By Paul McCowan

MANDATORY REPORTING of health practitioners by health practitioners

On 1 July 2010, the National Registration and Accreditation Scheme for ten health professions administered by a national agency commences throughout Australia.[1]

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It is the culmination of an initiative of the Australian Council of Governments (COAG) since the signing of an inter-governmental agreement in March 2008. Each state and territory government has progressively introduced complementary legislation to create national unity in the regulation of these health practitioners.[2] Not only will the new national scheme deal with registration and accreditation of health practitioners by the national agency, it also prescribes a uniform framework for complaints-handling and disciplinary action. This article focuses specifically on new mandatory reporting requirements of certain misconduct of health practitioners, or impairment of students, to the national agency by health practitioners, employers and education-providers.

WHAT IS NOTIFIABLE CONDUCT AND THE REASONABLE BELIEF REQUIRED?

A major reform in the disciplinary and regulatory context will be the requirement for mandatory reporting by health practitioners to the national agency where another health practitioner is reasonably believed to have engaged in 'notifiable conduct'.[3]

The mechanics of the mandatory reporting provision will require a health practitioner ('the first health practitioner') to report the notifiable conduct involving another health practitioner ('the second health practitioner') or student. While the scope of this provision might appear to require notification of the conduct of health practitioners or students from all health professions, not merely the profession of the 'first health practitioner',[4] this interpretation is not totally assured. For instance, given the onerous requirements imposed under the provision, a judicial interpretation may hold that the duty might arise only over conduct within the same profession as the first health practitioner, unless there was a clear legislative statement to the contrary.

'Notifiable conduct' is defined to mean conduct where a health practitioner has either practised their profession while intoxicated by alcohol or drugs, or engaged in sexual misconduct in connection with the practice of their profession. Additionally, the 'notifiable conduct' extends to placing 'the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment' or 'placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards'. The requirements also extend to an obligation upon health >>

practitioners to report circumstances where a 'student has an impairment that, in the course of the student undertaking clinical training, may place the public at substantial risk of harm'.[5] 'Impairment' is defined to mean:

> 'the person has a physical or mental impairment, disability, condition or
> disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect –
> (a) for a registered health practitioner or an applicant for registration in a health profession, the person's capacity to practise the profession; or
> (b) for a student, the student's capacity to undertake clinical training—
> (i) as part of the approved program of study in which the student is enrolled; or
> (ii) arranged by an education provider.'[6]

A further requirement extends to an employer of a registered health practitioner being obligated to notify the national agency of any behaviour by the employee health practitioner which is reasonably believed to constitute 'notifiable conduct'.[7] The employment relationship may be constituted either under a contract of employment or a contract for services.[8] The notification by the 'first health practitioner' must be made as soon as practicable after a reasonable belief is formed as to the notifiable conduct.[9] Ironically, in the case of an employer, there is no 'as soon as practicable requirement' for notification to be made. Theoretically, at least, an employer might escape any adverse outcome by reporting the 'notifiable conduct' at the first sign of trouble, before any regulatory action may be commenced.

Additionally, education-providers have a duty to notify the national agency where 'notifiable conduct' arises in respect of students enrolled in its programs that involve clinical training. The notifiable conduct extends first to students having an impairment which may place the public at 'substantial risk of harm'.[10] Secondly, the requirement extends to circumstances where the education-provider has arranged clinical training in respect of a student who is reasonably believed to have an impairment where, in the course of the student undertaking that clinical training, the public may be placed at substantial risk of harm.[11] The subtle distinction between these two situations is best exemplified in the case of the second, where a student may be referred to another arm's length education-provider, which might give rise to a notification requirement. Here an education-provider will need to keep communicating with the other education-provider to ascertain whether any 'notifiable conduct' has occurred.

Just what constitutes a 'reasonable belief' in the circumstances will be open to interpretation. A leading High Court authority dealing with the question might provide guidance:

> 'The objective circumstances sufficient to show a reason to believe something need to point more clearly to the subject matter of the belief, but that is not to say that the objective circumstances must establish on the balance of probabilities that the subject matter in fact occurred or exists: the assent of belief is given on more slender evidence than proof. Belief is an inclination of the mind towards assenting to, rather than rejecting, a proposition and the grounds which can reasonably induce that inclination of the mind may, depending on the circumstances, leave something to surmise or conjecture.'[12]

Thus, a reasonable 'belief' is more than mere suspicion, but falls short of a requirement of absolute proof.

CERTAIN EXCLUSIONS FROM DUTY TO NOTIFY

There are certain exclusions from obligations to make a mandatory notification. In the case of health practitioners in insurance roles, it is deemed that the 'first' health practitioner does not form the requisite belief as to the 'notifiable conduct' (involving a 'second' practitioner or student) in the case where the first practitioner is 'employed or otherwise engaged by an insurer that provides professional indemnity insurance that relates to the second practitioner or student', and the notifiable conduct is disclosed 'in the course of a legal proceeding or the provision of legal advice arising from the insurance policy'.[13] The concept is extended to absolving a practitioner (or a combined health and legal practitioner) from an obligation to notify where the requisite belief is formed in the course of providing advice 'in relation to the "notifiable conduct" or impairment for the purposes of a legal proceeding or the preparation of legal advice' alone, or where the legal advice is prepared in a case where the 'notifiable conduct or impairment is an issue'.[14]

Further exclusions exist in cases where the 'first' health practitioner:

> 'forms the reasonable belief in the course of exercising functions as a member of a quality assurance committee, council or other body approved or authorised under an Act of a participating jurisdiction and:
> - is unable to disclose the information that forms the basis of the reasonable belief because a provision of that Act prohibits the disclosure of the information; or
> - the first health practitioner knows, or reasonably believes, the National Agency has been notified of the notifiable conduct or impairment that forms the basis of the reasonable belief.'[15]

SANCTIONS FOR BREACH OF DUTY TO NOTIFY

The sanctions for a failure to make the report of the 'notifiable conduct' to the national agency are, in the case of health practitioners, certainly less punitive than the sanctions that applied to medical practitioners, for instance, under pre-existing registration legislation in NSW[16] and also Queensland. In Queensland, mandatory reporting of 'reportable misconduct' commenced on 1 January 2010. Similar to the NSW provisions, in Queensland a failure to report misconduct as required is deemed to be unsatisfactory professional conduct and could lead to a medical practitioner being liable for disciplinary action.[17] However, under the new national scheme, a health professional in contravention of the mandatory notification section is declared not to have committed an offence but the non-notification may constitute 'behaviour for which action may be taken under this Part'.[18]

There appears to be a considerable level of discretion as to whether or not disciplinary action might be taken under

the national scheme for failure to report 'notifiable conduct', given the disciplinary powers of a national board. In such cases, a board must determine whether 'the practitioner has behaved in a way that constitutes professional misconduct'.[19] No doubt this approach would be consistent with the need for discretion, given the myriad possibilities where failure to report 'notifiable conduct' may come to light. For instance, the conduct may be revealed only consequent to a disciplinary proceeding against a health practitioner which commenced as the result of a public complaint.

The ramifications for any other health practitioner who may be revealed to have had knowledge of the circumstances of the 'notifiable conduct' will undoubtedly in most cases require the scrutiny of an investigation. The culpability or otherwise of an ostensible failure to report 'notifiable conduct', as discovered, might lead to inconsistency in cases that are referred for disciplinary action because of the discretionary nature of the power to refer disciplinary action to a responsible tribunal. This would ultimately raise a proposition that the process may be referred to as one of 'mandatory notification',[20] where the sanction mechanisms for failing to report 'notifiable conduct' are not based upon a concept of strict liability, or deemed unsatisfactory professional conduct, or deemed professional misconduct.

In the case of employers, some deterrent against failure to report 'notifiable conduct' exists. If the national agency becomes aware that an employer has failed to notify it about the 'notifiable conduct', the agency is required to give a written report about the failure to the responsible minister from the participating jurisdiction.[21] A minister who receives such a report has a duty to report the failure by the employer to a health complaints entity, the employer's licensing authority or 'another appropriate entity in that participating jurisdiction'.[22] As part of risk management policies and procedures, employers will need to ensure that adequate measures are taken to deal with instances of 'notifiable conduct', however such conduct is exposed.

In the case of an education-provider, failing to report 'notifiable conduct' risks publication of the details of the failure on the relevant board's website.[23] Additionally, the national agency 'may, on the recommendation of the national board, include a statement about the failure in its annual report.' Again, risk management strategies will need to be formulated by education-providers in the fields of health practitioner clinical training to counter the potential for loss of reputation in failing to report 'notifiable conduct'. No doubt the potential for administrative action involving employers and education-providers in respect of alleged failure to report 'notifiable conduct' could be greater than for health practitioners. This is because action against those entities would not be contingent or predicated on a threshold question of disciplinary action against them.

As with health practitioners, an education-provider would not commit an offence under the legislation by failing to report 'notifiable conduct'.[24] Ironically, however, while there is no such exculpatory provision for employers, there is no express offence clause applying to employers who fail to report 'notifiable conduct'. While there is no clear mechanism for prosecuting a breach of the legislation by an employer for failing to report 'notifiable conduct', an administrative action for such failure could nonetheless be predicated on a pure breach of the legislation alone.

PROTECTIONS FOR THOSE WHO NOTIFY

Various protections exist for those who make a notification to the national agency under the legislation, provided it is made in good faith.[25] The protections absolve a person from any civil, criminal or administrative action for giving the information. The provision also makes it clear that the giving of the information in the circumstances does not 'constitute a breach of professional etiquette or ethics or a departure from accepted standards of professional conduct'. Additionally, there is no liability for defamation 'incurred by the person because of the making of the notification'.

Once this legislation comes into operation, insurers of health practitioners will undoubtedly field numerous enquiries as to whether a health practitioner, employer or education-provider is required to report what may amount to 'notifiable conduct'. Not only will questions be raised about that threshold test, but they will also arise as to whether any reporting will be in 'good faith'. Certainly, in the case of such independent advice being sought, it would be more likely for a person or entity to point to good faith being exercised if a report of 'notifiable conduct' is made following the advice. Similarly, pressure will be on those advisers to ensure that >>

their advice is capable of standing up to scrutiny if later called into question.

WILL THE SYSTEM BE BENEFICIAL?

The whole concept of mandatory reporting requirements for health practitioners has had a controversial, if relatively short, evolution. On the one hand, there have been enormous public pressures for mandatory reporting of this nature to be introduced in the interests of public health and safety.[26] Alternatively, persuasive arguments have been advanced as to the potentially retrograde effect on the benefits of robust professional self-regulation, as well as the potentially difficult definitional and interpretative aspects of standards and competence that might constitute 'notifiable conduct', leading to a diminution of standards in healthcare delivery.[27]

Another serious reservation expressed about the new legislation at its draft exposure stage has come from groups with experience in the confidential management of impaired doctors, a well-recognised pursuit throughout Australia. Specifically, the Board of the Victorian Doctors Health Program (VDHP), in its submission, expressed concern that the well-established system of managing impaired medical practitioners and students confidentially to remove any potential risk to the public would 'set back the enormous improvements seen in Victoria in terms of earlier presentation and accessing of the best available help for sick doctors and medical students'.[28]

The thrust of the VDHP submission is that the mandatory reporting regime will effectively drive underground those who would otherwise seek help for impairment at an early stage rather than allowing the problem to mature into a serious potential risk to the public before being brought to light, if at all, under mandatory reporting. However, if any impaired health practitioner or student is being managed properly from the outset of a self-referral for treatment, any agreed conditions of practice might conceivably ensure that the public was not being placed at any substantial risk. Theoretically this would circumvent any potential duty to notify the national agency. If the health practitioner or student dishonoured any conditions of a treatment regime, then clearly an obligation to notify the national agency if the relevant threshold were reached would arise.

It will also remain to be seen whether the mandatory reporting regime will identify the systemic incompetence of an individual health practitioner in cases of hospital workforce shortages and lack of supervision, as might occur in a regional or remote location. Furthermore, given that the mandatory reporting of 'notifiable conduct' might be held to apply only to health practitioners within the same profession, what happens where a health practitioner in a team environment in one profession witnesses what would clearly amount to 'notifiable conduct' in respect of a practitioner in another profession?

Further, the potential mis-notification by practitioners from different health professions on competence issues, through a lack of understanding of the clinical nuances of another profession, could lead to the destruction of trust in team environments. Ultimately, the promotion of trust is a cornerstone in the improvement of healthcare delivery.

CONCLUSION

No other English-speaking nations have any similar mandatory reporting regime (covering competence, misconduct and impairment) in the major health professions. Simply, there is no other such far-reaching national scheme in place in those jurisdictions. Just how the mandatory reporting regime and its precedent cases will play out in Australia remains to be seen, and will be followed with interest. The scheme may become the benchmark or, conversely, the anathema for other national health regulators. No doubt if the regime is to become a benchmark, a serious analysis of its benefits and pitfalls should begin from the outset, to allow an in-depth review three to five years on. Statistical analysis, and a large collection of reliable case studies, will play an important part in any review. Only then will it be possible to make an objective assessment of the viability of mandatory reporting, and whether any supplementary amendments or major review of the legislation are necessary. ■

Notes: **1** These professions will be chiropractors; dentists (including dental hygenists, dental prosthetists and dental therapists); medical practitioners; nurses and midwives; optometrists; osteopaths; pharmacists; physiotherapists; podiatrists; and psychologists. See the implementation website at www.nhwt.gov.au/natreg.asp, accessed 26 April 2010. **2** *Ibid.* The NHWT site identifies the legislation relevant to each state and territory. **3** See ss140-141 *Health Practitioner Regulation National Law Act* 2009 (Qld) (HPRNL), which is mirrored in other states and territories. Explanatory notes to the legislation are available at http://www.legislation.qld.gov.au/Bills/53PDF/2009/HealPraRegNLB09Exp.pdf, accessed 1 May 2010. **4** Section 5 HPRNL defines a health practitioner to mean 'an individual who practises a health profession'. **5** Section 141(1)(b) HPRNL. **6** Section 5 NPRNL. **7** Section 142 HPRNL. **8** Section 142(4) HPRNL. **9** Section 141(2) HPRNL. **10** Section 143(1)(a) HPRNL. **11** Section 143(1)(b) HPRNL. **12** *George v Rockett* [1990] HCA 26; (1990) 170 CLR 104 at [14] per Mason CJ, Brennan, Deane, Dawson, Toohey, Gaudron and McHugh JJ. **13** Sections 141(4)(a)(i)–(ii) HPRNL. **14** Sections 141(4)(b), (c) HPRNL. **15** Sections 141(4)(d)(i)–(ii), (e) HPRNL. **16** Section 71A *Medical Practice Act* 1992 (NSW). **17** By virtue of s166 *Medical Practitioner Registration Act* 2001 (Qld) and s124(1)(f) *Health Practitioner (Professional Standards) Act* 1999 (Qld). **18** Section 141(2) HPRNL. **19** Section 193 HPRNL (deals with the criteria for referral of disciplinary action to a responsible tribunal). **20** As provided in the heading to s141 HPRNL. **21** Section 142(2) HPRNL. **22** Section 142(3) HPRNL (definitions of 'employer' and 'licensing authority' appear in s142(4)). **23** Section 143(3) HPRNL. **24** Section 143(2) HPRNL. **25** Section 237 HPRNL. **26** See, for example, the *Report of the Commission of Inquiry into Queensland Public Hospitals 2005*, where a culture of concealment of adverse clinical outcomes was examined at Part F, pp473–519. **27** Parker and Jackson, 'Full Steam Ahead on the SS "External Regulator"? Mandatory Reporting, Professional Independence, Self-Regulation and Patient Harm' (2009) 17 JLM 29. **28** http://www.nhwt.gov.au/documents/National%20Registration%20and%20Accreditation/Bill%20B%20Submissions/V/Victorian%20Doctors%20Health%20Program.pdf, accessed 26 April 2010.

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