which have caused MBSA to halt or review a registrant. The benefit of independent secondary review will be lost under the national scheme.

Further, if policy exceptions to public safety requirements are determined to the lowest denominator to meet workforce needs as currently in some States, the standards of registration in others will also fall. An example of this lies in the current differences between States in the application of the English Language Policy for medical practitioners. Other examples can be provided, but the principle of not lowering standards is the key point.

One of the concerns raised in the submissions is the matter of creating an unnecessary disconnect between local accountability and authority over registration. The importance of a State based Statutory Authority having power to make autonomous decisions based on local understanding of the health sector and local professional resources is considerable. Should the governance arrangements of the model prove too central, prescriptive and stringent, there is potential for a dilution of autonomy in registration decision making powers at the local level. This negative consequence has been the experience in the United Kingdom following devolution of local regulation powers across Wales, Scotland and Northern Ireland to the General Medical Council central offices.

Similarly, decisions to restrict or revoke registration will need to handled efficiently and with authority at a local level with the necessary powers being delegated. The risk of a centralist control model must be resisted.

c. the effect of the scheme on standards of training and qualification of relevant health professionals

As stated above, the central important consideration must be the independence of the accreditation function over health professional education and post graduate specialist training. Currently this is a function undertaken by the Australian Medical Council. This body is highly

regarded internationally and has overseen significant development in the standards of medical specialist education. It will be vital that the Australian Medical Council or some similar agency be retained and continue to operate independently with the option of reporting to the National Board as the governing authority to be developed.

d. how the scheme will affect complaints management and disciplinary processes within particular professional streams

The area of complaints management is the most complex and difficult to achieve in the scheme due to the different judiciary and complaints handling bodies and processes and State and Territory level. Whilst there is expressed support for the New South Wales model of having an external complaints handling body in some quarters, this model is expensive to maintain and duplicate and has other administrative problems. Importantly, the separation of complaints handling from other regulatory functions has a deleterious effect. Please see further below for other comments.

Separation of Powers/Complaint Investigation

Regulation and complaint handling have fundamentally different philosophies and outcome objectives. The goal of complaint handling is to satisfactorily resolve complainants regardless of whether a public risk exists or not. Action is focused on the individual consumer and service provider. Regulation must consider public benefit and interests, not the interests of the individual.

Clear understanding of the above distinction between the functions, powers and purpose of the regulator and any State/Territory Health Complaints Commissioner (HCC) is necessary when determining their relationship and capacity to utilise each others resources.

There should be a formal relationship between the two bodies. The regulator being responsible for assessment, investigation and determination of notifications related to conduct, performance and health of a professional. The HCC investigates system issues and matters which are more amenable to direct resolution, unrelated to the above elements.

There are working examples of the above and we have provided examples to the consultation process. These arrangements have proven to be efficient, resource effective and allow for early resolution of matters.

The argument that a regulator may not fairly assess, investigate and conduct proceedings is unfounded. There are significant resource, expertise, efficiency and public safety reasons why the National Board and its delegated officers, committees or panels can and should oversee all aspects of any matters. In conjunction with the appropriate transparency and oversight, this works well, meets natural justice expectations and can be implemented quickly to avoid disruption to local matters during any transition to the national scheme.

Any appeal against a board decision could include the HCC as a representative body with standing who could lay a matter on behalf of the complainant directly to the board, (at the expense of the HCC). This should address the concerns expressed by consumer organisations whilst not transferring costs to the professions or disrupting the current working model.

e. the appropriate role, if any, in the scheme for state and territory registration boards

There is considerable role for the State and Territory boards in the area of local decision making across all aspects of regulation. Boards presently handle matters on a daily basis and advice is sought from local boards by the profession, employers and departments of health in relation to local issues. Any reduction in the autonomy of boards or shift in decision making to a national body reduces the capacity to assist in timely manner and potentially to

reduce the quality of the advice due to reduced local knowledge. It also has the effect of reducing local involvement in state policy decisions regarding health service delivery as the local office may be seen more as an administrative rather than a decision making body.

Local boards should also retain the complaint handling functions as well as considerable daily involvement in relation to international medical graduates seeking to practice in Australia. The workload attached to each of these registrants is considerable compared to Australian graduates and involves regular communication with local employers, supervisors and government departments.

f. alternative models for implementation of the scheme.

An alternative model which is possible and been discussed prior to the COAG announcement is the retention of current State and Territory boards and councils with the formation of a National Professional Board for each profession as proposed under the COAG agreement. The National Board would have representation from State and Territory boards. The issue of effective governance across the State and Territory bodies would still need to be addressed. However, could this be achieved through legislation. Then it is possible to achieve much the same outcome to that being proposed under the COAG model without the considerable costs and significant disruption currently experienced and anticipated into the future.

Under the current model, the National Board is not responsible for the employment or governance of the Chief Executive Officer or supporting managers and administrative staff. These persons report to the Agency Management Committee, a separate statutory body. The separation of the staff from a direct reporting relationship to the board is a considerable shift in accountability to the present structure where the State chief executive officers and registrars report to their respective boards and board presidents.

There is potential for conflicts of interest and reduced relationships between administrative staff and board and State committee members under the proposed arrangements.

The funds collected from the profession by way of fees is also separated from the National Board, again funds being controlled by the Agency. This further dilutes the autonomy of the professions and the model is not clear in how funding should be allocated and under whose authority expenditure ultimately occurs.

The capacity to preserve State initiatives is also critical in order not to create a stagnant process nationally. Local developments in the regulation framework have produced great benefits to local communities and professions as well as national advantages. An example is the development of different models for management of impaired practitioners across the States. Whilst different, they are adapted to local conditions and should not be lost in translation.

As a final comment, the greatest asset of the national regulation industry as it exists today is the persons currently working in the area. Significant expertise has been developed at all levels across the very broad range of functions. A major risk identified to governments by boards has been the risk of staff loss leading up to and following transition. Staff are unsure of their future and all senior staff will be made redundant. The significant risk of loss of expertise could reasonably result in a significant risk to the 'filter' of expert scrutiny across the health professional arena. This will have a direct and immediate effect on public safety nationally. This is not to be alarmist at all, but must be seen as a real and inevitable risk of the process. Indeed this is the highest level risk given the role of boards to ensure public safety through effective regulation.

Yours faithfully

JOE HOOPER
REGISTRAR / CHIEF EXECUTIVE OFFICER

Enc MBSA submissions in relation to:

1. *Issues Supplementary to the Intergovernmental Agreement on a National Registration and Accreditation Scheme for the health professions to be included in the first bill, September 2008*
2. *Proposed Registration Arrangements, October 2008*
3. *Proposed arrangements for handling complaints, and dealing with performance, health and conduct matters, November 2008*
4. *Proposed Staffing Strategy for the Implementation of the National Registration and Accreditation Scheme, November 2008*
5. *Other matters, December 2008*
6. *Proposed Arrangements for Specialists within the National Registration and Accreditation Scheme, February 2009*
7. *President's cover letter and MBSA Community Members submission, April 2009*

Submission to the Senate Community Affairs Committee

INQUIRY INTO THE NATIONAL REGISTRATION AND ACCREDITATION SCHEME FOR DOCTORS AND OTHER HEALTH WORKERS

From
COMMUNITY MEMBERS OF THE MEDICAL BOARD OF SOUTH AUSTRALIA

This submission is based on the outcomes of a meeting of community members of state and territory medical boards held in Melbourne on March 17, 2009. The views expressed in this submission reflect the opinions of those present at that meeting (including all the community members of the Medical Board of South Australia) they do not necessarily reflect the views of all individual medical boards or of all of their community members. These caveats notwithstanding, there was a strong general consensus emerging from the meeting that is reflected in this submission. We do not attempt to address all the terms of reference of the inquiry, and focus our comments on the role of community membership of boards in the proposed arrangements.

We also note that there has been some reference in submissions to the NRAS that the medical boards function as a means of professional self-regulation. We dispute that view. The profession is not "self regulating" given that the composition of medical boards includes community and members from other disciplines operating within specific legislation. (For example 5 of the 12 members of the Medical Board of South Australia are non-medical.) Rather, current state and territory medical boards are regulators protecting the public interest (with reference to objects and framework of relevant Acts).

Members present at the meeting

Ms Moira Deslandes	Medical Board of South Australia
Mr Paul Laris	Medical Board of South Australia
Ms Sophia Panagiotidis	Medical Practitioners Board of Victoria
Ms Kerren Clark	Medical Practitioners Board of Victoria
Ms Prudence Ford	Medical Board of Western Australia
Mr Antony Carpentieri	New South Wales Medical Board
Ms Diane Walsh	Northern Territory Medical Board
Mr Michael Clare	Medical Board of Queensland
Ms Megan Lauder	Medical Board of the ACT
Apologies:	
Dr Christine Putland	Medical Board of South Australia
Ms Virginia Rivalland	Medical Board of Western Australia
Mr Sean Lusk	Medical Practitioners Board of Victoria
Medical Council of Tasmania	

The function of community (lay) perspectives in current arrangements

- Enable expression of community views and expectations - build public confidence
- Community members prompt a focus on public interest in decision making about regulatory and professional conduct matters

- Shared governance expertise within the professional context, for example, strategic planning, financial management, communication
- Diversity of views enhances decision making. Medical professionals, community members, and lawyers bring different perspectives to discussions and decision making.
- Value of strategic/broader principle considerations versus clinical detail and experience.
- Balances public interest/individual views with objects and principles underpinning the legislative framework.
- Communicates outcomes back to the public through networks facilitating better awareness of what are reasonable expectations for the community to have of the profession.

Principles we want to see embedded in the new arrangements for National and State/Territory bodies

- "Community" not "consumer" representation. Community members should *not* be appointed as a representative of any particular consumer interest, but act as citizens to represent the broader public interest
- At least 1/3 of all bodies to be community members
- Lawyer members to be separate from and additional to, 1/3 community members. Important to have a least one legally trained member
- Community representation in the public interest should be a feature of all levels of the NRAS, including state based bodies
- Transparent, visible selection process for all members – non representative positions
- Diversity in membership is vital and
    - Fosters informed and transparent decision making
    - Enhances governance expertise
    - Gives voice to the voiceless
- The accumulated knowledge and experience of existing lay members should not be lost in the transition process

The importance of "Separation of Powers" – Who Should Investigate Complaints?

- The new framework refers to "notifier". This reflects the objective of investigating notifications for the purpose of establishing whether unprofessional conduct has occurred rather than resolving a complaint.
- The role of Medical Boards is to protect the public not to "put things right for complainant".
- There is a danger that a process of investigation that conflates complaints resolution for individuals with assessing and limiting risk to public health and safety through regulation will satisfy neither objective.
- Notifiers should be offered support to access/navigate the system - not as party to a "complaint" but as notifier or "witness".

Key Principles

- Preserve transparent complaint management structures and decision making
    - Tiered system preserves principles of natural justice.
- Optimum standards to apply, uniformly across professions, enhancing both access and public safety. The community expects highest ethical standards.

- Preserve professional expertise/review in early phase of notification in order to identify issues of public interest and determine level of risk.
- Preserve integration of regulatory and investigative process.
- Preserve capacity to act quickly at State/Territory level to protect public from perceived risk.
- Preserve ability to change the pathway that the matter takes – disciplinary, competency and impairment.
- Notifier to have the right of independent review if the decision in the preliminary phase is not to investigate.
    - Grounds for review include substance as well as administrative review
    - Grounds for request for review to be articulated by notifier
    - Parameters to trigger review to be set. (Reference made to the arrangements in S68 of the Consumer, Trade and Tenancy Act NSW).
- Preserve the capacity for issues of strategic/public interest to be raised across sectors and jurisdictions.
- Ensure public access to Medical Board at State/Territory level through effective pathways and communication.
- Effective protocols and communication arrangements between regulators and Health Complaints Commissioners at State level.
- Capacity at State/Territory level to "triage" notifications.

Other issues

- Importance of effective communication and consultation to be reflected in new operational arrangements:
    - Informed decision making. For example, demographic/geographic stakeholders relevant to people affected by Board's decision to be consulted prior to release of guidelines. An example of this is the Victorian Medical Board's establishment of a Community Consultative Committee which has a number of people selected through public advertisement appointed to serve on the Committee at arms length. The nominees are selected on the basis of their community involvement, commitment to issues of public safety by health professions and their capacity to approach issues strategically. Items of public interest and Board processes eg letters to notifiers and any public information produced by the Board are presented to them for input/scrutiny to ensure that community input is obtained as necessary.
    - Community members of Boards and other NRAS bodies need adequate and appropriate orientation, support and access to information. It should be acknowledged that a diverse membership will require differing levels and types of support.
    - Pro-forma's for appropriate language and sensitive communications in letters to notifiers about progress and outcome of notification.

This Submission has been prepared by the community members of the Medical Board of South Australia : 199 Ward Street, North Adelaide 5006 South Australia
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April 16, 2009