

Mandatory reporting of professional incompetence

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Removing the protection of confidentiality will not help raise standards of care

Governments confronting serious adverse health care events feel obliged to be seen to be doing something. They often set up an inquiry or, less commonly but peremptorily, amend legislation, attempting to avoid repetition of the events.

The Davies Inquiry, “with particular reference to Dr Jayant Patel.”, was Queensland’s response to adverse incidents in that state.¹ By contrast, New South Wales responded to adverse incidents relating to Dr Graeme Reeves² by amending the *Medical Practice Act 1992* (NSW) in the *Medical Practice Amendment Act 2008* (NSW), obliging practitioners to notify the NSW Medical Board of “disruptive”³ or “wayward”⁴ colleagues (see Box).

The amendments, welcomed by the Board, allow for generally speedier suspension or deregistration of professionally incompetent doctors. These actions can, however, still be delayed by doctors appealing to the Medical Tribunal (customarily, two medical practitioners in the same field of practice as the respondent, a lay person, and a District Court judge as chairman) or the Supreme Court (which has, on legal grounds, stayed the Board’s suspensions of two subsequently deregistered doctors), and by the inclusion of lay persons in these inquiries.

In NSW, unlike in other Australian states, the Health Care Complaints Commission, not the Board, investigates and prosecutes breaches of the Act, and the Medical Tribunal, not the Board, strikes off and re-registers doctors. The Board’s jurisdiction covers registration, impairment, performance, and disciplinary breaches that would not warrant de-registration. The amendments to the Medical Practice Act allow the Tribunal to take into account, in a re-registration application, complaints received subsequent to deregistration. Further, the proceedings of the Medical Board’s professional standards committees (PSCs) will no longer be confidential, will be chaired by a legal practitioner, and their findings made public.

The mandatory notification included in the amended Act overcomes some of the problems facing whistleblowers who, traditionally, are encouraged to voice their concerns locally — at their hospital or Area Board.⁵ Already, in many jurisdictions, doctors must report colleagues with health problems that could affect their practice of medicine. Mandatory reporting in the areas of professional standards and competence, however, is a first for Australia. Such reporting is mandated in seven of the United States of

Reportable misconduct under the *Medical Practice Amendment Act 2008* (NSW) (Section 71A)

NSW doctors must report if they reasonably believe or ought reasonably to believe that a colleague has:

- engaged in sexual misconduct in the practice of medicine;
- practised while intoxicated by drugs or alcohol; or
- flagrantly departed from accepted standards of professional practice or competence, risking harm to patients. ♦

America (Arizona, Delaware, Montana, Nebraska, New Jersey, Oregon and Texas). The NSW Board’s much publicised standards of professional care expect doctors to make such notifications⁶ in accordance with section 86E of the Act: persons may notify the Board of “any matter that the person thinks indicates that the professional performance of a registered medical practitioner is unsatisfactory”.

Failure to report concerns has led to serious consequences: the United Kingdom General Medical Council set a precedent when it found a senior anaesthetist guilty of serious professional misconduct for failing to pursue complaints that a locum was endangering patients.⁷ In 2005, it punished two doctors who had not reported their concerns about a patient of Harold Shipman,⁸ found guilty of murdering 15 patients and implicated in the deaths of many more.

Despite longstanding obligations to report “impaired” colleagues, we know that there is a continuing reluctance among doctors to do so. Will they be any more forthcoming in reporting “incompetent” colleagues?

Unless harm to patients is qualified to refer to serious, perhaps life-threatening, harm, as in New Jersey (“conduct which would present an imminent danger to an individual patient or to the public health, safety or welfare”⁹), the way could now be open for cross-complaints where “turf wars” exist between branches of the profession. Some plastic and reconstructive Fellows of the Royal Australasian College of Surgeons are dismayed by the work of “cosmetic physicians” who lack surgical training; and orthopaedic and neurosurgeons might dispute one another’s spinal surgery techniques. These areas of practice are bedevilled by patients’ complaints.

With the amendments now effective, the effects of the “law of unintended consequences” (inevitable unanticipated consequences of the actions of people, and particularly of governments¹⁰) remain to be seen. How will the NSW Medical Board, Medical Tribunal and Supreme Court define a flagrant departure from accepted standards? Proof that a doctor ought reasonably to have believed that a colleague warranted being reported will, no doubt, trigger much legal disputation.

Over the past two decades, the NSW Medical Board has moved away from seeing all breaches of standards as requiring punishment. Part 5 of the Medical Practice Act enables the Board to help doctors in difficulty continue in practice, with appropriate treatment and monitoring (provided they are no threat to the public). Under Part 5A, the Board has a well established system of performance appraisal. Both procedures are based on confidentiality.

A balance needs to be struck between the public interest of raising standards through frank discussion (in confidence) among professional peers, and satisfying individual patients’ or relatives’ desire to know the facts of individual mistakes. Just as the confidentiality of meetings on maternal and perinatal mortality and morbidity and on anaesthetic deaths has led to improvements in standards, so too has the confidentiality of meetings of PSCs.

From its inception in 1987, the PSC was understood, and accepted by the NSW Government, as a *professional* assessment of standards. Cabinet agreed to the trade-off of confidentiality to encourage respondents to be frank and truthful, thus assisting PSCs to improve standards. Respondents are, therefore, not legally represented at these professional hearings. By contrast, serious breaches go to the Medical Tribunal, where respondents have legal representation before a judge, with a right of appeal on points of law to the Supreme Court.

Now that PSC findings are no longer confidential, respondents are faced with representing themselves in potentially career-damaging proceedings with publicly available findings. This might make them decline to appear, instead entrusting the defence of their reputation to a barrister before the Medical Tribunal. Such a change, from a discussion with colleagues about techniques or therapies, aimed at improving standards, to a courtroom with a barrister, trying to prove no wrongdoing, is inconsistent with raising standards of care.

Are these proposals then simply another example of a government wishing to be seen to be doing something, or are the benefits likely to outweigh the disadvantages? In view of the established policies of the Medical Board, breaches of which are already sufficient to attract disciplinary action, the only gain would seem to be directing whistleblowers to the Board instead of to their local hospital or Area Board.¹¹ This could avoid the futility experienced by nurse Toni Hoffman, in informing her hospital superiors of her concerns about Dr Patel.¹²

Regrettably, as agreed by complainants’ advocate Terry Stern,¹³ the abolition of the confidentiality of PSC hearings will hinder the Medical Board’s attempts to improve medical standards. The

looming uncertainty, of course, is how these issues will be handled if, when and how the Council of Australian Governments’ proposals for national registration of health care professionals¹⁴ are implemented.

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