ADAVB COMMENTS ON EXPOSURE DRAFT - HEALTH PRACTITIONER REGULATION NATIONAL LAW 2009 – BILL B

INTRODUCTION

The Australian Dental Association Victorian Branch (ADAVB) welcomes the opportunity to comment on the exposure draft of the Health Practitioner Regulation National Law 2009 – Bill B.

The ADA operates as a federation and ordinarily the ADA Inc. (the federal body) responds to Commonwealth initiatives and issues. In this case, where regulatory measures are being transferred from a State jurisdiction to a new national scheme, but with some continuing State based variations, we feel it is necessary for separate submissions to be made.

Representing over 90% of registered dentists in Victoria, the ADAVB is the peak professional body for dentists, and has a long history of acting in the public interest as well as representing our members. The ADAVB mission statement reads:

> *"The ADAVB is an association of dentists* ***committed to advancing the*** *art, science and* ***ethics of dentistry, the care of the oral health of all Victorians****, and the professional lives of its members."*

We highlight the ethical and community dimensions here because health professions are sometimes characterised (unfairly we believe) as being simply 'vested interests'. Our view of professional obligation continues to place patient welfare first, and that means we hold strong views about the way regulations need to be framed to protect public health and safety.

The community is now far better educated about health services and access to basic information about health conditions and treatment options is widely available online. However, the complexity of factors that need to be taken into account when determining a treatment plan or in providing a health service can sometimes be forgotten, and the sophisticated blend of competencies required for optimal delivery of health services can be overlooked.

The ADA supports the regulation of professional conduct and the protection of public health and safety, and we are pleased to support a nationally consistent approach to these matters. Our comments within are therefore aimed at improving the effectiveness of the proposed approach rather than seeking to oppose the entire initiative.

KEY ISSUES SUMMARY

The ADAVB supports the:
- Creation of a national Dental Board of Australia charged with establishing consistent regulatory measures covering all jurisdictions. (Please see our further comments about the structure of this body below).
- Recognition of the current 11 dental specialties, as without this the public would have been deprived of clearly identifiable expert care when treatment problems are beyond the skills of general practitioner dentists.
- Mandatory CPD.

We acknowledge that much change has already occurred in the framing of this legislation. Some of these changes are most welcome and appreciated, notably:
- Recognition of the need for accreditation bodies to be independent of the registration boards
- Ensuring that the profession specific National Boards report directly to the Ministerial Council rather than through a single governing board.

Other changes made recently include (inter alia):
- Criminal history checks
- Mandatory reporting
- Three additional professions have been included in the scheme.

Key issues remain in a number of areas, particularly:
- S. 164 and S.165 allow a decision to be taken as to whether to refer a complaint to a disciplinary body before any investigation has been undertaken. A preliminary assessment should be confined to the question of relevance and appropriateness. Premature referral of a matter to a tribunal or Professional Standards Panel without having obtained the evidence that will need to be presented to such a body is likely to result in cases being dismissed as groundless. The ADAVB considers that this element of the complaint management process is so fundamentally flawed that it could make the Boards' disciplinary functions ineffectual. The structure of S.165 should therefore be modified to reflect the need for both greater procedural fairness and administrative effectiveness at this preliminary assessment stage.
- The capacity for any State or Territory to opt out of national law complaint processes means that the Public Interest Assessor (PIA) arrangements, and other complaint mechanisms, will not apply in that jurisdiction. In our view that will ultimately lead to inconsistencies, which will be perceived by some parties to be unfair. It will also substantially undermine the characterisation of the NRAS arrangements as the much vaunted 'nationally consistent approach to professional regulation'.
- Proposals to allow practitioners who have not met local qualification requirements to practice in so-called 'areas of need';
- The intention to drive through workforce reforms such as 'workforce substitution' by means of the new system;

- Failure to require Health Workforce Australia (HWA) to consult with health professional registration boards and associated course accreditation bodies such as the Australian Dental Council;
- Linkage of the registration legislation with a push to give health funds more control over the shape of health services and in particular, clinical decisions;
- The potential for the PIA to turn the regulation of professional conduct into an adversarial consumer complaint system, where patients are made de facto parties to disputes with practitioners rather than tribunals making objective judgments about the extent to which practitioners have complied with professional standards; and
- Five types of practitioners will be regulated by a single Board with representatives from ancillary roles who do not understand dentistry fully. This will gravely undermine the credibility of the Dental Board of Australia (DBA). Only three dentists are proposed for this Board, when in all other Boards at least six practitioners with equivalent qualifications are available to oversee the development of suitable standards.
- While mandatory reporting arrangements are supported when it involves a treating practitioner, we argue that
    - Immediate family members should be exempt. We also urge that agents and nominees of professional indemnity (PI) insurers should be exempted along with their employees.
    - A second health practitioner can only form a reasonable belief about a first practitioner based on information that would establish the conduct posing a threat to patient safety **has** occurred. Mere allegation would not be enough to form a reasonable belief and so the wording of this section requires review.
    - Good Samaritan actions by an off duty health practitioner assisting a person in an emergency should be protected from disciplinary actions.

RESPONSES TO THE EXPOSURE DRAFT

PART 1 Preliminary

S.3 Object of Law

ADAVB supports protecting the health and safety of the public by means of registration and regulation.
We recommend that:
Section 3 be amended by the addition of the words "from risk of harm" after the words "protect the public".

S.4 Objectives and guiding principles of national registration and accreditation scheme

(1) The objectives of the national registration and accreditation scheme are as follows: ...
(e) to facilitate access to health services in accordance with the public interest,
(f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, practitioners.

Comments:

- The ADA supports the regulation of professional conduct and the protection of public health and safety through a nationally consistent approach to these matters. However, we remain concerned that Health Ministers have provided themselves with numerous opportunities to subvert those purposes in the alleged public interest without an explicit public interest test being provided for in the draft legislation. This concern is particularly triggered by the inclusion of new objectives (e) and (f) which have not previously been evident in most State and Territory professional regulation legislation.
- How the scheme intends to facilitate access to health services as suggested in sub paragraph (e) is unclear. Sub paragraph (f) indicates that health professionals are on notice for work force reform and innovation, which may be subject to Ministerial direction.
- Sub-paragraph (e) links to specific provisions permitting the registration boards to provide limited registration to people who would not otherwise qualify for registration. A member of the Productivity Commission recently made the point at a presentation attended by ADA representatives, that if a workforce measure is acceptable in a remote part of Australia, then it should be acceptable anywhere in the country. In our view, this signals the willingness of the Government to subvert the very standards the NRAS legislation is meant to protect.
- The parallel development of the Health Workforce Australia Bill, with the establishment of a separate structure to support provision of clinical training places has also raised concerns, particularly as there is no sign of HWA having any obligation to confer with the national registration boards about their work and its impact on the regulation of the health workforce. Boards may be directed by Ministers to cooperate in making rules more flexible because of political issues

such as waiting times, many of which are actually caused by inadequate funding rather than inappropriate regulation.

- The National Registration and Accreditation Scheme is hosted on a website badged the "National Health Workforce Taskforce" (NHWT). In addition to the information provided about the scheme, other pages provide insight into public sector workforce flexibility and restructure proposals, which are motivated by the needs of less than 20% of the service delivery system, and fail to take account of private sector and office based practice perspectives. The following extract from the NHWT website highlights the commitment to create expanded roles for less qualified healthcare workers, and to achieve this as part of the NRAS reform process.

  "Reforming the Workforce

  - *System, funding and payment mechanisms to support new models of care and new and expanded roles.*
  - *Redesigning roles and creating evidence based alternative scopes of practice.*
  - *Developing strategies for aligned incentives surrounding productivity and performance of health professionals and multi-disciplinary teams.*

  The agency will work with and across all jurisdictions to develop and articulate a national strategy for workforce reform and progress the demonstration, piloting, evaluation and implementation of new workforce models and reforms to assess their contribution to improving the efficiency and effectiveness of service delivery, within a framework of safety and quality of care.

  The agency will identify, from innovation both locally in Australia and overseas, those areas of major job evolution/substitution and redesign that have potential national significance and demonstrate net benefit to the community. Funding will also be provided to support jurisdictions in implementing new models tested and evaluated. The agency will link into the National Registration and Accreditation Scheme to ensure sufficient regulatory protection for workforce redesign pilots and to support changes to scopes of practice." (emphasis added)

  Source: http://www.nhwt.gov.au/coag.asp - accessed on 25 April 2009

- Arguments that the entire health care system needs to shift to a 'models of care' approach when in fact that only really applies in large institutions like hospitals and nursing homes, chiefly in relation to medical services, potentially hold the rest of the health service providers to ransom. While we recognise that there are issues with the provision of some health services and that some parts of the system are stressed, we do not accept that the workforce reforms proposed will be appropriate or effective solutions.

- It is alleged that *"The exploration of new approaches to health workforce planning is being driven by demographic shifts and broad health system changes, including, a predominance of illness associated with an ageing population, increasing consumer demand for services and increasing costs"* (Australian Health Workforce Advisory Committee, Australian Medical Workforce Advisory Committee and Australian Health Workforce Officials' Committee (2005), A Models of Care Approach to Workforce Planning - Information Paper, Health Workforce Information Paper 1, Sydney, page 4, accessed at http://www.nhwt.gov.au on 1 April 2009). This rationale is not explained further so that the reader can understand why these changes necessitate redesign of professional roles such as those performed by dentists or pharmacists. It is essentially an unsubstantiated assertion. It also appears to be driven by a view that doctors could do more if they were able to delegate more duties to nurses. Even if this were true, it has little to do with establishing a need to change other health occupations.
- In response to a related NHWT initiative, the Victorian Department of Human Services recently published a discussion paper on Health Workforce Competency Principles, which refers to the above quotation about a 'models of care' approach to workforce planning. The Executive Summary in that paper admits that:

  > *"<u>The paper does not seek to provide definitive answers to the 'why', 'what' and 'how' of a 'models of care' approach to workforce planning.</u> It is anticipated that answers to these questions will evolve over time as planners and stakeholders further consider or work with this planning approach and reflect and learn from their experiences."* (ibid)

- Thus this is a policy that is to be imposed on the Australian community and all health professions without any good reason being offered. This is why we believe that ideology is driving the reform agenda rather than an objective rationale. In its present form, it is 'a solution looking for a problem'.
- We see the potential relationship between the NHWT, the new HWA and the NRAS initiative as a coordinated approach by Government to the imposition of measures such as 'workforce substitution' without adequate regard to evidence based policy and public health and safety. Assurances have been received that HWA and the NRAS agencies will be entirely separate bureaucracies, and that there is no intention of using the NRAS legislation in this way, however we remain suspicious of plans for radical workforce reforms being fast-tracked without proper evidence or scrutiny.
- The proposal to establish a Core Competency Framework for the Health Workforce is a key workforce reform initiative, which we see as closely linked to the national registration and accreditation scheme. An NHWT Information Sheet on this subject dated May 2008 states:

  > *"Identifying a core competency framework could provide a mechanism by which skill and knowledge can be recognised outside of the traditional silos of discrete professions. A core competency*

framework is a tool to describe specific skills and knowledge a person has and could assist in facilitating staffing across profession and/or service stream that could result in encouragement of workforce flexibility and role redesign. It is not clear if evidence exists that such a framework will impact on reducing key shortages across the health workforce."

- One interpretation of what the NHWT is proposing is the creation of a universal healthcare worker, with only a core set of competencies and no specialised skill to be able to deal with more complex matters within a field of professional service. Furthermore, this proposal is not based on any evidence that it will actually solve the problem of health workforce shortages (which we suggest relate more to distribution problems than overall shortages).
- The so-called "professional silos" are normally referred to by the professions as specialised 'bodies of knowledge'. Researchers, academics and professionals have spent centuries building up insights, skills, understandings and a knowledge base in each of these fields. Rather than seeing them as silos, we view them as the pillars and foundations on which our high quality healthcare system is built, yet certain reformers propose to dismantle them.
- On the one hand we have the community, media and the courts demanding that greater specialisation and skill training should be assured in our health service delivery so that we avoid adverse and sentinel events. On the other, we have Government agencies and Ministerial Councils suggesting that the rich and highly articulated bodies of knowledge in each of the health professional fields are troublesome 'silos' that need to be done away with in the interests of 'flexibility'.
- It seems strange that the Government should advocate the establishment of more and more stringent safety and quality measures – such as those being proposed concurrently by the Australian Commission on Safety and Quality of Health Care, while entertaining proposals to 'dumb down' the training of health service providers, resulting in Australians depending on generic healthcare workers, whose ignorance of the detailed bodies of knowledge in specialised areas may mean that 'they don't know what they don't know'?
- We are concerned that, with the exception of scrutiny of national regulations as provided for in S.285, the Ministers are not accountable to any Parliament for the decisions they take. No appeal mechanism is currently available against a decision that is judged to be poor. Given the significance of the public health and safety issues (as illustrated in the cases of Drs Patel and Kossman), we strongly urge inclusion of such a review mechanism.
- We note that the objectives do not include any intention to provide a consumer dispute resolution mechanism but appropriately, they focus on protection of the public by regulating professional standards. We raise this point in connection with the recent introduction of a new layer of complexity in the structure with the creation of the previously unheralded PIA. (See our comments on S.35 below.)

(2) The guiding principles of the national registration and accreditation scheme are as follows: ...

(c) restrictions on the practice of a profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.

Comments*:*

- Sub-paragraph (c) clearly states the scheme's intention is not to impose restrictions unless justified on safety or quality grounds. There is great potential here for disagreement between professional bodies and the Boards based on ideological and philosophical grounds.
- We have been advised that each State may adopt its own legislation to cover the complaints process. We note that if a State chooses to follow the National system, there will be no right of external review/appeal (e.g. by a District or Supreme Court judge). In this regard any review/appeal process under the National Scheme remains "in the Scheme". This is not a healthy appeal system. We argue that because of this, guiding principle (a), which states that the scheme should operate in transparent and fair way, is undermined. We urge the inclusion of judicial appeal provisions.

S.6 – Definitions

clinical privileges *means the range and scope of clinical responsibility that a health practitioner may exercise at a hospital or other facility at which health services are provided, including the following:*
(a) the area of clinical practice,
(b) the use of facilities or specialised equipment,
(c) the performance of specific operations or procedures.

Comment:

- The use of the term 'area of clinical practice' should be changed to 'field of practice'. See also comments below re **S.85 Limited registration for area of need.**
- Alternatively, a new definition should be included as follows: "area of clinical practice for a health profession means the performance of specific clinical duties and procedures using a collection of necessary knowledge, skills, experience and professional attributes as recognised by the relevant health profession".

Criminal history*, of a person, means …*

(c) every charge made against the person for an offence, in a participating jurisdiction or elsewhere, and whether before or after the commencement of this Law.

Comment:

- As one of the guiding principles of the Bill is that the scheme should operate in a transparent and fair way, it seems inconsistent to require that charges which have not been progressed or which were not found proven should be included in a criminal history. We note that a subsequent definition of criminal history law, indicates that "spent or other convictions do not form part of a person's criminal

history", and so the failure to exclude charges that were dropped or found unproven seems to be an oversight. ("Spent or other convictions" is a vague phrase and should be clarified).

health practitioner *means an individual who practises a health profession.*

Comment:

- We recommend this be amended to read 'means an individual who practises a registrable health profession. If it is meant to include non-registered persons then perhaps it should say "an individual who practices a health occupation, whether registered or not".

health profession *means the following professions, and includes a recognised specialty in any of the following professions: ...*
(d) dental (including the profession of a dentist, dental therapist, dental hygienist, dental prosthetist and oral health therapist) …

Comment:

- It appears the dental register will now have five divisions unless the oral health therapist division allows endorsement as a hygienist, a therapist or an oral health therapist. This would permit a reduction to three divisions.
- The title oral health therapist does not exist in most State jurisdictions at present, and no definition of this has been offered. We take it to mean a person registered / endorsed to practice as both a hygienist and a therapist.

impairment*, in relation to a registered health practitioner or student, means the practitioner or student has a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or may detrimentally affect:*
(a) the practitioner's capacity to practise the practitioner's profession, or
(b) the student's capacity to undertake clinical training in the profession.

Comment:

- This definition needs amending to overcome the difficulties encountered by Boards with practitioners suffering from 'controlled' blood-borne infections such as Hep C, Hep B and HIV who wish to continue to practice.

reportable conduct*, in relation to a registered health practitioner, means the health practitioner has:*
(c) placed the public at risk of substantial harm in the health practitioner's practice of the profession because the health practitioner has an impairment, or
(d) placed the public at risk of substantial harm because the health practitioner has practised the profession in a way that constitutes a departure from accepted professional standards.

Comment:

- The term 'at risk of substantial harm' is open to wide interpretation and guidance will be required from the Boards. Desirably an agreed approach to this will be evident across all Boards in the interests of consistent regulation.

***unprofessional conduct**, of a health practitioner, means professional conduct that is of a lesser standard than that which might reasonably be expected of the health practitioner by the public or the practitioner's professional peers, and includes:*
(d) providing a person with health services of a kind that are excessive, unnecessary or otherwise not reasonably required for the person's well-being, and …
Comment:
- Practitioners will be seeking, and need, specific guidance on these matters from their professional bodies.

PART 2 Ministerial Council

S.10 – Policy directions

(3) Without limiting subsections (1) and (2), a direction under this section may relate to:
(d) a particular accreditation standard of a National Board.
(4) However, the Ministerial Council may give a National Board a direction under subsection (3)(d) only if, in the Council's opinion, the accreditation standard will have a substantive and negative impact on the recruitment or supply of health practitioners to the workforce.
(6) The National Agency or a National Board must comply with a direction given to it by the Ministerial Council under this section.
Comment:
- A direction would ordinarily act as a guide, but the direction provided in this instance must be complied with, therefore it is an instruction. This further suggests that this legislation has been developed to combat workforce issues rather than what it should be about - protection of the public.
- Given the problems in workforce prediction and management, it is difficult to comprehend that the Ministerial Council will be able to justify the need for direction in accreditation standards. These standards require expertise in the health discipline concerned, which is not held by the Ministerial Council. They will not be equipped to judge the 'collateral damage' impact of any decisions they might make either.
- According to all earlier documentation on this legislation, the function of accreditation is to be "independent of Government". This is now contradicted by the exposure draft.
- See also comments under Part 6 below.
- We therefore recommend:
  - Deletion of Section 10(3)(d) and 10(4).
  - Alternatively Section 10 (4) be amended to limit the opportunity for the Ministerial Council to provide such directions by replacing the words:
    "will have a significant and negative impact on the recruitment or supply of health practitioners to the workforce"
    with:
    "will have a significant and negative impact upon the safely and quality of health care."

11 Approval of registration standards

(2) Without limiting subsection (1), a registration standard for a health profession may be about the following:
(c) the nature, extent, period and recency of any previous practice of the profession by applicants for registration in the profession …

Comment:

- 'Recency' of practice used in this manner seems to indicate a time limitation rather than a more extensive interpretation currently used by several Boards. Para 11 is sufficiently broad enough to accommodate these other matters. See comments on S.99 Power to enquire about qualifications, registration status and practice in the profession.

13 Approval of areas of practice for purposes of endorsement

Comment:

- The use of the term 'area of clinical practice' should be changed to 'field of practice'. The term 'area of need,' which appears in S.85, seems to relate mainly to geographic areas, and so use of 'field' when describing a clinical field within a discipline would offer a less ambiguous meaning. See also comments in relation to **S.85 Limited registration for area of need.**
- If the new definition of the term "area of clinical practice for a health profession" is adopted as which we have suggested above, then this problem may be overcome.

PART 3 Australian Health Workforce Advisory Council

S.17 Function of Advisory Council

Comment:

- The open ended nature of the Advisory Council's functions and the potential for most members to have no health expertise is of concern, especially as they will have no public accountability and may provide their advice to the Ministerial Council without any public scrutiny.
- This Council's view of what is the public interest may well be at odds with the view taken by registration boards, and a common definition of the public interest should govern the work of both the Council and the Boards.

PART 4 Australian Health Practitioner Regulation Agency

Division 4 Public interest assessor

S.35 Public Interest Assessor

(1) The Ministerial Council is to appoint a person as the Public Interest Assessor.

Comment:

- This appears not to be the same person as the independent assessor referred to in S.152. There is a strong likelihood that all States and Territories will retain their

respective health complaint entities. The PIA role appears to be predicated on usual practices between States' and Territories' Boards and their health complaints commissioners. The functions of the PIA should be restricted to those matters referred to the Board to be dealt with. Otherwise, there will be an additional requirement for the PIA to be consulted. This would introduce an additional, unnecessary health complaints structure on top of the multiple complaint avenues already available to consumers of health services.

- We have received assurances that the PIA is obliged to review the evidence held by a registration board in the same way – that is to determine whether a notification or complaint should be dealt with in a variety of ways that objectively address the promotion of professional standards rather than the resolution of a dispute between a consumer and a practitioner. Dispute resolution mechanisms exist in each State and Territory, either via Health Complaints Commissioners with conciliation powers or small claims tribunals and courts. Recognition of their continuing role within S.166 is most welcome.
- The provisions of S.171 must be honoured and health consumers must not be made 'de facto parties' to the professional regulation processes. The PIA needs to recognise consumers as notifiers of issues requiring impartial consideration of adherence to standards and the promotion of the highest standards of health care. In other words, the success of such a process is not to be determined on the basis of whether or not a particular consumer is happy with the outcome. Commercial consumer disputes over matters such as fees should be dealt with in other jurisdictions, where mechanisms are already available to address such matters.
- S.36 does not make explicit the requirement that the PIA must use precisely the same criteria for assessment of a complaint as the Board - greater clarity on this is needed. The 'let out clause' in S.36(c) appears to give Ministers the power to override the earlier sections of the legislation, and to ask the PIA to do other unspecified things.
- Because assurances have been given to the professions that the introduction of the new regulatory measures will not lead to the imposition of additional costs, Governments should fund the operation of the PIA in each jurisdiction rather than registration fees paying for this aspect of the scheme. It is not a requirement for professional regulation, which already has consumer involvement in each and every Board. Asking registrants to fund this would make the new scheme more onerous and costly despite claims that this was to be avoided.

PART 5 National Boards

Division 1 – National Boards

The ADAVB supports:

- ✓ the principle that Boards must be expert and have half to two-thirds of members and the Chairperson as experts in the field;

- ✓ the DBA having two community members, one dental therapist, one dental hygienist and one dental prosthetist;
- ✓ not registering and so not including non practitioners i.e. dental technicians; and
- ✓ all dental practitioners being covered by the same Board.

While the ADAVB acknowledges that the DBA has been recognised as a special case with its multiple occupations, we do not believe that this Board is properly constituted to fulfil the role of maintaining patient safety and quality of service, which is the objective of the Scheme.

Consistent with past submissions, the ADAVB strongly argues that the following further modifications to the DBA need to be made:

- The Board should be extended to include five dentists to ensure that it can effectively carry out its functions including determining standards for all of dentistry. The dentist is the team leader in the practice of dentistry and is the only practitioner with the knowledge and skills to practice all of dentistry. While dental hygienists, dental therapists and dental prosthetists have by and large appropriate knowledge and skills, these are confined to small, specific areas of dentistry. Such practitioners will be properly represented on the DBA as they are qualified to comment on their segment of dentistry, but cannot be regarded as expert or informed about all aspects of dentistry. Reference is made to the attached diagrammatic representation – "Dental Treatment Field and Levels". The General Dental Council in the United Kingdom is comprised of 29 members, of whom 19 are dental care providers, with 15 dentists and four non-dentist practitioners. A similar ratio is required on the DBA to ensure that the Board's policy deliberations are adequately informed by comprehensive dental knowledge. We fear that the work of the DBA will be impossible given the unique circumstances in which five occupations are to be regulated by only one Board. The nearest equivalent amongst other national boards is the Nursing and Midwifery Board, which only has two professions to deal with.
- Asking as few as three dentists to be responsible for complex regulatory matters in a field with not only five occupational groups but also 11 recognised specialties, is far too onerous. These 11 specialty fields are:

  Endodontics
  Dento-Maxillofacial Radiology
  Oral Medicine
  Oral and Maxillofacial Surgery
  Oral Pathology
  Orthodontics
  Paediatric Dentistry
  Periodontics
  Prosthodontics
  Public Health Dentistry
  Special Needs Dentistry

- Likewise, expecting that the determinations of the three practitioner members who are not dentists will be credible amongst the 12,000 dentists expected to comply with regulations they have determined is unreasonable – especially if those determinations lead to workforce substitution and expansion of duties without processes that are evidence based and transparent.
- We believe the special circumstances within the dental field justify special arrangements for the structure of the DBA, so that five dentists are appointed to it.
- The Chairperson of the DBA must be specified as a dentist. While the other dental practitioners should be represented, only dentists are trained and practise in all fields of dentistry and have the overall expertise required to regulate all of dentistry. If a non-dentist were permitted to be Chairperson, they would often have to deal with matters beyond their expertise and this would place at risk community safety and thereby put the credibility of the Board's decisions in question. Without strong dentist representation the Board's clinical authority will be significantly undermined, and this will inevitably lead to practitioner resistance to Board guidance.
- With over 12,000 dentists to be regulated, 11 specialist fields as well as general practice, and four different ancillary provider groups, the DBA will have at least as complex a role as the Medical Board (which does NOT include nurse practitioners). The Medical Board will have at least six medical practitioners. In our view this justifies five dentist members of the DBA,
- Our proposal allows you to still meet the requirement to have one practitioner from each of the five large jurisdictions and one from the three smaller jurisdictions. Special provisions were already being considered for the DBA and so we are merely asking for a different set of special provisions.
- If there is concern to keep practitioner numbers down, then an alternative would be to reduce the other practitioner representation, so that only one therapist or hygienist representative was appointed, or, so that a dual-qualified therapist-hygienist was appointed. There are increasing numbers of dual qualified practitioners and such an appointment would bring the perspectives of therapists, hygienists and dual qualified people to the Board's deliberations
- Our experience with State Boards affirms that without implementing these variations the credibility and effectiveness of the new Board in achieving the objectives of the Scheme (i.e. the improvement in the safety and quality of healthcare delivery) will be seriously compromised.
- These recommendations are made in the public interest with the sincere intention of improving on the model proposed, as regulation of dentistry is a special case. We seek to ensure that decisions about the delivery of dental treatment are made by a body that is best equipped to do this.
- We urge amendment of the composition of the DBA to five dentists and that only a dentist can be Chairperson.

Division 2 Functions and powers of National Boards

S.49 Functions of National Boards

Comment:
The ADAVB supports the proposed functions and power to approve accreditation standards and other standards, codes and guidelines (with the exception of registration standards).

S.57 Consultation about registration standards, codes and guidelines.
Comment:
- The ADAVB welcomes the commitment to consult about these key regulatory instruments, as acceptance of the validity of requirements specified in these instruments is a key success factor in their promulgation.
- This section should indicate what is meant by "*wide ranging consultation", and to that end we suggest that the* COAG *Best Practice Regulation-A Guide for Ministerial Councils and National Standard Setting Bodies – October 2007* should be followed.
- We agree with the ADA Inc. suggestion that the effectiveness of this provision is totally undermined by the inclusion of S.57 (2) which states that a contravention of S.57 (1) will not invalidate the registration standard code or guideline. This is nonsensical.
- We recommend:
    - That S.57 (1) be the subject of specific regulation identifying the nature of the "*wide ranging consultation*" required in accordance with the COAG Best practice Regulation-*A Guide for Ministerial Councils and National Standard Setting Bodies – October 2007*.
    - That S.57 (2) be deleted.

PART 6 Accreditation

Comment:
- The accreditation provisions in the Bill represent an improvement on earlier suggested approaches, and are generally welcomed.
- The Ministerial Council's power to direct the national Board on an accreditation standard under S. 10 (3)(d) could be used to weaken safety and quality standards, and safeguards against its use for such purposes are required. Making such decisions subject to judicial review is therefore desirable.
- Public interest tests should also be used whenever such decisions are contemplated.
- We understand that Public Interest Tests are based on the principle that all regulatory provisions operate within the interests of the community. Butterworth's Australian Legal Dictionary defines the term "public interest" as:

  "an interest in common to the public at large or a significant portion of the public and which may, or may not involve the personal or proprietary rights of individual people."

- The Office of Best Practice Regulation states that a public interest test should be used where a regulatory proposal is likely to have a significant impact on stakeholders:

  "The Government requires that [Regulatory Impact Statements] include a comprehensive assessment of the expected impact (costs and benefits) of each feasible option. The objective should be to choose the most appropriate option for resolving the identified problem and to provide readily accessible evidence to support this decision. The overall expectation is that the ***benefits to the community*** *of the recommended option exceed its costs and have the greatest net benefits (benefits minus costs) to the community of all alternative approaches considered."*

  (Source: Office of Best Practice Regulation Handbook, August 2007, p 68. Emphasis added)
- To the extent that boards are required to consult stakeholders about regulatory proposals before they are introduced, we welcome the adoption of regulatory impact statement processes which will help to ensure that guiding principle (a) is followed, and the scheme operates "in a transparent, accountable, efficient, effective and fair way". We urge a similar commitment in relation to matters of policy such as the determination of accreditation standards by the Ministerial Council, recognition of overseas trained practitioners, or registration of people in specific / limited registration classes.

PART 7 Registration of Health Practitioners

Division 2 – Specialist registration

S.75 Eligibility for specialist registration

Comment:

- The ADAVB shares the concerns expressed by the ADA Inc. that there is no pre-requisite of *"general dentist registration"* prior to being registered as a *"specialist dentist"*.
- Allowing specialist registration without requiring the applicant to be registered as a general dentist may enable the practitioner to practise in areas outside of their specialty, and potentially expose the public to harm.
- We therefore recommend:
  - Section 75(1) be amended by the inclusion of a new sub paragraph (b) (iii) stating:

    "in the case of dentistry, eligibility requirements for general registration as a dentist."

Division 3 – Provisional registration

S.80 Eligibility for provisional registration

S. 80(1) states:

> *'An individual is eligible for provisional registration in a health profession, to enable the individual to complete a period of supervised practice that the individual requires to be eligible for general or specialist registration'*...which means they are not current eligible for registration.
> However, it then goes on to say, '...'*if the individual is qualified for general registration'*,

Comment:

- The very reason these applicants need provisional registration is because they are not 'qualified'. It appears that the purpose of this section is to register someone who, for example, has not practised for more than three years, but has a registrable qualification. Because they don't meet the recency of practice requirements, they must complete a period of supervised practice for which they need to be registered for. As presently worded, this appears to be a contradiction in terms.

Division 4 – Limited registration

- 'area of need' – remains ill defined and appears to be at the discretion of the Minister at the time – a workforce issue
- S.86 – 'public interest' is ill defined. This appears to be a 'catch all' to direct the Boards to register someone who does not fit within the other categories of registration.

S.86 Limited registration for area of need

(1) An individual may apply for limited registration to enable the individual to practise the profession in an area of need decided by the responsible Minister under subsection (5. ...

(5) A responsible Minister may decide there is an area of need for health services in the participating jurisdiction, or part of the jurisdiction, if the Minister considers there are insufficient health practitioners practising in the particular health profession in the jurisdiction or the part of the jurisdiction to provide the service at a level that meets the needs of people living in the jurisdiction or the part of the jurisdiction.

Comment:

- The impression given is that the term 'area of need' includes both geographic location and/or 'field of practice' (inclusive of general and specialist registration. Clarification should be provided by specifying whether either or both apply. If the limitation only permits the registrant to practice in a confined geographic area, the terms in which the confinement is to be expressed should be indicated in the Bill.

S.91 Limited registration not to be renewed or restored

Comment:

- S.91 states that the limited registration cannot be restored or renewed, and that the period of registration must not exceed two years. We ask:
  - is this for each sub-section of limited registration or once one type of limited registration has been granted, that is all that can ever be granted?
  - Is two years long enough for someone to complete post-graduate studies on a part-time basis?
  - How will those who fail the Australian Dental Council Examinations on their first attempt resit the exam if they are unable to have their limited registration restored?
  - Similarly, how would someone who requires additional clinical training in preparation for the examination do so without restoring their limited registration?
  - How would a practitioner who has had limited registration for the purposes of clinical training in preparation for the examination be able to apply for limited registration for the purposes of undertaking the ADC examination – or are these considered new applications?
- In the light of the above questions we suggest that a period of four years may be more sensitive to the circumstances of many who will require limited registration.
- Dental schools are going to find it difficult to obtain academics locally, and they may well need to call on overseas trained practitioners who do not necessarily meet local requirements for registration as a general practitioner. Advice should be obtained for dental schools on whether they need special limited registration provisions

Division 6 – Application for registration

S.94 Application for registration

Comment:

- To expedite registration, the following should also be included with an application for registration rather than the Board having to check:
  - evidence of the applicant's qualifications and supervised practice experience that the applicant believes qualifies them for registration
  - evidence of successful completion of an examination (if required) set by or on behalf of the responsible Board
  - evidence of blood borne virus status.

S.97 Power to enquire about qualifications, registration status and practice in the profession

(1) Before deciding an application for registration, a National Board may, by written notice: ...

> *(c) if the applicant's qualifications were obtained more than three years before the day the application is made, ask an entity nominated by the applicant for confirmation that the applicant has practised the profession*

within the three years before the day the application is made and information about that applicant's practice of the profession.

Comment:

- This would appear to suggest that an applicant's most recent practice should be at least three years - it is currently two years.
  Note S.100 (b) states:
  'After considering an application for registration and any submissions ... decide to refuse to register the applicant in the relevant health profession if:
  (i) the practitioner is ineligible for registration in the profession, or
  (ii) it would be improper to register the applicant because the applicant or someone else gave the National Board information or a document in relation to the application that was false or misleading in a material particular.
- In addition, S.102 states that the applicant has the right to review the Board's decision not to register a person and that reasons must be given for the decision.
- Having gone through the requirements and received the relevant documentation etc, S.103 states '*The failure by the Board to make a decision [about registration] is taken to be a decision to refuse to register the applicant*'. Is this fair and just? And what is to stop the Boards from going through the motions and then getting to that end point where they fail to make a decision about registration, thereby not having to give reasons for the refusal and opening it up to a review of the decision?

S.101 Conditions of registration

(1) If a National Board decides to register a person in the health profession for which the Board is established, the registration is subject to the following conditions:
(a) for a registered health practitioner other than a health practitioner who holds non-practising registration:
(i) that the registered health practitioner must complete the continuing professional development program required by the National Board, ...

Comment: CPD will be mandatory.

Division 7 – Student Registration

S.104 National Board must register persons undertaking approved programs of study

Comment:

- In the interests of uniformity (and preparing students for general registration), the Bill should specify that student registration is mandatory for all students in all professions at the point of enrolment and for the duration of the course.

S.106 Registration of students

Comment:

- We suggest deletion of S.106 (2)(a) which states that the Board must not require a person to complete an application for registration as a student. In our view, completing the form prepares them for registration and their association with the registration Board.

Division 8 Endorsement of registration

Subdivision 1 Endorsement in relation to scheduled medicines

S.110 Endorsement for scheduled medicines

Comment:

- This appears to be an unnecessary extension of the register and duplication of effort where these matters are dealt with by Medicare. There also appears to be an omission of notifying the Medicare of any changes or conditions imposed by the Board.

S,124 Annual statement

Under this section, each applicant for renewal of registration must give to the relevant National Board a statement that includes:

(d) if the applicant's billing privileges were withdrawn or restricted under the Medicare Australia Act 1973 of the Commonwealth or by a private health insurer ... because of the applicant's conduct, performance or health, details of the withdrawal or restriction of the privileges …

Comment:

- The concept of "billing privileges" here is wrong, as it implies that health funds have the power to determine whether or not an independent practitioner can invoice for their services. The concept should be restricted to payments of rebates for health services.
- More seriously, the section assumes that the checks and balances under the Medicare scheme are reflected in the private health industry - this is not so. Correspondence sent by a major health fund to our Western Australian Branch confirms that they have no intention of abiding by the rules of procedural fairness. (This is detailed in the ADAWA submission on this Bill.)
- A decision by a private health insurer to derecognise a practitioner can be made arbitrarily, without affording the practitioner the opportunity to respond to allegations before a final decision is made, thereby denying them procedural fairness. Each private health insurer has its own policy and criteria on which the decision can be based to derecognise a practitioner.
- Our legal advice indicates that there are two elements to procedural fairness. Firstly, the 'hearing rule' requires that a decision maker is to provide a person with the adverse information on which a decision may be based and hear that person's submissions in reply before making a decision that affects their rights, interests or legitimate expectations. Secondly, the 'bias rule' requires the decision maker to be detached, impartial and free of any reasonable apprehension of bias.

  In *Kioa v West*, Mason J of the High Court of Australia stated:

  > *'It is a fundamental rule of the common law doctrine of natural justice…when an order is to be made which will deprive a person of some right or interest or the legitimate expectation of a benefit, he is entitled to know the case sought to be made against him and to be given an opportunity of replying to it…The reference to 'right or interest' in this*

> *formulation must be understood as relating to personal liberty, status, preservation of livelihood and reputation, as well as to proprietary rights and interests'.*

In *Muin v Refugee Review Tribunal*, McHugh J of the High Court of Australia stated:

> *'Natural justice requires that a person whose interests are likely to be affected by an exercise of power be given an opportunity to deal with matters adverse to his or her interests that the repository of the power proposes to take into account in exercising the power. This does not mean that the source and nature of all material that comes before the decision-maker must be disclosed. But 'in the ordinary case…an opportunity should be given to deal with adverse information that is credible, relevant and significant to the decision to be made'. What is required to discharge the duty depends on the circumstances of the particular case'.*

- As for the impartiality issue, great potential exists for the commercial arrangements practitioners enter into with private health insurers to be a focus of difficulty under these provisions should the arrangement be broken or ended acrimoniously by the insurer or practitioner. Sometimes, as can be seen from review of de-recognition policies published by various health funds, the decision can be based purely on the fact that the insurer decides the practitioner has acted in a way adverse to the interests or business reputation of the insurer, or that the insurer decides the provider does not have facilities that meet standards determined by the insurer. The decisions made and standards imposed by each fund are arbitrary, and do not afford procedural fairness to the providers.
- In summary, we are very concerned at the Inclusion of PHI organisations in S. 124. PHI bodies do not share the transparency or consistency of approach that Medicare Australia uses. De-recognition can be based purely on commercial criteria rather than professional conduct. **We urge deletion of reference to PHI organisations**.

S.125 Decision about renewal

Comment:

- Section 125(4) appears to have a typographical error.
- We suggest that "subsection (1)(c)" should read "subsection (3)(c)".

Subdivision 2 Practice protections

Division 11 – Title and practice protections

S.135 Restricted dental acts

(d) performing any permanent procedure on, or the giving of any treatment or advice to, a person that is preparatory to or for the purpose of fitting, inserting, adjusting, fixing, constructing, repairing or renewing artificial dentures or a restorative dental appliance.

technical work *means the mechanical construction or the renewal or repair of artificial dentures or restorative dental appliances.*

Comment:

- If dental technicians are not registered then they should not carry out a 'restricted dental act' regardless of whether it is on the prescription of a dentist or not. As it is stated in the exposure draft, under the prescription of a dentist, a dental technician is able to carry out the restricted dental acts.
- As currently worded, this section allows a dental technician to fit an orthodontic appliance if a dentist prescribes it, and yet they have no training, skill or competence with which to do this, and may injure patients if they tried.
- The definition of 'restricted dental act' appears to permit untrained persons to fabricate trays, mouthguards, study models etc.

S.135 (2)(a) should read, 'the performance of any invasive or irreversible procedure on the human teeth or jaws or associated structures'.

Subdivision 3 Obligation of registered health practitioner to provide information

S.142 Information about offences, clinical privileges and billing privileges

(c) the practitioner's billing privileges have been withdrawn or restricted under the *Medicare Australia Act 1973* of the Commonwealth or by a private health insurer because of the practitioner's conduct, performance or health.

Comment:

- Great potential exists for the commercial arrangements practitioners enter into with private health insurers to be a focus of difficulty under these provisions should the arrangement be broken or ended acrimoniously by the insurer or practitioner. See also our comments related to S.124 above.

PART 8 Complaints, performance, health and conduct

General Comment:

- The capacity for any State or Territory to opt out of National Law complaint processes means that the PIA arrangements, and other complaint mechanisms, will not apply in that jurisdiction. In our view that will ultimately lead to inconsistencies, which will be perceived by some parties at least to be unfair. It will also substantially undermine the characterisation of the NRAS arrangements as the much vaunted 'nationally consistent approach to professional regulation'.

Division 2 Making a complaint

S.153 How complaint is made

(1) A complaint may be made to the National Agency:
(a) Verbally, including by telephone, or
(b) in writing, including by email or other electronic means.
(2) A complaint must include particulars of the ground on which it is founded.

Comment:

- A verbal complaint should not be acceptable – a complaint should be in writing. Verbal complaints often make the foundations of the complaint unsafe. A written record of the complaint ensures that it remains a stable point of reference rather than shifting during the course of an investigation or hearing. This is required to ensure fairness in the process.
- We support S.154 (1), but do not support S.153 (1)(a). If S.154(1) is included then, in the interests of documenting an accurate account of the complaint and being able to communicate that with all parties, it would be best if complaints were in writing.
- For administrative ease, it is best that an appropriate form be used. This allows for the necessary information to be collected and reported on, i.e. the particulars of the allegation (in the words of the notifier), the identity of the practitioner against whom the notification is made, the identity of the notifier, the notifier's contact details and consent to exchange information.

Division 3 Other matters taken to be complaints

S.156 Mandatory reporting by health practitioners

(1) This section applies to a registered health practitioner (the ***first health practitioner***) who reasonably believes another registered health practitioner (the ***second health practitioner***) has behaved in a way that constitutes reportable conduct.

Comment:

- Practitioners will be seeking guidance and advice on what might constitute a reasonable belief.
- While we support mandatory reporting <u>by treating practitioners</u>, we do not believe these obligations should apply to immediate family. There are many practitioner families in which parent/child and sibling relationships should be recognised as well as spouses.
- S.156(1) - (3) provides that:
    1. If a registered health practitioner forms **a reasonable belief** that another registered health practitioner has behaved in a way that constitutes "**reportable conduct**", then the first health practitioner must report the second health practitioner to the National Agency.
    2. Reportable conduct is defined in S.6 to mean the health practitioner **has** practised whilst intoxicated by drugs or alcohol or engaged in sexual misconduct in connection with the practice of his/her profession or placed the public at risk of substantial harm because the health practitioner has an impairment or has practised in a way that constitutes a departure from accepted professional standards.
    3. Failure to comply with the requirement may constitute behaviour for which disciplinary action may be taken.
- Our legal advice indicates it is arguable that the definition of reportable conduct assumes that a determination has been made that the relevant conduct occurred. In this regard we highlight the use of the word "**has**". This is taken to mean that the second health practitioner can only form a reasonable belief

based on information that would establish the conduct **has** occurred. It follows that mere allegation is not enough to form a reasonable belief.

- Good Samaritan actions by practitioners who are not 'on duty' when called upon to assist a person in exigent need should also be protected. Currently, a practitioner who assists a person in an emergency would be exposed to potential disciplinary action if they did so at a venue such as a hotel or licensed restaurant where they had consumed alcohol. This should be remedied in the drafting.
- Mandatory reporting should also be balanced against support for self-reporting and rehabilitation measures. As noted above, impaired practitioners should be supported to remain in or return to productive practice to the extent possible, while protecting public health and safety.
- Dentists will also be concerned about the need to be satisfied that the relevant conduct puts the public at risk of "substantial harm". Such a subjective term will result in differing standards being applied. The same can be said of the expression "accepted professional standards".
- Various ADA Branches have long employed senior dentists to assist members and professional indemnity insurers, with whom they have corporate authorised representative agreements, to administer dento-legal matters. In fact, most of the advice they provide is for complaint resolution rather than for the purpose of a legal proceeding (and our legal advice indicates it is arguable that a disciplinary matter is not a legal proceeding) or for the purpose of being provided to a lawyer for the preparation of legal advice.
- We therefore urge that these 'agents and nominees' of the PI insurers also be included in the exemption detailed in S.156 (4)(a)(i) so that it would read:

  (4) Subsection (2) does not apply if:

  (a) the first practitioner

  (i) is <u>an employee, agent or nominee of</u> an insurer that provides professional indemnity insurance ...

S.161 National Board may deal with complaints about same person together

Comment:

- While it may seem convenient to deal with multiple complaints "en bloc" we argue that if this were to occur, the National Board may be unduly influenced in its view of the practitioner. Details of complaints relating to incidents involving other patients, unrelated conduct or practice matters would not be relevant to the matter at hand.
- Recommendation:
  - That S.161 be amended by deletion of the ability to hear unrelated complaints "together" and introduce a limitation that complaints can only be considered "together" if the "complaints are arising out of the same course of treatment or arise from the same complainant."

S.164 Preliminary Assessment

Comment:

- Our concern here is that a decision is to be taken as to whether to refer a complaint to a disciplinary body before any investigation has been undertaken.

- A preliminary assessment should be confined to the question of relevance and appropriateness. With the possible exception of a situation requiring immediate action under Division 5, all other options for action related to professional conduct should only occur after the completion of an investigation. Referral of the matter to a health complaints entity (S.165 (4)(f)) or rejecting the complaint (S.165 (4)(g)) would not require completion of an investigation of course.
- To refer the complaint to a relevant tribunal (S.165 (4)(b)) without having established whether there is any foundation to the complaint is a gross denial of procedural fairness. Likewise referring a matter to a Professional Standards Panel (PSP) under Division 7 (S.165 (4)(d)), or to a Health Assessment under Division 8 (S.165 (4)(e)).
- Premature referral of a matter to a tribunal or PSP without having obtained the evidence that will need to be presented to such a body is likely to result in cases being dismissed as groundless.
- The ADAVB considers that this element of the complaint management process is so fundamentally flawed that it could make the Boards' disciplinary functions ineffectual. The structure of S.165 should therefore be modified to reflect the need for both greater procedural fairness and administrative effectiveness at this preliminary assessment stage.

s 166(2) Relationship with health complaints entity

Comment:

- Where a health complaints entity has given the National Board a copy of a complaint received by the entity it is implied that the Board then deals with that complaint as per S.164. Perhaps this could be made explicit.

S.167 Rejection of complaint

(2) If a health complaints entity receives a complaint about a health practitioner, the health complaints entity must, as soon as practicable after its receipt:
(b) give to the National Board:
(i) a copy of the complaint or, if the complaint was not made in writing, a copy of the health complaints entity's record of the details of the complaint, and

Comment:

- This appears to contravene the concept of natural justice. Vexatious and unproven complaints should be excluded from any consideration of a pattern of behaviour. How can it be considered part of a pattern of behaviour if the breach was never proved?
- Does this mean rejecting a complaint before or after an investigation has commenced?
- It would be difficult to determine whether a complaint is frivolous, vexatious, misconceived or lacking in substance without commencing an investigation. Powers should be provided to enable Boards to seek further or better particulars from the notifier as part of the initial assessment. The suggestion that the complaint is 'lacking in substance' is enough to warrant seeking more information to substantiate such a claim?!

- With regard to sub-paragraph 167(2), we do not support rejected complaints being taken into consideration as part of a pattern of behaviour. If this clause is to be included as is, then all complaints should be investigated and finalised. It may be that the outcome results in 'no further action', but at least the matter was investigated.
- Would the 'rejected complaint' be investigated before being taken into consideration at a later time as part of a pattern of conduct?
- The capacity for any State or Territory to opt out of National Law complaint processes means that this will ultimately lead to inconsistencies, which will be perceived by some parties at least to be unfair. It will also substantially undermine the characterisation of the NRAS to take the nationally consistent approach to professional regulation' that was promised.
- Other concerns about the complaints processes include:
  - Provisions for performance and health are considered problematic and underdone
  - Processes are not clear and workable
  - The Bill:
    - treats performance as misconduct but is very different
    - does not differentiate adequately between performance and unprofessional conduct
    - forces performance assessment before any action is commenced
  - health impairment:
    - the philosophy should be that the Board will work with the practitioner to keep them working – whether the intervention starts through self referral or complaint
    - legal power is required to allow Boards to move though the process without an adversarial approach being their only option

Division 5 Immediate Action

S.168 Immediate suspension or imposition of condition

Comment:

- This provision permits the Board to take action that could include suspension or surrender of the practitioner's right to practice without any formal approach having been made to the practitioner. We are concerned that the basis for such action is only the Board's *"reasonable belief", as this* is too low a standard of evidence given that this "Immediate action" may have the most serious consequences for the practitioner and the practitioner's patients.
- "Reasonable belief" implies a belief based on the balance of probabilities. This is the civil burden of proof only, yet it is being identified as forming the basis of a belief that will enable a Board to take action regarding a practitioner's ability to practise. This is inappropriate. The standard of belief must equate with the severity of the penalty being imposed.
- Where the register is being annotated to show the outcome of such immediate action, the annotation should be accompanied by the words "pending an investigation".

Division 6 Referring complaints to tribunals

S.172 Decision

(2) A decision by the responsible tribunal to dismiss the complaint does not prevent a National Board or disciplinary body taking the complaint into consideration at a later time as part of a pattern of conduct or practice by the health practitioner.

Comment:

- As for S.167.

S.173 Action that may be taken by the tribunal

(d) impose a condition on the practitioner's registration, including, for example:
(iv) a condition requiring the practitioner to manage the practitioner's practice in a specified way, or

Comment:

- This appears to potentially immerse the Tribunal in commercial matters that it may have no expertise to deal with. Nor would they be prepared for the potential commercial losses and liabilities - especially in corporate type practice models.

Division 7 Professional standards matters

Subdivision 2 Professional Standards Panels

S.189 Decision of professional standards panel

(3) A decision by the professional standards panel to take no further action in relation to the complaint does not prevent a National Board or disciplinary body taking the complaint into consideration at a later time as part of a pattern of conduct or practice by the health practitioner.

Comment:

- As for S.167.

Division 8 Health Matters

Subdivision 2 Health assessments

S.193 Requirement for health assessment

Comment:

- This section does not appear to address the known problems of ensuring cooperation of the practitioner during the assessment and the assessed practitioner providing consent for release of the report.

S.197 National Board's decision

(3) A decision by the National Board to take no further action in relation to the complaint does not prevent a National Board or disciplinary body taking the complaint into consideration at a later time as part of a pattern of conduct or practice by the health practitioner.

Comment:

- As for S.167.

S.198 Action by National Board at end of proceeding

Comment:

- Sub-paragraph 1(a)(iv) permits the Board to "impose a condition on the practitioner's or student's registration. While this is recognised as appropriate, we suggest that the nature of the problem and the details of the condition need not be public and that a Board should have the discretion to not disclose those details where they consider it is in the interests of the practitioner or student's **rehabilitation**. The register could simply indicate that a condition has been imposed, without specifying what it is or why it was imposed. This reflects the sensitivity of most impairment cases, as already acknowledged by S.206, where these hearings are not open to the public

S.208 Decision of health panel

(2) A decision by the health panel to dismiss the complaint does not prevent a National Board or disciplinary body taking the complaint into consideration at a later time as part of a pattern of conduct or practice by the health practitioner or student.

Comment:

- As for S.167.

Subdivision 4 Power to enter places

S.220 Entering places

Comment:

- We argue that <u>private</u> practice rooms should not qualify as a "public place".
- If a Board has reason to conduct an investigation then it should obtain a warrant in the normal manner, and as provided for in sub-paragraph 220 (c).

Subdivision 6 Procedure after investigation

S.240 Investigator's report about investigation

Comment:

- At which point does natural justice get exercised if at all?

PART 9 Finance

No comment

ADA VICTORIA

PART 10 Information and Privacy

Division 1 – Privacy

S.259 Application of Commonwealth Privacy Act

Comment:

- This will cause some conflict between the States and Territories health complaints entities and the National Board.

S.266 National Board to publish certain decisions

Comment:

- We do not support S.266 as currently worded. Only decisions where there is an adverse finding against a practitioner should be published.
- Patient details should always be de-identified.
- For matters that are not serious misconduct issues, the practitioner details should also be de-identified.
- S. 266(c) appears to have suffered a drafting error. We assume it is meant to read "decisions made by health panels established by the Board". This section also raises concern as there has been longstanding recognition that impaired practitioners should not have details of their circumstances published.
- As regards S.266(2), we ask, what criteria the Board are expected to use when determining whether non-publication of decisions is in the public interest. In our view, such criteria need to be explicit and consistently applied across all boards. Without explicit criteria inconsistencies are bound to occur, and guiding principle (a) will once again be subverted.

Division 3 – Registers in relation to registered health practitioner

S.271 Information to be recorded in registers

- A practitioner's undertaking does not appear to be included on the register unlike imposed conditions or as per undertakings of students on the student register. (See S.273)
- As regards S.271 (2)(b), we agree that no private contact information should be included on the publicly available register (although postal and practice address may differ & important for Board to have postal addresses), the practice address(es) should appear in full on the publicly available register to improve access to care and assist professional referrals.
- In addition to current conditions and suspensions, the register could list details of any adverse findings.

Division 4 Student registers

S.275 Information to be recorded in student register

Comment:

- The information to be included in this register would be easily sought and more accurate if the Board were able to require students to complete an application form and provide proof of both identity and enrolment.
- Details of the course which the student is undertaking would be usefully included.
- The date of registration in S.275 (2)(e) should be the same as S.275 (2)(f).

Division 5 Records

S.276 Records to be kept by National Boards

Comment:

- In relation to sub-paragraph (f) 'information about the practitioners PII arrangements' - this could be just a declaration from an individual that there is, or will be, in force in relation to the individual professional indemnity insurance arrangements (which is currently the case for the DPBV).

PART 11 Miscellaneous

No comment.

PART 12 Transitional Provisions

No comment.

ENDS

ENQUIRIES:

Mr Garry Pearson
Chief Executive Officer
ADAVB Inc.
Ph. 03 8825 4600
garry.pearson@adavb.org