MEDICAL PRACTICE AMENDMENT BILL 2008

Page: 8108

Second Reading

The Hon. PENNY SHARPE (Parliamentary Secretary) [8.19 p.m.], on behalf of the Hon. John Hatzistergos: I move:

That this bill be now read a second time.

I seek leave to incorporate the second reading speech in *Hansard*.

Leave granted.

I am pleased to bring before the House the Medical Practice Amendment Bill. This important piece of legislation will improve the protection of the New South Wales community by improving the powers of the relevant authorities to quickly and effectively deal with complaints about medical practitioners, to improve the transparency and accountability of those processes, and to introduce mandatory reporting requirements on the medical profession itself to report medical practitioners whose conduct may be harming or abusing patients.

This legislation follows revelations about failures of the regulatory system to protect the public from dangerous or poorly performing medical practitioners. Most recently, we have seen the case of the obstetrician and gynaecologist Dr Graeme Reeves. Prior to that, in late 2006, revelations came to light about the Sydney general practitioner Dr Suman Sood.

There were some common themes in these cases. In both, there were a series of complaints and concerns raised about the medical practitioners. In both cases, the practitioner was able to continue practising for a considerable period of time before the matter came before the Medical Tribunal. Both practitioners were ultimately deregistered.

Following the Dr Sood matter coming to light in 2006, the former Minister for Health ordered a review by an independent team of experts. The review team comprised former Federal Court judge Deirdre O'Connor, Professor Peter Castaldi and Mr Vernon Dalton providing legal, clinical and community input respectively.

This review made recommended changes to the legislation that make up most of the changes proposed in the bill that I present to Parliament today.

Following revelations about Dr Reeves earlier this year, I asked Ms O'Connor to conduct a further review to identify any additional changes which could be made to the bill to further improve the system. A number of additional changes focusing on enhancing the transparency and the accountability of the disciplinary process were proposed by Ms O'Connor and have now been included in the bill.

The overarching principle in all proposed amendments is the protection of the public. To this end, the bill proposes amending the object section of both the Medical Practice Act 1992 and the Health Care Complaints Act 1994 to state that the protection of the health and safety of the public is the "paramount consideration" in the exercise of all functions under the legislation.

The amendments proposed by the bill cover four main areas:

- the powers of the Medical Board to take urgent action to protect the public under section 66 of the Medical Practice Act

- the ability of relevant authorities in dealing with a complaint against a medical practitioner to have regard to the full picture of any previous complaints and previous adverse findings against that practitioner

- improving the accountability and transparency of disciplinary processes in respect of medical practitioners

- imposing mandatory reporting requirements on the medical profession requiring a medical practitioner to report to the Medical Board a fellow medical practitioner whom he or she believes has engaged in sexual misconduct, is intoxicated by drugs or alcohol at work, or has flagrantly departed from accepted standards of practice.

I will now deal with each of these areas of change in more detail.

The changes to the Medical Board's powers under section 66 of the Medical Practice Act will improve its capacity to

take steps to protect the health and safety of the public.

In the Dr Sood case, the Board took action and exercised its section 66 powers to suspend Dr Sood. However, the New South Wales Supreme Court subsequently stayed the Board's decision on technical grounds. Dr Sood was allowed to continue practising until the Medical Tribunal eventually deregistered her some years later.

In the case of Dr Reeves, the Medical Board held a section 66 inquiry after becoming aware that Dr Reeves had been practising as an obstetrician in breach of his conditions of practice. The inquiry found that Dr Reeves could not adequately explain why he had breached his conditions, and expressed concerns about Dr Reeves' candour. Notwithstanding this, the inquiry felt that it was unable to suspend Dr Reeves by reason of the strict wording of section 66 that allows the Board only to take such action as is "necessary" to protect the life or health of a person.

This situation is obviously unacceptable! It is therefore proposed that the Board's powers under section 66, and the avenues of appeal or review in respect of these powers, be amended in five main ways to prevent a recurrence of this situation arising again.

First, item [8] in schedule 1 to the bill amends section 66 of the Medical Practice Act to clarify that the actions under this section must be guided by what is needed to protect the public interest.

The Board is not, therefore, required to limit itself to the least restrictive option as occurred in the inquiry into Dr Reeves. Rather, they should look to the outcome which best addresses the statutory purpose of the protection of the public or is otherwise in the public interest.

If this broader test had been applicable at the time of the section 66 inquiry in the Reeves matter, combined with the clarification that the paramount consideration is the protection of the public, there may well have been a different conclusion as to the appropriate action to take in order to protect the public.

Item [17] in schedule 1 to the bill amends the Act to provide the Board with a new statutory power to require any person to provide it with information, documents or evidence for the purpose of exercising these powers.

At present the Board has no powers to compel the production of documents or information for these purposes. It must rely on such information as it has available to it. Whilst it is the role of the Health Care Complaints Commission rather than the Board to carry out investigations into complaints, in the exercise of this very important power the Board must ensure the protection of the public.

I consider the Board should be given such powers as are necessary to ensure it has all relevant information or documents available. This may include, for example, documents in the possession of hospitals or other health service providers. The proposed provision includes a maximum penalty of 20 penalty units for failure to comply with a request by the Board without a reasonable excuse.

Item [8] in schedule 1 to the bill also amends the Act to require the Board to include at least one non-medical practitioner on section 66 inquiries. The Board advises that its usual practice at present is to use two medical practitioners to carry out such inquiries.

Public confidence in the system demands that section 66 inquiries are more representative of interests other than those of the medical profession. This is particularly relevant given the Board itself includes community, consumer and legal sector representatives.

The fourth proposed amendment to section 66 processes arises from proposed new provisions, contained in item [5] in schedule 1 to the bill, that will permit Professional Standards Committees and the Medical Tribunal to designate certain orders as "critical compliance" orders or conditions—which, if breached, will lead to automatic suspension and deregistration.

In the Dr Reeves case it is clear the conditions imposed by the Professional Standards Committee in 1997 that he not practise obstetrics arose because of serious concerns held about deficiencies and failings in his practice as an obstetrician. The bill proposes permitting a PSC or the tribunal in such circumstances to determine that, having regard to the case before it, compliance with the order or condition is critical to public protection and that breach of the condition or order by the medical practitioner will therefore result in automatic deregistration of the practitioner.

Under Item [8] in schedule 1 to the bill, breaches of these types of orders will go to a section 66 hearing. The Board will, if it is satisfied the facts show the practitioner breached the order or condition, be required to immediately suspend the practitioner from practice and refer the matter to the Medical Tribunal. If the tribunal subsequently is satisfied that the practitioner has breached the critical compliance order or condition, then the tribunal is to deregister the practitioner.

Item [20] in schedule 1 to the bill amends the process for appeal or review from section 66 decisions in the Medical Practice Act. Currently medical practitioners who have been the subject of a section 66 inquiry may seek judicial review of the Board's action in the Supreme Court. It is via this review mechanism that Dr Sood was able to continue practising, notwithstanding the Board's serious concerns about her. The bill creates a new avenue of appeal on points of law to the Chairperson or a Deputy Chairperson of the Medical Tribunal.

The Chairperson and Deputy Chairpersons of the Medical Tribunal are judges of the District Court, and their expertise and experience in sitting on the Medical Tribunal will be of assistance in exercising this power appropriately. Medical practitioners must exhaust this avenue of appeal before they can seek judicial review by the Supreme Court.

Finally, the bill proposes introducing a number of other more minor changes to section 66 powers and processes, including:

permitting the Board following a section 66 inquiry to order a practitioner to take part in performance assessment under Part 5A of the Act, but only if the Health Care Complaints Commission concurs with this proposed action

requiring the Board to make an audio recording of section 66 inquiries

allowing the Board to provide the Health Care Complaints Commission with any information or documents obtained by the Board for the purpose of a section 66 inquiry, including the audio recording of the inquiry

providing the Board with the power to provide notice of action taken under section 66 to any agency or person whom the Board considers appropriate

requiring complaints arising from action taken by the Board under section 66 of the Act to be listed for final hearing by the Medical Tribunal or a Professional Standards Committee as soon as practicable; and

clarifying when the Chairperson or a Deputy Chairperson of the Medical Tribunal can extend a period of suspension of a medical practitioner following a section 66 inquiry.

The second area of amendments introduced by the bill relates to the way in which the system deals with medical practitioners who have multiple complaints or previous adverse findings made against them. In the case of Drs Reeves and Sood there had not only been multiple complaints received by the Medical Board, but in both cases a Professional Standards Committee had made findings of unsatisfactory professional conduct and had imposed conditions on them.

As this bill makes clear, the overriding object of both the Medical Practice Act and the Health Care Complaints Act is the "protection of the public". In this context, an approach that focuses exclusively on individual complaints or incidents may miss patterns of conduct or poor performance by practitioners. The proposed amendments contained in the bill will allow such patterns of conduct or the existence of multiple complaints against a practitioner to be taken into account a number of new ways.

The proposed section 140A requires that when the Board is dealing with a complaint or exercising its public protection functions, it must, to the extent they are relevant, have regard to the following matters about a practitioner:

any other complaint against the practitioner;

any previous finding or determination of a professional standards committee or tribunal constituted under a health registration Act; and

the outcome of any performance assessment in relation to the practitioner.

Item [19] in schedule 1 to the bill amends the Medical Practice Act to ensure that where, as in the case of Dr Reeves, complaints are received after a medical practitioner has been struck off the register that such complaints must be considered if and when the practitioner applies to be reregistered in New South Wales.

The bill also makes two important changes to the powers of the Medical Tribunal and Professional Standards Committees, which ensures they will be able to take into account a practitioner's past conduct.

First, item [26] in schedule 1 to the bill amends schedule 2, clause 5 of the Act to clarify that where multiple complaints in relation to the same practitioner are prosecuted concurrently before the Medical Tribunal or a PSC, that body may have regard to the cumulative effect of all the material relating to all complaints when it makes factual findings and determines whether the conduct should be characterised as unsatisfactory professional conduct or professional misconduct.

Second, at present these disciplinary bodies are not permitted to have regard to evidence of a previous finding or decision by another disciplinary body in relation to a complaint that is not being concurrently prosecuted. This means the disciplinary body cannot be assisted by the previous proceedings in drawing its conclusions.

This inconsistency means that a previous finding or decision against a practitioner cannot be taken into account, even where commonsense suggests that it indicates there may be a pattern or course of professional misconduct by a practitioner. This restriction on the powers of the Medical Tribunal and PSCs is inconsistent with the requirement that in the exercise of all functions under the Act, the protection of the health and safety of the public is the paramount consideration.

Accordingly, item [25] in schedule 1 of the bill amends schedule 2, clause 4 of the Act to permit the Medical Tribunal and PSCs to take into account previous decisions and findings by a disciplinary body in relation to the same practitioner. Where the tribunal or PSC is of the opinion that the judgement or finding is capable of establishing that a practitioner has engaged in conduct that is sufficiently similar to the conduct alleged against the practitioner in the proceedings, it may rely on the judgement or finding in two ways:

in making a finding that the practitioner is guilty of unsatisfactory professional conduct or professional misconduct; and

in exercising any of its powers of sanction under the Act.

Finally, item [3] in schedule 1 to the bill amends the definition of professional misconduct in section 37 of the Medical Practice Act to clarify that a practitioner can be found to have engaged in professional misconduct based on a series or pattern of apparently less serious instances of conduct. Considering each instance or episode of conduct individually may not give rise to serious concerns about a practitioner. But when the totality of the practitioner's conduct is considered, it may be clear that there are more fundamental issues of misconduct or poor performance involved.

The bill also contains proposed amendments to the Health Care Complaints Act mirroring those proposed to be made to the Medical Practice Act to ensure the Health Care Complaints Commission also has adequate powers to take into account multiple complaints against the same practitioner. Again, the common overriding principle is public protection.

Currently the Health Care Complaints Act does not require the Health Care Complaints Commission to consider previous or further complaints made about a practitioner when exercising its investigative and prosecutorial functions although I am advised the Commission often does so as a matter of good practice. Item [5] in schedule 2 of the bill amends the Health Care Complaints Act to clarify the Commission must have regard to previous complaints including discontinued or terminated complaints or further complaints against a practitioner.

Item [8] in schedule 2 to the bill amends the Health Care Complaints Act to require the Director of Proceedings of the Health Care Complaints Commission to consider prosecuting multiple complaints against the same practitioner at the same time.

It is critical that there is public confidence in the operation of the regulatory system. This has clearly been undermined by information which has come to light in the Dr Reeves matter, which has led to a public perception that the standards applied to medical practitioners by other practitioners give inordinate weight to professional interests, as opposed to the public interest. This perception has been exacerbated by the closed culture of Professional Standards Committee processes.

The Medical Practice Act provides for a two-tier tribunal system for the hearing of disciplinary action against medical practitioners. All matters where the complaint, if substantiated, may provide grounds for the practitioner to be deregistered or suspended are required to be heard before the Medical Tribunal. All other matters are heard before Professional Standards Committees. However, as both the Dr Reeves and Dr Sood matters indicate, PSCs may deal with serious allegations of inappropriate conduct or clinical practice.

At present under the Act, PSC hearings are required to be held in private, unless the Committee directs otherwise. Further, there is generally restricted access to PSC decisions. The unique power of the medical profession to cause harm or even death to the members of the public means that any allegation that a medical practitioner has engaged in unsatisfactory professional conduct is a matter of public interest. Further, greater openness and transparency of the process will also help build public confidence in the disciplinary system, and enhance the accountability of that system.

Accordingly, item [28] in schedule 1 to the bill amends the Medical Practice Act to make PSC proceedings open to the public, unless the PSC directs otherwise. This will mean, for example, that where a complainant objects to such proceedings from being open to the public in part or whole the Committee can make an appropriate direction to protect the interests of the complainant, in a manner similar to the operation of the tribunal at present.

At present, the Act limits the persons to whom a PSC is required to disclose its decision, although the PSC has a discretion to make its decision more widely available. In practice, PSCs almost invariably do not make their decisions publicly available. Further, where there are multiple complainants each complainant will usually only receive that part of the PSC decision that affects him or her. This means that those involved will not be aware of the totality of the PSC's findings. Item [29] in schedule 1 of the bill amends the Medical Practice Act to require that PSC decisions must be publicly available, unless the PSC directs otherwise, in a manner identical to the Medical Tribunal.

The final proposed amendment aimed at improving the accountability of PSC processes relates to the composition of PSCs. At present PSCs are comprised of two medical practitioners and one lay person. Because the decisions of PSCs require a minimum of two votes, the medical members can effectively overrule the lay member. Consistently with the other changes to PSC processes, item [26] in schedule 1 of the bill proposes adding a fourth member to PSCs who is not a medical practitioner and who is to be legally qualified. This member must also act as the chair of the PSC.

This proposal mirrors the composition of the Medical Tribunal. It will ensure greater representation of non-medical practitioners on PSCs, as well assist in the proper and fair conduct of PSC proceedings. This is particularly important given the proposal to make PSC hearings open to the public.

Since 2005, medical practitioners in New South Wales have had an ethical obligation under their Professional Code of Conduct to report adverse performance and conduct of their colleagues. However, the Medical Board advises that the level of reporting by practitioners since that time has not greatly changed. This reinforces the public's perception of a "closed shop" culture in the medical profession. This Government has therefore decided it is an appropriate time to impose legal mandatory reporting on the medical profession.

Item [18] in schedule 1 to the bill inserts a new section 71A of the Medical Practice Act which requires medical practitioners to make a report to the Medical Board where the medical practitioner believes, or ought reasonably to

believe, that another medical practitioner:

has committed sexual misconduct in connection with the practice of medicine

is intoxicated by drugs or alcohol while practicing medicine, or

has flagrantly departed from accepted standards of professional practice or competence and that risks harm to a patient.

A demonstrated failure of a medical practitioner to report a colleague in these circumstances will be unsatisfactory professional conduct, which in serious cases may even result in that medical practitioner being deregistered.

The legislation provides protections for medical practitioners who make a report in good faith against another practitioner from legal action or other reprisals because they made a report.

The scheme focuses on serious issues of misconduct. Sexual misconduct and being intoxicated on the job are clearly matters that should be reported. The requirement to report flagrant departures from accepted standards of practice is intended to result in the reporting of only the most serious and obvious failures to comply with proper medical practice and where there is a clear potential for harm to patients.

Further miscellaneous amendments to the Medical Practice Act proposed by the bill include:

enabling the Board to require medical practitioners to provide information about where they work, so the Board can notify their employer about any orders or conditions imposed on the practitioner; and

requiring medical practitioners to provide the Board with evidence on an annual basis of current professional indemnity insurance coverage.

In undertaking its review, the independent review headed by Ms O'Connor consulted with a number of stakeholders, including:

the New South Wales Medical Board;

the Health Care Complaints Commission;

the Australian Medical Association;

the Chairperson of the New South Wales Medical Tribunal;

consumer representatives;

representatives of medical indemnity insurers; and

the Medical Services Committee of New South Wales.

For the purpose of Ms O'Connor's further review arising out of the Dr Reeves matter, she also consulted with representatives of the Medical Error Action Group. I thank all of these stakeholders for their invaluable contributions to the legislation before the House today.

This bill will better protect the public by improving the transparency and accountability of the disciplinary system for medical practitioners in New South Wales. It will give the relevant authorities greater powers to deal with practitioners who are practising in a manner that places members of the public at risk. The provisions are measured, and carefully seek to reset the balance between the need to protect the public and the rights of practitioners to procedural fairness and the protection of their reputation and livelihood. Finally, the bill places a greater obligation on the medical profession itself to be proactive in reporting medical practitioners who are acting in a way that abuses or harms patients.

I commend the bill to the House.