

From the Chairman

Some things, such as insurance risks and the global financial system, are uncontrollable and at times unpredictable. Others, such as the prospect of an Australian summer break, are reliable and reassuring milestones, good times to relax and regroup. We at MIIAA wish you a peaceful, happy and rejuvenating festive season.

Kind regards and best wishes

Dr Andrew Miller
MIIAA Chairman

National registration

In March 2008 the Council of Australian Governments (COAG) agreed to implement a National Registration and Accreditation Scheme for the Health Professions. Since March 2008 legislation has been introduced to the Queensland Parliament which covers the aspects of the Intergovernmental Agreement that address the structural elements of the new scheme.

There have also been a series of Consultation Papers released which cover registration arrangements as well as complaints, conduct, health and performance arrangements. Further Consultation Papers are being regularly released with tight time frames for consideration and submission development.

At the time of writing this newsletter the MIIAA had provided two detailed submissions on the Scheme, on the following topics:

- The proposed arrangements for handling complaints, and dealing with performance, health and conduct matters; and
- The proposed registration arrangements

Copies of the full submissions can be obtained by emailing Samantha Hicks at admin@miiaa.com.au.

A summary of some of the key aspects of the complaints handling submission is below.

Mandatory reporting

The MIIAA made lengthy submissions on the issue of mandatory reporting. The MIIAA is concerned that mandatory reporting is likely to discourage practitioners from disclosing incidents and seeking advice from their colleagues, a treating doctor and other services, such as medical indemnity insurers and the Doctors' Health Advisory Service. These play an integral role in maintaining professional standards and it is important to maintain the trust and confidence of health practitioners in the provision of services that assist in maintaining professional standards.

From a medical indemnity insurer perspective, the mandatory reporting obligations will impact upon the ability of the medical practitioner members of the medical indemnity insurer's Council, Board and other committees, as well as the employees of the medical indemnity insurer who are medical practitioners, to undertake their work within the organisation. There is also a risk that medical practitioners may delay or even fail to report incidents to their medical indemnity insurer, resulting in potential risks to the insurer and the inability of the medical indemnity insurer to provide prompt remediation and implementation of risk management strategies to assist the individual medical practitioner.

It appears from the proposals that practitioners will be obliged to report certain matters even after a complaint about the matter has been made to the board. The fact that the board may

already know about the matter is not an excuse for not reporting. This situation will invariably arise in the case of medical practitioners employed by medical indemnity insurers, who in assisting to advise the medical indemnity insurer and medical practitioners against whom a complaint has been made, will be obliged to report a matter already known to the board or other body, creating an unnecessary burden on the body receiving the reports.

If the "extended obligations" options are adopted, the MIAA submits that the legislation should provide exceptions for the following classes of person:

- (a) Any registered medical practitioner who is employed under a contract of service or for services by a medical indemnity insurer with whom the other medical practitioner is insured and whose advice has been sought with respect to the reportable misconduct or to whom the reportable misconduct has been disclosed in accordance with the terms of the insurance policy or the duty of utmost good faith;
- (b) Any registered medical practitioner whose advice is sought in contemplation of, or in connection with, a legal proceeding or an anticipated or pending legal proceeding in which the reportable misconduct may be an issue;
- (c) Any registered medical practitioner who is treating the other registered medical practitioner;
- (d) Any registered medical practitioner who is the spouse of the other registered medical practitioner;
- (e) Any legal practitioner who is also a registered medical practitioner and provides legal services to the other registered medical practitioner in legal proceedings in contemplation of, or in connection with, an anticipated or pending legal proceedings in which the reportable misconduct may be an issue;
- (f) Any other person or class of person who is exempted by the Regulation from doing so.

Ensuring accountability, transparency and procedural fairness

The MIAA submits that it is both legally and politically pragmatic, as well as commercially sensible, for there to be a separate agency responsible for receiving and investigating notifications for the following reasons:

- Separate agencies with separate functions provide a clearer demarcation of responsibilities, which reduces the

chance of conflicts of interest arising;

- Abstract separations within each board will not create a sufficiently strong public perception of separation. It is arguable, from the perspective of a concerned public, that professional boards may appoint individuals to committees and panels with interests that mirror their own; whereas a physically separate agency is significantly more likely to be perceived to make independent appointments;
- A centralised health complaints commission (HCC) responsible for receiving and investigating all health care complaints will create economies of scale placing downward pressure on the cost of assessing and pursuing complaints;
- A centralised HCC will have greater expertise at dismissing vexatious or frivolous complaints and of recognising serial offenders. For instance, it may keep a record of notifiers that regularly make unmeritorious notifications across the health professions. It may also keep a record of practitioners who regularly have notifications made against them;
- Smaller professional boards may not have the expertise and experience that a centralised HCC would have to appropriately investigate the totality of the complaint in order to meet public expectations of transparency and accountability;
- A centralised HCC would be better able to co-ordinate multidisciplinary investigations. It is anticipated that the following types of issues may arise for boards acting jointly, which could impede speedy investigations. There may be issues about which board's budget should cover the costs of an investigation and how information is to be shared between them. Administrative costs may be duplicated.
- A centralised HCC will be better placed ensure that multidisciplinary systemic matters are dealt with expeditiously. It makes little sense for the boards to be investigating practitioners concurrently with a separate HCC. In particular, the cost of having a HCC also conduct the investigation into practitioner conduct will be lower than those costs being additionally expended by the respective boards. As the taskforce has noted at 9.2, "it is important that there be a co-ordinated and consistent approach to the assessment, management and investigation of these types of cases." Boards acting independently will not be as expeditious because each of their investigations will be run from the beginning and information flows will be

slower. This may result in boards “reinventing the wheel” with respect to each individual practitioner involved in the systemic issue being addressed.

- A centralised HCC would be sufficient to safeguard procedural fairness and public confidence in the scheme and provide a ‘one stop shop’ for consumers to make notifications.

A summary of key aspects of the submission on the proposed registration arrangements follows:

Criminal history checks

The MIIAA submits that an alternative proposal that supports legislation requiring criminal history checks be applied to all new applications for registration from 1 July 2010, and for self declaration obligations imposed on registrants both at annual renewal and during the registration period. We note that medical practitioners are already required to report criminal convictions to the relevant registration authorities so that the criminal history of current practitioners ought be known to those authorities.

If it is deemed necessary to perform further criminal history checks, the MIIAA would support a reasonable random sample of practitioners being checked on an annual basis. Such a provision should not be at the discretion of the relevant board.

Rights of review of registration decisions

It is appropriate that health professionals have access to a merits review tribunal with respect to registration decisions of the respective authority. However, the proposal excludes an appeal with respect to points of law to the Supreme Court of each state. Any proposal that appears to, or does in fact, limit a practitioner’s right to judicial review of an executive authority runs contrary to common law rights of due process and will lead to perceptions of injustice and may in fact lead to unjust outcomes.

It is noted that Proposal 10.10.1 of the Consultation Paper on Complaints Handling makes provision for rights of appeal to the various Supreme Courts from the various tribunals on points of law. The proposed legislation should make it clear that a practitioner’s right to judicial review is not abrogated in any way.

Annual reporting obligations on registrants

The MIIAA does not accept the proposed requirement for registrants to report any medical negligence claims.

Medical negligence claims are a poor tool for the assessment of the professional conduct and/or performance of medical practitioners. Research has shown that the claims experience of a medical practitioner is not a marker of professional competence.

Many medical negligence claims that are instituted are either unmeritorious claims later discontinued that provide no useful information for risk or performance analysis, or single acts of negligence that do not serve to highlight any kind of systemic or practice failures. In fact, statistics collected by MIIAA members show that approximately 30 per cent of claims are discontinued. In addition, a number of medical negligence claims are settled on a commercial basis. The inclusion of unmeritorious data may skew analyses and place an unnecessary burden upon those required to report and those required to collect and interpret the data in question.

The experience in Queensland has been that few, if any, disciplinary proceedings have been instituted as a result of settlements and judgments in court proceedings being reported. The MIIAA submits that the reporting of “any medical negligence claim” is unnecessary, could well be unhelpful, and that either no reporting of medical negligence claims or reporting of judgments with a threshold of \$20,000.00 is preferable.

Powers to issue guidelines about professional standards

The MIIAA does not support the national medical board being involved in the development of clinical practice guidelines (defined by the Institute of Medicine as ‘systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances’). The development of clinical practice guidelines is a complex task and requires a critical appraisal of scientific evidence.

Ellen Edmonds-Wilson
MIIAA CEO

Abortion Law Reform Act 2008

On 12 September 2008 following prolonged debate and a conscience vote in the Victoria Parliament, the Abortion Law Reform Act 2008 (the Act) was passed. On 23 October 2008, the Act came into effect. The purpose of the Act is to reform the law as it relates to abortion, to remove abortion as a criminal and common law offence and to regulate health practitioners performing abortions.

The Act treats abortion before 24 weeks and after 24 weeks gestation differently. A registered medical practitioner (doctor) may perform an abortion on a woman who is not more than 24 weeks pregnant without being required to undertake any further inquiry. If a woman is more than 24 weeks pregnant then the doctor must establish that the abortion is "appropriate in all the circumstances." These include the medical circumstances as well as the woman's "current and future physical, psychological and social circumstances." As well, the doctor must consult with another doctor who also reasonably believes the abortion is appropriate.

Thus the act appears to provide an unfettered right to abortion before 24 weeks gestation and a mechanism for obtaining an abortion beyond 24 weeks.

The Act provides in Section 8 that registered health practitioners who have a conscientious objection to abortion are not required to advise on or perform abortions. However, they must refer a woman who seeks advice or the performance of an abortion to another registered health practitioner who they know does not have a conscientious objection.

Further Section 8 of the Act requires a doctor, even if they hold a conscientious objection to abortion, to perform an abortion in an emergency where the abortion is necessary to preserve the life of the pregnant woman.

The Act appears to codify the mechanism for the procurement of an abortion that operated in Victoria following the Menhennitt ruling but adds an obligation on doctors who hold a conscientious objection to abortion that did not previously exist in law. This latter obligation was the subject of intense debate in the Parliament and in public forums however the Parliament, in the face of that debate, did not amend the bill before passing it

into law.

The Act contains no penalty for a breach of Section 8 however it is likely that if a complaint was made to the Medical Practitioners' Board of Victoria that such a breach would expose the offending doctor to sanctions from the Board.

John Arranga
Avant Mutual Group

Australian Medical Council Draft Code of Professional Conduct

The MIIAA supports the principles behind the Code of Professional Conduct (Good Medical Practice) and recognises the importance to the community of identifying the standards of conduct expected of medical practitioners in relation to their professional work. From the point of view of consumers, a Code is useful for setting expectations about how practitioners will conduct themselves, while for practitioners the Code is useful for understanding how their peers expect them to interact with their patients and between one another.

However, the MIIAA believes that the Australian Medical Council's (AMC's) draft Code is unnecessarily prescriptive and in this regard is inconsistent with the principle expressed at paragraph 1.2, of the Code which states that doctors "must use [their] judgement to apply principles to the various situations [they] face." This sentiment is mirrored by the findings of the Picker Institute which illustrated the:

"important role of judgement in resolving some of the tensions inherent in good medical practice between the needs of the individual patient and the wider population."

The MIIAA is concerned that the Code inhibits practitioners from exercising their professional judgement. The inclusion of excessive detail into a Code of Professional Conduct does not assist in its interpretation.

The MIIAA is concerned that the legal status of the Code is not clear, and that the purpose of the Code is being confused with the purpose of law. At paragraph 1.2 it says:

"It is anticipated that this code will be adopted by the new

national medical board and the principles in this document will apply in the regulation of medical practice in the future."

It is not said how the Code intends to "apply in the regulation of medical practice". If the Code is intended to be incorporated into statute then its current manifestation is grossly inadequate. Even more so if, as paragraph 1.2 goes on to say, failure to meet the standards set by the Code may have consequences for a practitioner's registration. The extent to which the Code's provisions may be used in disciplinary proceedings should be made clear.

The MIIAA submits that the Code should be amended to reflect broader guiding and aspirational principles that will allow practitioners to exercise their professional judgement without fear of prosecution; except where their actions are contrary to law. This will preclude the Code from conflicting with law while laying an adequate foundation for peer and consumer expectations.

Codes of Professional Conduct are important and desirable tools for communication and managing public and practitioner expectations. However, it is not, nor should it be, the purpose of a Code to make specific mandatory prescriptions for practitioner behaviour. Prescriptive regulation should be left to the legislature. Insofar as professional codes seek to set standards of conduct they should be referable to the determined legal standards, or otherwise be broad and flexible enough to maintain relevance over time. While the MIIAA is supportive of a national Code, the present draft prescribes conduct to an undesirable degree. By mandating how practitioners should make professional evaluations, the Code encroaches on the territory of the law and risks becoming both irrelevant and illegitimate in the eyes of consumers and practitioners alike. The MIIAA submits, therefore, that the Code should adopt a greater degree of generality and place a greater emphasis on the use of professional judgement to manage the variety of tensions that arise in the course of medical practice.

The MIIAA has provided a detailed submission to the AMC on the draft code. If you wish to receive a copy of the submission please contact Samantha Hicks at admin@miaa.com.au.

Ellen Edmonds-Wilson
MIIAA CEO

2008 Medical Indemnity Forum

The MIIAA held its second Medical Indemnity Forum in Melbourne on 4 September 2008. 100 people attended the event which covered some key areas of the medical indemnity debate. Major discussions were held on improving professional competence, with speakers including Dr Joanna Flynn speaking on the Australian Medical Council's Draft Code of Professional Conduct, Beth Wilson speaking on the experience of the Victorian Health Services Commission, A/Prof Julian Rait launching the Royal Australasian College of Surgeons' publication on Surgical Competence and Performance, and Dr Sara Bird speaking on the role of medical indemnity insurers on the assessment of a doctor's competence.



The session on emerging risk was addressed by Kate Booth from Maurice Blackburn, Dr Heather Wellington from DLA Phillips Fox, Dr Beres Wenck from the RACGP and Philip Cohen from the Victorian Managed Insurance Authority.

The introductory session highlighted the major challenges to the medical profession and the medical indemnity sector. Veronica Hancock from the Department of Health and Ageing presented statistics on the government medical indemnity support schemes, Dr Rosanna Capolingua, President of the AMA, discussed medical workforce issues and problems associated

with role substitution, Stephen Glenfield from APRA provided an overview of the regulatory controls imposed on insurers, and David Minty from Insurance Statistics Australia analysed the report on premiums and claims data.

Copies of the PowerPoint presentations from most of the speakers can be obtained from the MIAA website at: <http://www.miaa.com.au/seminars.php>

Our thanks go to the speakers, the session chairmen who included Dr Liz Mullins and Dr Jonathan Burdon from Avant Mutual Group and Dr Andrew Miller from MDA National.

The 2009 Forum will be held in Sydney. If you wish to receive advance information on the event please email us at admin@miaa.com.au.

Ellen Edmonds-Wilson
MIAA CEO

New MIAA Office Bearers elected

The MIAA Annual General Meeting was held on 5 September 2008. Dr Andrew Miller, a board member of MDA National, was elected the new Chairman of the association. Dr Jonathan Burdon, deputy Chairman of Avant Mutual had fulfilled the role of Chairman for the previous two years. He has now been elected the Vice-Chairman of the MIAA.



Dr Andrew Miller – MIAA Chairman



Dr Jonathan Burdon – MIAA Vice Chairman



Mr Graham Reynolds

Mr Graham Reynolds, Chairman of MDA National Insurance, was elected the Treasurer of the MIAA.

The MIAA has a new Board member, Mr Vyn Tozer. Mr Tozer is a director of Avant Mutual Group Limited and also serves as the Chairman of Avant Insurance Limited. He has a strong background in finance, accounting and insurance. Formerly he was managing director of Fortis Australia, director of the Insurance Council of Australia and the Insurance Statistics Australia. Currently Mr Tozer is a director of the Australian Health Services Alliance Limited (Chairman) and Elders Financial Services Group Ltd.



Vyn Tozer