Medical Council
OF*NEW*SOUTH*WALES

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Executive Officer
Medical Board of Australia
Australian Health Practitioner Regulation Agency
GPO Box 9958
MELBOURNE VIC 3001

By Email: medboardconsultation@ahpra.gov.au

Dear Dr Katsoris,

Re: Consultation on the Board funding external doctors' health programs

I refer to the public consultation paper on Board funding of external doctors' health programs dated 8 February 2012.

I advise that the Medical Council of NSW (the Council) considered the consultation paper at its meeting held on 3 April 2012. The Committee noted that, as part of the consultation, a series of questions have been posed for consideration with respect to the funding of external doctors' health programs.

Do you see any value in, or need for external health programs for medical students and/or doctors? Please explain your reasoning.

It is the view of the Council that a limited external program, such as the NSW Doctors' Health Advisory Service (DHAS), which offers support via its telephone help line and extensive online resources, may have a role as an adjunct to a regulatory program, such as the Council's Health Program. There is a clear distinction between the purely supportive role of the DHAS and the role of the regulatory authority which also affords support but within a framework of public protection as the primary aim.

However, the responsibility for regulation with respect to doctors who have health problems should not be delegated to an external body and oversight and monitoring of all doctors deemed to be impaired under the Law should remain with the regulatory authority. Whilst the consultation paper does not provide detail of the relationship and interface between the Victorian Doctors Health Program (VDHP) and the State Board, the VDHP website states that its services include "Case management, aftercare and monitoring program (CAMP)" and that this includes "workplace monitoring and chemical monitoring".

It is the Council's view that what is called case management and monitoring are regulatory functions and should properly be undertaken by the regulatory authority, rather than a third party. This includes the initial assessment of whether or not the doctor is fit to practise, having regard to the nature of the impairment and if so, what conditions or other restrictions are necessary in order to ensure that the public is adequately protected.

The Council understands that there are instances in which the VDHP is managing and monitoring an impaired doctor without the knowledge of the State Board. Moreover, there is no clear arrangement for VDHP and no defined criteria or threshold for the VDHP to make notifications to the State Board about doctors it is managing. This raises significant concerns of public safety, given that doctors undertaking workplace and chemical monitoring with VDHP who are not known to the State Board would not have conditions on the national register.

If such doctors were to move interstate, there would be no way of knowing about their health history including any information about non-compliance or breaches of monitoring arrangements. Moreover, the public and employers are not advised of conditions which might be necessary to regulate the doctor's practice, for example, limitations on hours of work or working as the only doctor on site. Such conditions would in NSW, be published on the on-line register and the employer would be advised of these conditions, as they do not relate to the treatment or monitoring of the doctor's health. Under the VDHP proposal, employers would not be aware of such restrictions, making monitoring of compliance more difficult.

Of the existing models in Australia as described above, is there a model that you would prefer to see adopted nationally? Is there an alternative model that you would like to see adopted nationally?

The Council submits that the NSW model should be adopted nationally.

As outlined in the consultation paper, the Doctors Health Advisory Service (DHAS) NSW is a relatively economical service which offers personal advice and support via a telephone help line and also provides a wide range of written resources and links via its website.

In NSW, the DHAS is clearly distinguished from the Council's Health Program and it has no role in Council's regulatory functions. The Council's Health Program has been operating under the provisions of the *Medical Practice Act 1992* and now the *Health Practitioner Regulation National Law (NSW)* since 1992, and is the longest established health program in Australia. Since its inception, over 235 doctors have successfully exited the Program, having fulfilled the Council's monitoring requirements. The primary objective of the Health Program is to protect the public whilst maintaining impaired doctors in practice, if it is safe to do so. These objectives are achieved by means of conditions, some of which are publicly available and all of which are available to other State and Territory Boards, should a doctor change his or her principal place of practice.

In NSW, there is a clear and well-defined process for initial assessment and ongoing management of doctors with possible impairment in NSW. When a notification indicates that a doctor may be impaired, according to the statutory definition, the doctor will be assessed by a Council-appointed (independent)

practitioner, often a psychiatrist, who will prepare a report for the Council. If the notification indicates that interim immediate action is necessary in order to protect the public, then the Council will take that action and if necessary, will either suspend or impose conditions on the doctor's practice. The Council's Health Committee will review this report and decide whether to convene an Impaired Registrants Panel Inquiry. Again, interim immediate action can be taken if the report concludes that this is necessary.

In NSW, treatment is undertaken by the doctor's own clinician, with no Council involvement, other than gaining the doctor's authorisation for the treating clinician to notify the Council if the doctor is non-compliant, terminates treatment or fails to attend. The Council does not seek information from the treating doctor, thereby avoiding any conflict of interest or potential to compromise or harm the therapeutic relationship.

Instead, the impaired doctor's progress is monitored by the Council-appointed clinician, who reports regularly to the Council. The Health Committee monitors compliance with the conditions placed on registration, which may require treatment by the registrant's nominated clinician, urine drug testing, restriction of prescribing authority, restrictions as to the nature or scope of practice and regular review by the Council-appointed practitioner and the Council.

By ensuring that all impaired doctors are managed through the Council's Health Program, the Council can at any time, take interim immediate action if this is necessary due to non-compliance or significant decompensation of the doctor. The Council has a statutory duty to ensure public protection. This means that the protection of the public always remains the principal focus during the doctor's involvement in the program, and the potential for other factors to blur this focus, such as treatment and rehabilitation, are minimised.

The Council's Health Program ensures that the Council is informed about all aspects of the doctor. The Health Program integrates with the Council's Performance and Conduct pathways so that decisions in response to a complaint concerning a doctors' conduct or performance can be made with the full knowledge of their health status. This ensures more informed and ultimately better decision-making when managing complaints about doctors.

The strengths of the Council's Health Program include:

- its clear focus on regulation with independent assessment which is distinct from treating relationships
- its philosophy of allowing the treating relationship (or any support sought from external health providers such as DHAS or the Medical Benevolent Society) to remain confidential, which allows a focus on facilitating the doctor to return to good health and minimises the risk that the therapeutic relationship may be compromised
- its acceptance by the profession and other stakeholders, such as medical defence organisations, as a consistent program that fosters cooperation and achieves its public protection goals in a fair and objective way and facilitates treatment and rehabilitation of impaired practitioners
- the action taken being proportional to the level of risk, thereby allowing practitioners to continue working if it is safe to do so

- its structured but non-disciplinary and non-adversarial nature
- its cautious, long term monitoring of impaired doctors
- its flexible integration with all other Council activities such that every decision about a doctor is made in full knowledge of their health status
- its reliance on the mixture of independent opinion and regular face to face review interviews with the impaired doctor provides a sound basis on which to be able to judge whether a doctor should be referred for disciplinary measures because of non-compliance with conditions

Do you believe that it is the role of the Board to fund external health programs?

It is the view of Council that the Board should regulate and manage all impaired doctors who satisfy the statutory definition of impairment and that it is not appropriate to outsource critical functions, such as case management and compliance monitoring to an external health program. Nor is it appropriate for external health programs to undertake any of the regulatory functions that should be undertaken by the Board.

The Council does not consider that it is the Board's role to fund external health programs, but rather to register and regulate doctors. The annual costs of running VDHP, being $500,000, are substantial and an additional cost of $25 per registrant per year is unlikely to be well received by doctors, particularly those in NSW where there is already a comprehensive Health Program run by the Council, which is fully funded from current registration fees.

What services should be provided by doctors' health programs?

The Council's view is that external health programs should provide an adjunct service to programs administered and operated by the regulatory authority. This may include provision of telephone advice, development of a list of practitioners willing to treat colleagues, publication of resources and education of doctors to raise awareness of health issues. Council is of the view that case management (including initial assessment of fitness to practise as a result of the impairment and assessment and determination of the appropriate conditions or restrictions) and compliance monitoring are regulatory functions and should properly be undertaken by the regulatory body.

Conclusion

The Council supports the view that a nationally consistent approach to management of doctors with impairment is ideal. However, the Council submits that the VDHP model involves inherent risk to public safety, as regulatory functions, including case management and workplace and chemical monitoring, are being undertaken by an external body with no statutory responsibility to ensure public protection. Moreover there are no clear or transparent reporting requirements and no mechanism to ensure that AHPRA and employers are aware of health issues.

The Council suggests that the Australian Health Workforce Ministerial Council should be given the opportunity to consider other models, including the model that operates in NSW and in other States and Territories. The NSW model is

accepted by the profession and stakeholders and is recognised for its maturity and success at ensuring public protection whilst maintaining impaired doctors in practice.

The Council would be happy to provide further information to the Australian Health Workforce Ministerial Council if the opportunity arose.

Yours faithfully,

Dr Joanna Hely
Medical Director
Medical Council of NSW