AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | info@ama.com.au
W | www.ama.com.au
42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

AMA Submission: Mandatory Reporting

The AMA has long called for changes to the Mandatory Reporting law. Australia's medical practitioners desperately need legislation that does not actively discourage them from seeking medical treatment when they need it. Practitioners are also patients and should have equal rights to access confidential high-quality medical treatment as their own patients and all other Australians.

As the AMA has continually stated, the unintended consequences from the operation of the current National Law are far reaching. Doctors are avoiding seeking treatment for their own health concerns, particularly mental health concerns, out of fear of the consequences and they and their families are suffering as a result. Ironically, current mandatory reporting law put in place to protect the public is actually more likely to expose it to untreated, unwell doctors. For the treating practitioner, it has also had a detrimental impact on the confidentiality of the doctor-patient relationship, impairing the ability of the practitioner to deliver an appropriate level of care.

It is for this reason that, when the COAG Health Council (at its meeting of August 2017) agreed *"that doctors should be able to seek treatment for health issues with confidentiality whilst also preserving the requirement for patient safety"*, the AMA saw the potential to finally fix the issue.

A nationally consistent approach to Mandatory Reporting provisions will provide confidence to health practitioners, enabling them to seek treatment for their own health conditions anywhere in Australia.

The AMA took part in the resultant public consultation process and lodged the attached submission (**Attachment A**) outlining the case for change. This submission highlights the tragic levels of suicide within the medical profession and includes the sobering statistics from the *Beyondblue* study which confirm 'Mandatory Reporting' laws are a clear and present barrier to seeking help. We have reattached that submission to form part of our response to this round of consultation. These statistics need to be front of mind in redrafting the National Law, as they contribute to understanding the extent to which practitioners' interpretations of the current legislation deters access to treatment.

Ultimately, the AMA submission argued that 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. Furthermore, the AMA is supportive of removing the exemption for sexual misconduct, and

therefore strongly supported what was colloquially known as 'WA lite', on the basis that the likely interpretation of the law, and therefore its practical effect, were known.

With no evidence that the WA model is doing anything other than improving practitioner health, and therefore, improving consumer protection, the AMA would still support Ministers choosing to implement the tried and tested WA or WA lite models. There appears to be no reason not to adopt the WA model as a first choice. It has the benefit of not only being simple, but having been proven to work, with no downsides, and as far as the AMA is aware, supported by a number of peak groups. We know how doctors will interpret it, how the other professions will interpret it, how the MBA/AHPRA will interpret it and how legislators interpret it. It remains successful because of this shared understanding.

In November 2017, the AMA again noted the commitment by the COAG Health Council to *"progress with a predisposition to a national system that supports the mental health of the health professions whilst protecting patients, for consideration by the COAG Health Council out of session as a matter of urgency".*

The AMA welcomed the opportunity to present to Health Ministers at the April 2018 COAG Health Council meeting. What became clear to the AMA at that meeting was the intent of Health Ministers to amend the law to increase access to treatment for practitioners, but also that the WA model was not being considered as a solution they would adopt.

In the absence of adopting a proven approach, the meeting also considered the paramount need for clarity in the *actual wording* of the legislation in order to address the existing perception problem. That is, the current threshold of 'risk of substantial harm' is actually seen as a very low threshold and this perception creates a very real barrier to seeking treatment.

Wisely, the COAG Health Council agreed to undertake further consultation on the draft legislation. Our views on the proposed amendments are below.

Feedback on the August 2018 draft amendments

Designing a law to increase treatment and support

The mandatory reporting requirements for treating practitioners have a threefold effect: some health practitioners will not seek treatment at all; some may delay accessing treatment and become much sicker as a result; and, of those who do seek treatment, some may not divulge all the necessary information to receive appropriate care.

A key principle for the AMA is that the amended legislation should encourage and support a practitioner to seek medical treatment. The current problem has arisen in part as the wording of the National Law has been interpreted to provide a very low threshold for mandatory reporting by the treating practitioner. In practice, the reporting threshold is applied by treating practitioners at the lowest level, rather than at a level of 'substantial harm' as anticipated by the legislators. This is because treating practitioners, naturally, seek to limit their risk.

This is why the AMA supported the WA and WA lite models. It was clearly understood how these solutions would be interpreted and used by the professions. It was clear they achieved the intent of the COAG Health Council, which was to support timely access to treatment for the profession. The AMA strongly believes that healthier doctors lead to healthier patients, and the fact that levels of mandatory reporting in WA have not substantially changed, signal that the WA approach is working.

Recognising the COAG Health Council's intent to amend the National Law to achieve the same outcome, the language used will be critical. The legislation needs to not only state that doctors can seek treatment without fear – it must be perceived by the profession in such a way.

It is for this reason the AMA believes the following amendments are absolutely necessary to 'lift' the mandatory reporting threshold for treating doctors to a level that will achieve Health Ministers' intent.

Raising the risk threshold; maintaining a consistent harm threshold

Looking at the draft legislation, it is clear what is being proposed is to raise the existing 'risk' threshold to become 'substantial risk', but only for a treating practitioner, as per clause 141B(1). The AMA believes this intent to 'raise the bar' is a move in the right direction. Additionally, we support page 10 of the consultation document, which clearly states that the intent is to adopt a 'higher threshold' for mandatory reporting by treating practitioners.

Treating practitioners need to feel they have the discretion, and the 'space', to use their years of clinical judgement to enable them to do their job – treating patients and developing viable treatment plans. For the practitioner-patient, we need to ensure the National Law is interpreted as allowing them to seek treatment and, during that treatment, to be open and honest about their concerns. This is essential to establishing a viable and effective treatment regime. Only by doing so will the legislation promote better doctor, and therefore patient, health.

However, the proposed amended clause is highly problematic as, while it raises the 'risk threshold', for unclear reasons, it simultaneously lowers the harm threshold.

The existing notification threshold of all professions is 'risk of *substantial* harm' (Section 140(c)). This clause is not being amended.

The new threshold which will only be applied to treating practitioners is '*substantial* risk of harm'.

Raising the risk threshold to exclude trivial risks is laudable, however, the AMA does not support the lowering of the harm threshold. We believe that a threshold of harm should be consistent across this legislation (i.e. '*substantial* harm'). To have this level of inconsistency in dealing with such a pivotal threshold continues to invite risk averse interpretations, which will result in medical practitioners not seeking treatment. This is not the stated aim of the COAG Health Council.

For example, applying the amended definition a treating practitioner may determine there is a substantial risk of a practitioner-patient causing a very low level of harm (such as inconvenience caused by rescheduling procedures). This is unlikely to be the kind of harm that the drafters of the clause are targeting. This uncertainty creates the same kind of interpretation issues as are occurring with the professions' understanding of the current thresholds.

Furthermore, maintaining 'substantial' in Section 140(c) as a measure of consequence ('substantial harm') and in Section 141B as a measure of likelihood ('substantial risk of harm') is confusing and inconsistent with standard approaches for assessing risk. Further, we note a risk-based approach to regulation is an international movement, across all government portfolios. The foundation of this is a clear description of both the frequency and impact of a risk. It is high and moderate impact events that regulation should be aimed at, not minor and infrequent events.

Note also that this language ('substantial risk of harm') is currently used in clause 141(1)(b) to describe notifiable conduct for students. In other words, under the proposed approach treating practitioners need to apply the same test to practitioner-patients as they apply to students ('substantial risk of harm'), but health practitioners who work with the same practitioners everyday need to apply a different test ('risk of substantial harm').

The need for holistic assessment for healthier doctors and increased consumer protection

<u>The overlap of alcohol, drugs and impairment</u>

The AMA welcomes the statement in the consultation document that the intent of the proposed amendments is to allow the treating practitioner to make a 'holistic assessment of risk' and that, as per page 11 *"This holistic approach is intended to encourage practitioners to fully disclose the nature and extent of their impairment, including any related intoxication or performance issues. Full disclosure by a patient will allow the treating practitioner to provide more effective treatment."*

Likewise, the consultation diagram on page 6 also reflects the interrelationship between impairment, substance use and professional standards. For many patients with mental health problems, intoxication and substance abuse are linked to this condition and they cannot be considered separately.

However, the draft legislation does not, in its current form, reflect this stated aim of the consultation document. Proposed clause 141B(1) separates out alcohol and drugs from other types of impairment. It is our strong opinion that this is not necessary. Some 'impairments' include the related issues of drugs and alcohol. The draft legislation's definition of impairment recognises this, stating that an impairment includes a: *"condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect…".*

The effect of separating clause 141B(1) out, as per the proposed amendments, is likely to be perceived by the profession as creating two separate clauses that both deal in some way with alcohol and drugs. This will only create confusion.

It may also prevent some practitioner-patients from seeking needed treatment because alcohol is involved. While it may appear counter-intuitive, the reality is including clause 141B(1)(b) as a separate category for mandatory reporting may create uncertainty for a practitioner with a health issue that involves, to some degree, alcohol and drugs. This is likely to translate to them avoiding treatment - at great cost to themselves, their families and possibly their patients.

Clause 141B(1)(b) should be removed so that the draft legislation reflects the stated intent of the consultation document and removes the inherent uncertainty in the existing wording. This is so that it is clear to practitioners with these issues that there is a confidential avenue for them to seek help. Once they do, they are more likely either to be treated (thereby improving patient safety as their condition improves) or, if treatment is not possible, reported (again, improving patient safety).

Neither of these scenarios is as likely occur with the clause included. This would be a detrimental outcome if the goal is to improve patient safety and practitioner's wellbeing.

Consistent application of the 'decision-tree' in 141B paragraph 5

Secondly, while the consultation document talks about 'holistic' assessment, as page 6 exemplifies, *"A practitioner-patient's conduct relating to impairment, intoxication or departure from professional standards may be interrelated or connected. Under the reforms, a treating practitioner may make an overall assessment about a practitioner-patient's conduct in deciding whether a mandatory report is required"*, proposed clause 141B(5) does not reflect this.

The guidance a treating practitioner may consider for impairment, as outlined in clause 141B(5), is via a type of 'decision-tree'. This decision-tree allows consideration as to whether the practitioner-patient is taking steps to address the impairment, and the extent to which it can be managed with an appropriate treatment plan.

However, this 'decision-tree' *only* applies to 'impairment'. It does not, as the consultation document suggests, apply to drugs and alcohol, nor a departure from professional standards. The AMA's concern is that this again creates confusion as it means two or three sets of rules may apply to the same condition.

For example, if an impairment involves alcohol, under the current draft of the legislation, both treating practitioner and practitioner-patient will be unclear as to whether clause 141B(5) can be applied in determining risk/harm. Given the professions' tendency to adopt a risk averse stance, they are both likely to interpret this section as requiring mandatory reporting. This will discourage practitioners with drug and alcohol issues from either seeking treatment or, if they do seek treatment, being honest with their treating practitioner about the extent of their impairment.

Likewise, an impairment that involves a level of departure from professional standards will cause confusion. As soon as an impairment, even one that is being satisfactorily managed, involves even a low-level departure from professional standards, the interpretation can be that a mandatory report must be made. Again, while the consultation document makes it clear that

this is not the intent, the AMA is concerned that practitioners will read the legislation as requiring reporting.

The most straightforward solution would be to ensure that clause 141B(5) (the decision-tree) applies to all the conditions listed under proposed clause 141B(1), not just impairment. This would provide clear legislative support for the holistic assessment outlined in the consultation document.

Like the scenario outlined by the AMA above, removing a deterrent to seeking treatment will ultimately improve patient safety, not lower it. Furthermore, applying the 'decision-tree' in clause 141B(5) to all the conditions in clause 141B(1) will not mean that professional conduct issues unrelated to an impairment go unreported. If a departure from professional standards is not related to an impairment then a treating practitioner applying the 'decision-tree' should conclude that it cannot be managed via a health management plan and, depending on the risk and harm, must be reported. This may lead to greater reporting of issues, which will ultimately result increased patient safety.

Finally, these amendments would also be consistent with the proposed approach to students, where alcohol is treated in the same way as any other impairment (Section 141(1)(b).

Removing any perceived deterrent to treatment from the proposed amended legislation

The amendments proposed by the AMA above are focused on removing actual or perceived barriers to medical practitioners seeking help. For the same reason, the AMA considers that it is unnecessary and counterproductive for the 'decision-tree' in clause 141B(5)(a) to expressly require the treating practitioner to consider "*the nature, extent and severity of the impairment*". This is because:

1. A treating practitioner will already need to take these issues into account to satisfy clauses 141(5) (b), (c) and (d) which state:
   (b) the extent to which the second health practitioner or student is taking, or is willing to take, steps to manage the impairment;
   (c) the extent to which the impairment can be managed with appropriate treatment;
   (d) any other matter the treating practitioner considers is relevant to the risk of harm the impairment poses to the public.
2. It is not possible to consider the steps needed to manage an impairment, and the extent to which an impairment can be managed with appropriate treatment, without first considering the nature, extent and severity of the impairment.

However, the express inclusion of these words, while not adding any additional guidance for the treating practitioner, does present a deterrent for the practitioner-patient. Since practitioners are risk adverse, practitioner-patients may attempt to predict what the treating practitioner may diagnose, or potentially overestimate the severity of their condition (i.e. catastrophise), and avoid seeking treatment simply because these words have been expressly called out.

Such an outcome is highly likely when you consider that the current legislated threshold of 'risk of *substantial* harm' is currently being interpreted by the profession as requiring the reporting of any risk of substantial harm, no matter how slight.

Exemption for Doctors Health Services

The AMA's final recommendation for improvement is an express exemption for Doctors' Health Services. Doctors' Health Services across the country are funded with support from the (MBA). They provide a range of services including telephone triage, advice and referral, education, and limited case management services.

The MBA has recognised Doctors' Health Services as being critical services to support the profession and medical students and effective in encouraging access appropriate help. While the draft legislation is intended to encourage access to care, the 'decision-tree' approach is not compatible with the actual operation of Doctors' Health Services, particularly in circumstances where they receive a crisis phone call from a distressed practitioner.

The strong advice that Doctors' Health Services have provided to the AMA is that it will be impossible for them to assess a patient against the 'decision-tree' in clause 141B(5), meaning that practitioners and students who call these services are left without the 'safe harbour' protection afforded by clause 141B(5). The practical outcome is that practitioners and students would be discouraged from contacting these services, despite their widely acknowledged benefit.

This would be rectified by including an express exemption for Doctors' Health Services in clause 141C(2).

Conclusion

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 in their course, to minimize exposure to risk of harm to practitioners and the public alike.

The counter-productive impacts of existing Mandatory Reporting legislation 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 practitioners. However, in practice it is failing to achieve this aim, and it is the AMA's position that the existing provisions are costing the lives of practitioners across the country.

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

Ultimately, the WA exemption for treating practitioners works because of a shared understanding – between the profession, government and legislators – as to what the legislation means.

In trying to find an alternative solution with these proposed amendments, it is critical we achieve that same level of understanding.

Therefore, we must remove language that creates any level of ambiguity for the treating practitioner – otherwise, as with the current National Law, they will seek to manage their own risk by over reporting.

Likewise, patient safety will not be served by practitioner-patients interpreting the law as creating a barrier to care. The AMA is extremely concerned that we have a situation now where health practitioners are avoiding appropriate health care. By extension, this raises a risk of harm to patients when health practitioners are not being appropriately treated. We need to remove this risk for patient and practitioner alike.

If practitioners feel they can seek assistance, then we will see practitioner health improve. We do not expect to see a drop in the mandatory reporting rate – we have not seen it in WA. **The reality is that most health practitioners become aware of risk of harm to patients by another practitioner while working with that practitioner, not by providing treatment to them. The same mandatory reporting requirements still apply in these situations.**

All medical professionals in all jurisdictions deserve the same level of access to care for their own health as they provide for their patients, in a nationally consistent manner. All patients deserve to be treated by healthy practitioners who do not have to hide any impairments from the practitioners who treat them.

Finally, but equally as critical, if a change to Mandatory Reporting legislation occurs (including all the amendments suggested), there will still need to be an extensive education and communication campaign with the profession. This education and communication will need to communicate that the law is *intended* to allow practitioners to seek treatment; it will need to highlight what Ministers, Governments and Regulators *interpret* as the increased 'substantial risk of substantial harm' thresholds, and therefore work to align the professions interpretation to match.

Furthermore, as part of such a campaign, the development of practical guidelines, that include examples/ case studies of how the 'decision tree' can, and should be applied, would help allay expected concerns from treating and patient practitioners alike that the proposed amendments remain complex. It would be an important mechanism in assuring practitioners that the law is intended to achieve the *same outcome* as the WA exemptions, despite being structured differently. Without such education and communication, the legislative changes are at risk of being less than fully effective.

31 August 2018

AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | info@ama.com.au
W | www.ama.com.au
42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

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

Jodette Kotz
Senior Policy Advisor
Medical Practice Section

29 September 2017

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