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AMA Submission: Mandatory Reporting

The AMA calls for changes to the reporting scheme so that the provisions in the National Law do not prevent a practitioner from seeking medical treatment. Practitioners are also patients, and should have equal rights to their patients, in that their access to medical treatment should be equal to all other Australians.

The unintended consequences from the operation of the current law are far reaching, with doctors and their families suffering, and a less safe system for patients. For the treating practitioner it has also had a detrimental impact on the confidentiality of the doctor-patient relationship.

The provisions in the law in Western Australia (WA) provide a suitable and tested model. There is no evidence to suggest diminished patient safety in WA. Adoption of the WA model would also provide much needed national consistency.

Healthy doctors are best placed to help patients.

Impact of the scheme

Doctors and other health workers have the highest suicide rate in Australia's white-collar workforce, according to data from the Australian National Coronial Information System. This shows that between January 1, 2011, and December 31, 2014, there were 153 health professionals who died as a result of suicide. Within the profession, that represented a suicide rate of 0.03 per cent, lower than for some occupations but the highest among white-collar workers.

By raw numbers, more health professionals died by suicide in the three-year period than any other professional group.

Specifically, in relation to medicine there is evidence that doctors are at greater risk of mental illness and stress-related problems and more susceptible to substance abuse[1] [2]. Further, depression and anxiety are common among doctors and their suicide rate is higher than in the general population[3]. Medical

[1] Willcock SM, Daly MG, Tennant CC, Allard BJ. Burnout and psychiatric morbidity in new medical graduates. Med J Aust 2004; 181: 357-360
[2] Schattner P, Davidson S, Serry N. Doctors' health and wellbeing: taking up the challenge in Australia. Med J Aust 2004; 181: 348-349
[3] Elliot L, Tan J, Norris S. The mental health of doctors –A systematic literature review executive summary. Melbourne: beyondblue: the national depression initiative, 2010. http://www.beyondblue.org.au /index.aspx?link_ id=4.1262&tmp=FileDownload&fid=1947

students also experience higher rates of depression and stress[4]. We also know that the suicide rate among female medical practitioners is higher than their male colleagues.

At the AMA National Conference 2017, the issues surrounding mandatory reporting were raised by members as these regulatory requirements form a significant barrier to those seeking help at early stages of their illness. Indeed, an extensive study of over 12,000 doctors undertaken by *Beyondblue* in 2013, revealed that one of the most common barriers to seeking treatment for a mental health condition was concerns about the impact of this on medical registration (34.3%)[5]. The report highlights that the work experience of Australian doctors is stressful and demanding, and further highlighted that 52.5% say a fear of lack of confidentiality/privacy is a barrier to treatment – an issue closely related to fears surrounding mandatory reporting.

The AMA would also argue that mental health issues, in particular, will continue to be stigmatized within the profession, if the national law continues to result in a fear of mandatory reporting and potential deregistration. As the *Beyondblue* report itself states, "As doctors also play a pivotal role in educating the community about important health issues, doctors' attitudes towards mental health problems play an important role in reducing the stigma of mental illness in the community at large". An article in the Journal of Law and Medicine further reinforces this point, stating "the stigma around seeking health care already creates a serious barrier for doctors with mental health issues. Raising the barriers (perceived or real) to health access by introducing mandatory reporting clearly undermines the very purpose of the National Law with its focus on patient safety"[6].

AMA members at the National Conference provided their unanimous support for a motion calling for the urgent removal of mandatory reporting across the country, reflecting the strength of the concern within the profession.

The mandatory reporting requirements for treating practitioners have a twofold effect: some health practitioners will not seek treatment at all; and those who do seek treatment may not divulge all the necessary information to receive appropriate care.

It is critical that every health practitioner can have the confidence to access medical care and treatment in a timely way so that health conditions are diagnosed and managed early. Patient confidentiality is fundamental to the doctor-patient relationship, including when the patient is a health practitioner. It is critical that if a health practitioner does seek treatment, that they can have an open discussion about their symptoms so they can be properly diagnosed and treated. This is the only way to avoid the impairment issues that may put patients at risk of harm.

The AMA is extremely concerned that we have a situation now where health practitioners may be avoiding appropriate health care. By extension, this raises a risk of harm to patients when health practitioners do not have appropriate health care. This far outweighs the risks posed by an exemption for treating practitioners from mandatory reporting.

Our members are reporting that their care of health practitioners is being compromised because they know some of their patients who are health practitioners are withholding information. Doctors Health

[4] Dahlin M, Joneborg N, Runeson B. Stress and depression among medical students: a cross-sectional study. Med Educ 2005; 39: 594–604

[5] https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report_web

[6] Goiran N (MLC), Kay M, Nash L, Haysom G. Mandatory reporting of health professionals: The case for a Western Australian style exemption for all Australian practitioners. Journal of Law and Medicine 2014; 209-220.

Advisory Services have previously reported a significant drop off in the level contact from medical practitioners following the introduction of the current mandatory reporting regime. There is anecdotal evidence to suggest that some practitioners are travelling to Western Australia to seek care, safe in the knowledge that they do not have to worry about a mandatory notification by their treating doctor.

The issues caused by the mandatory reporting regime are front of mind for the medical profession. The profession understands that the original design of the provisions was to protect the public from unsafe doctors. However, in practice it is failing to achieve this aim and it is the AMA's position that the provisions are costing the lives of doctors across the country. The current mandatory reporting provisions, in practice, are being interpreted as requiring a doctor who is treating another doctor who they believe to be in some way impaired, to report that doctor to AHPRA. Then begins an opaque and clumsy investigation period where the livelihood of the doctor in question is put at risk while their stress and anxiety, naturally, continues to worsen.

Reforms

The AMA proposes the adoption of the 'WA model' across Australia, as outlined in Option 2.

The opportunity to design a system that supports practitioners and the public must not be squandered.

A key principle for the AMA is that the new provisions should not prevent a practitioner from seeking medical treatment. The current problem has arisen as the wording of the National Law has been interpreted to provide a very low threshold as to when a notification must be made by the treating practitioner. In practice, the test threshold is applied at the lowest level, rather than as anticipated by the legislators. This is because treating practitioners, naturally, seek to limit their risk.

For this reason, both Option 1 and Option 3 as outlined in the discussion paper will simply not address the problem at hand, and as such, will likely continue to deny practitioners access to health services. Both create a level of ambiguity for the treating practitioner, which will inevitably be managed by limiting risk. Option 3, is very similar to the current model in Queensland, and would result in the same problem of requiring a medical practitioner to make a judgement as to whether the practitioner being treated may pose a substantial risk harm at some indeterminate point in the future.

The Parliament of Western Australia accepted the medical profession's arguments on this issue. Consequently, the Western Australian National Law contains an explicit exemption from mandatory reporting for treating doctors.

We note that no Government has produced any evidence to demonstrate that harm to patients could have been prevented if a health practitioner's treating practitioner had reported the practitioner to the relevant registration board. The reality is that most health practitioners become aware of risk of harm to patients by another practitioner while working with that practitioner. The mandatory reporting requirements apply in these situations.

The Snowball Review of 2014 recommended that the National Law be amended to reflect the same mandatory notification exemptions for treating practitioners established in Western Australian law.

The WA model does not stop the medical profession's ethical and professional responsibilities to report a practitioner who may be placing the public at risk. AMA analysis of the publicly available data is that variation in the Western Australian law does not appear to have made a material difference to the rate

of mandatory notifications, and this was affirmed by the review. WA treating practitioners still have an ethical and professional obligation to report where a patient poses a serious risk to the public. Furthermore, as the AHPRA Annual Report data highlights, the introduction of the WA exemption has not led to a drop in mandatory reporting in WA, but rather the opposite – rising from 12 mandatory notifications for 2011/12 to 37 in 2015/16.

Bismark et. al was similarly unable to interrogate data provided by AHPRA to determine that the exemption in Western Australia was detrimental to public safety[7]. Bismark found that 92% of mandatory reporting was made by fellow colleagues and employers. To put another way, if an exemption was made to mandatory reporting for the treating practitioner in other states and territories, the overwhelming majority of mandatory reports which are being made by colleagues and employers, would not be impacted. There is no evidence to suggest that the WA exemption has had a detrimental impact on public safety in that state.

The inconsistency across the jurisdictions regarding mandatory reporting by treating practitioners can be removed by adopting this model uniformly across the country.

Should it be impossible to adopt the WA model nationally, an option to exempt treating practitioners from reporting impairment (but not sexual misconduct) would provide a greater level of assurance to practitioners seeking treatment than currently exists. This could potentially be achieved by modifying Option 4. The model would need to exempt notifiable conduct related to impairment for both future and past behavior. If not, it creates a situation where a full discussion as part of the treatment cannot be had, again leading to a detrimental outcome.

Any new, unproven model introduced that still seeks to have the treating practitioner try to make a judgement about future 'risk' will likely simply result in practitioners not being able to access health services (as we have seen with the Queensland model)– leaving the problem we are seeking to address still very much in place. Furthermore, it will not provide a nationally consistent scheme. Medical professionals in all jurisdictions deserve the same level of access to care for their own health in a nationally consistent manner, and the same level of care they provide for their patients.

Contact

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[7] Bismark, M, Spittal M, Plueckhahn TM, Studdert DM, MJA 2014; 399-403.