Mandatory reporting of health professionals: The case for a Western Australian style exemption for all Australian practitioners

Hon Nick Goiran MLC, Margaret Kay, Louise Nash and Georgie Haysom*

This article discusses the current mandatory reporting obligations for health practitioners in Australia under the Health Practitioner Regulation National Law. It provides a summary of the mandatory notification legislation, and contextualises the introduction of this law. The details of the Western Australian exemption, under which a treating doctor is exempt from mandatory reporting of a doctor-patient, and the rationale for its introduction are examined. This is followed by a consideration of the potential impact of the mandatory reporting obligations. The authors argue that the Western Australian exemption has merit and should be considered for adoption throughout Australia.

[T]he secret of the care of the patient is in caring for the patient.[1]

In 1927, Sir Francis Peabody was terminally ill when he wrote his seminal paper, "The Care of the Patient".[2] Recognised as a landmark paper in medicine, Peabody articulated his insights about the importance of the doctor-patient relationship, noting that the "personal relationship between physician and patient cannot be too strongly emphasized".[3]

Do mandatory reporting obligations impact on the therapeutic relationship between a treating doctor and doctor-patient? Do doctor-patients perceive they could be reported and therefore not access care? This article specifically focuses on the unique statutory exemption from mandatory reporting obligations that is currently available in Western Australia when a health practitioner provides treatment to another health practitioner. Should this unique exemption be adopted by other States and Territories?

The *Health Practitioner Regulation National Law* (National Law) covers 14 health practitioner groups that are registered with the Australian Health Practitioner Regulation Agency (AHPRA). This article focuses specifically on the medical profession, but recognises that many of the issues presented here are also relevant to other health practitioners.

National Registration and Accreditation Scheme

The National Registration and Accreditation Scheme commenced in Australia on 1 July 2010 in all jurisdictions except Western Australia, where the scheme commenced on 18 October 2010. Its origins were in a 2006 Productivity Commission report[4] that recommended the establishment of a national health practitioner registration scheme to, among other things, encourage workforce mobility and

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[1] Peabody FW, "The Care of the Patient" (1927) 88 JAMA 877 at 882.

[2] Peabody, n 1 at 878.

[3] Peabody, n 1 at 878.

[4] Productivity Commission, *Australia's Health Workforce: Productivity Commission Research Report* (December 2005), http://www.pc.gov.au/projects/study/health-workforce/docs/finalreport.

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reduce administrative red tape. The Commission's recommendations were adopted by the Council of Australian Governments, and the intergovernmental agreement to establish the national scheme was signed in March 2008. Due to a lack of constitutional power, the Commonwealth could not enact standalone federal legislation. Rather, each State and Territory was required to pass its own legislation. The National Law was first enacted in Queensland in 2009. Legislation adopting the Queensland Act was then passed in all other jurisdictions.

The National Law: What is notifiable?

Embedded within the National Law is the legal obligation for registered health professionals to report "notifiable conduct".[5] The term "mandatory reporting" has been coined to refer to notifications made to AHPRA when fulfilling this legal obligation. The National Law obliges a health practitioner to notify AHPRA if, in the course of practising the first health practitioner's profession, he or she forms a reasonable belief that another health practitioner has behaved in a way that constitutes notifiable conduct.[6] Section 140 of the National Law[7] defines "notifiable conduct" in relation to a registered health practitioner, to mean that:

> the practitioner has –
> (a) practised the practitioner's profession while intoxicated by alcohol or drugs; or
> (b) engaged in sexual misconduct in connection with the practice of the practitioner's profession; or
> (c) placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or
> (d) 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.

Health practitioners are also required to notify a student to AHPRA if the student "has an impairment that, in the course of the student undertaking clinical training, may place the public at substantial risk of harm".[8]

The mandatory notification requirement applies not only to registered health practitioners but also to employers of registered health practitioners[9] and, in the context of students, to education providers.[10]

The Medical Board of Australia has produced guidelines for mandatory notifications which clearly state that the threshold for triggering a mandatory notification is high.[11] While doctors in Australia have always had an ethical duty to report doctors whose practice places the patient at risk of harm, it is only through the National Law that this ethical obligation has become a mandatory legal requirement. The professional obligation to report remains in place as outlined in the *Good Medical Practice: A Code of Conduct for Doctors in Australia*[12] and in the voluntary notification provisions of the National Law.[13]

HISTORICAL BACKGROUND

The concept of mandatory reporting is not unusual in legislation. The importance of reporting a health issue that threatens public safety is well known with regard to reporting infectious disease with the purpose of enabling actions that will protect the public. The concept of mandating reporting by health

[5] *Health Practitioner Regulation National Law Act 2009* (Qld), s 140, as in force in each State and Territory (National Law).

[6] National Law, s 141.

[7] National Law, s 140.

[8] National Law, ss 141, 143.

[9] National Law, s 142.

[10] National Law, s 143.

[11] Medical Board of Australia, *Guidelines for Mandatory Notifications* (2013), http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx.

[12] Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (2014) at [8.3], http://www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx.

[13] National Law, s 144.

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professionals about issues other than infectious disease is most often recognised as being associated with the mandatory reporting of child abuse. This approach was advocated strongly in the early 1960s by Kempe et al.[14] Over the decades, this approach has been extended to other professionals, and indeed to the general community in some places. The effectiveness of this approach, however, over and above the awareness created by public discussion and education around this legislation, continues to be debated.[15]

This article focuses on one particular aspect of mandatory reporting: a doctor's obligation to report a doctor who is a patient.

There are a number of cases in the literature, presented as examples of failures of self-regulation by the profession, that are used to argue the case for the introduction of mandatory reporting.[16] While these cases from Australia and overseas illustrate failures within the health care system, there is still debate about whether mandatory reporting could have prevented these events.

In Australia, the National Law was introduced as a "response to perceived failures in medical self-regulation".[17] By the year 2000, concerns had already been raised internationally about the need for safer systems within the health sector to identify and thus minimise error.[18] Over the next few years, similar reports were commissioned in Australia, including the *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Garling Report)[19] and the *Queensland Health Systems Review*.[20]

Concern was heightened with the well-publicised investigations into the practice of a number of individual doctors in Australia, including the investigation of Dr Reeves,[21] Dr Patel[22] and Dr Khalafalla.[23] Only a few years before, in the United Kingdom, similar investigations were held into a number of medical practitioners, including Dr Harold Shipman[24] and Professor Dick van Velzen.[25]

These investigations identified a complex picture of system failures between regulation, professional issues and the delivery of care within the health system.

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[14] Krugman RD and Korbin JE (eds), *C Henry Kempe: A 50 Year Legacy to the Field of Child Abuse and Neglect* (Springer, 2013), http://www.springer.com/social+sciences/wellbeing+%26+quality-of-life/book/978-94-007-4083-9.

[15] Goodyear-Smith F, "Should New Zealand Introduce Mandatory Reporting by General Practitioners of Suspected Child Abuse? NO" (2012) 4 J Prim Health Care 77; Donald TG, "Does Mandatory Reporting Really Help Child Protection? The View of a Mandated Australian" (2012) 4 J Prim Health Care 80.

[16] Jackson K and Parker M, "Full Steam Ahead on the SS 'External Regulator'? Mandatory Reporting, Professional Independence, Self-regulation and Patient Harm" (2009) 17 JLM 29.

[17] Parker M, "Embracing the New Professionalism: Self-regulation, Mandatory Reporting and Their Discontents" (2011) 18 JLM 456.

[18] Kohn LT, Corrigan JM and Donaldson MS (eds), *To Err is Human: Building a Safer Health System* (National Academy Press, 2000), http://www.nap.edu/openbook.php?isbn=0309068371.

[19] Garling P, *Final Report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals* (27 November 2008), http://www.dpc.nsw.gov.au/__data/assets/pdf_file/0003/34194/Overview_-_Special_Commission_Of_Inquiry_Into_Acute_Care_Services_In_New_South_Wales_Public_Hospitals.pdf.

[20] Forster P, *Queensland Health Systems Review: Final Report* (September 2005), http://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2005/5105T4447.pdf.

[21] Garling P, *First Report of the Special Commission of Inquiry – Inquiry into the Circumstances of the Appointment of Graeme Reeves by the Former Southern Area Health Service* (31 July 2008), http://www.lawlink.nsw.gov.au/Lawlink/Corporate/ll_corporate.nsf/vwFiles/FirstReport.pdf/$file/FirstReport.pdf.

[22] Davies G, *Report: Queensland Public Hospitals Commission of Inquiry* (2005), http://trove.nla.gov.au/work/20106300?q&versionId=23693557.

[23] Health Quality and Complaints Commission, *Report of the Health Quality and Complaints Commission: An Investigation into Concerns Raised by Mrs De-Anne Kelly MP about the Quality of Health Services at Mackay Base Hospital* (August 2008), http://rti.cabinet.qld.gov.au/documents/2008/Aug/HQCC%20Report%20into%20Mackay%20Hospital/Attachments/HQCC%20report%20on%20Mackay%20Hospital.pdf.

[24] Smith J (Chair), *The Shipman Inquiry: Fifth Report* (December 2004) Vol 2, http://webarchive.nationalarchives.gov.uk/20090808154959/http://www.the-shipman-inquiry.org.uk/fifthreport.asp.

[25] Hunter M, "Alder Hey Report Condemns Doctors, Management, and Coroner" (2001) 322 BMJ 255.

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Although the individual recommendations in each report varied, there was an overarching concern to improve public safety through the implementation of more consistent reporting of error with the establishment of better processes to identify recurrent or serious error. Threaded through these reports were other common elements, including the recognition of the importance of the professional duty of a medical practitioner to report a colleague who was impaired and/or practising in a sub-standard manner. The need to ascertain fitness to practise or competency was raised a number of times, with the responsibility for determining this resting with professional colleges and medical regulatory bodies. Importantly, the inquiry into Shipman's case heard that "Harold Shipman would, of course, have passed any appraisal of fitness to practise with flying colours".[26]

These cases illustrate failures within the health care system that resulted in patient harm. They are commonly referred to as reasons for the introduction of mandatory reporting. There was no recommendation, however, in any of these Australian or international inquiries that health practitioners should be *mandated* to report the health practitioners they cared for within a therapeutic relationship.

Each of these inquiries captured the attention of the media. Despite the debate about whether stricter regulation would have identified these doctors earlier, as publicly funded health systems also have a political dimension, a political response was considered necessary.

A mandatory reporting obligation on doctors to report their colleagues was first legislated in Australia by the New South Wales Parliament in 2008. This followed "revelations about failures of the regulatory system to protect the public from dangerous or poorly performing medical practitioners", in particular the New South Wales cases of Graham Reeves and Suman Sood in the mid-2000s.[27]

The *Medical Practice Amendment Act 2008* (NSW) came into effect on 1 October 2008 and amended the now repealed *Medical Practice Act 1992* (NSW). This legislation introduced the notion of "reportable misconduct". A registered medical practitioner was said to commit "reportable misconduct" in the following circumstances:

> (a) if he or she practises medicine while intoxicated by drugs (whether lawfully or unlawfully administered) or alcohol,
>
> (b) if he or she practises medicine in a manner that constitutes a flagrant departure from accepted standards of professional practice or competence and risks harm to some other person,
>
> (c) if he or she engages in sexual misconduct in connection with the practice of medicine.[28]

In 2009, similar legislation was passed in Queensland.[29] The proposal to introduce this legislation was announced by the Queensland Health Minister[30] in his response to the release of the Health Quality and Complaints Commission Report into concerns about the quality of health services at Mackay Base Hospital.[31] The Hon Stephen Robertson stated:

> The report has recommended a number of changes which need to be made in Queensland Health and I have directed the Director General Mick Reid to make this happen.
>
> Today cabinet endorsed my proposal to introduce mandatory reporting of misconduct by medical practitioners into hospitals.[32]

[26] Osborne J and Osborne B, quoted in United Kingdom, Department of Health, *Good Doctors, Safer Patients: Proposals to Strengthen the System to Assure and Improve the Performance of Doctors and to Protect the Safety of Patients – A Report by the Chief Medical Officer* (July 2006) p iv, http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4137276.pdf.

[27] New South Wales, Legislative Council, *Parliamentary Debates* (4 June 2008) p 8108 (Second Reading Speech, *Medical Practice Amendment Bill 2008* (NSW)).

[28] *Medical Practice Act 1992* (NSW), s 71A(1).

[29] *Health and Other Legislation Amendment Act 2009* (Qld).

[30] Robertson S, "Health Minister Releases HQCC Report into Mackay Hospital", Media Statement (4 August 2008), http://statements.qld.gov.au/Statement/Id/59553.

[31] Health Quality and Complaints Commission, n 23.

[32] Robertson, n 30.

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He also stated that this was "a very practical way to improve the safety of patients in our hospitals and ensure that problems are identified early and acted on".[33] This statement juxtaposes the need to introduce changes to improve patient safety with the proposal to introduce mandatory reporting, even though this report did not recommend mandatory reporting as one of these changes.

Notably, and in contrast to the New South Wales legislation, the Queensland legislation included practising with an impairment in the definition of reportable misconduct:

> practice of the profession –
>
> (i) while affected by a physical or mental impairment, or other health condition, other than intoxication by a drug or alcohol; and
>
> (ii) that causes, or is likely to cause, significant harm to a person receiving professional services from the registrant practising the profession.[34]

This legislation was passed in Queensland on 29 October 2009 on the same day the National Law was passed and remained in place until the National Law provisions took over on 1 July 2010.

A decade prior to the introduction of mandatory reporting for all health professionals in Australia, the New Zealand medical profession had already debated whether to introduce mandatory reporting, although this proposal related to the reporting of concerns about competence rather than impairment. Coates[35] presented a clear argument against the introduction of mandatory reporting, identifying six specific concerns:

1. the presence of impaired practice was likely to be a subjective determination and thus difficult to define;
2. mandated reporting of practitioners would mean they were less likely to be open about their mistakes for fear of being reported;
3. health professionals may avoid engaging with situations where they were concerned about the existence of impaired practice, for fear of having to engage with the process of mandatory reporting;
4. the risk of reporting in bad faith (vexatious reporting) would be significant;
5. there was a clear risk that any unjust complaint could severely impact upon the career of a health professional; and
6. mandatory reporting would be difficult to enforce.

He determined that there was a risk that true cases of incompetence may actually be less likely to be exposed through the process of mandatory reporting.

Coates then went on to argue the importance of collegiality within the health professional team and the need for team-based self-regulation with appropriate monitoring systems in place. This focus is consistent with the approach recommended in Kohn et al's report from the United States, *To Err is Human: Building a Safer Health System*.[36] While this report discussed mandatory reporting, it clearly presented the case for hospitals and health care organisations to have the capacity to gather data about the health outcomes of their patients, including the mistakes. The intention of this reporting was to develop a robust system with greater transparency in the monitoring of care where errors can be openly acknowledged and managed with the intention of avoiding error in the future. This report focused on the system rather than the individual and did not advocate mandatory reporting of the doctor-patient by their treating doctor.

In Australia, as the introduction of the National Law appeared imminent, it was feared that mandatory reporting could "set back improvements made in recent years that have resulted in earlier presentation of sick doctors and improved access to the best available help".[37] This concern was raised in the Garling Report with reference to submissions on the issue:

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[33] Robertson, n 30.

[34] *Medical Practitioners Registration Act 2001* (Qld), s 166.

[35] Coates J, "Mandatory Reporting of Incompetence" (2001) 114 NZMJ 193.

[36] Kohn et al, n 18.

[37] Breen K, "National Registration Legislative Proposals Need More Work and More Time" (2009) 191 MJA 464.

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> [T]he new reportable misconduct provisions do not contain a reasonable excuse exception to the mandatory reporting requirement. They submitted that the provisions may therefore have unintended consequences, such as requiring medical practitioners who counsel or treat other practitioners to report information conveyed to them in the course of their therapeutic relationship. The organisations pointed out that it would be contrary to the public interest to deter practitioners from engaging in a fulfilling therapeutic relationship.[38]

The Garling Report also noted there was:

> much force in these submissions … it would be appropriate for NSW Health to undertake a review of the operation of the legislation after the legislation has been operating for 12 months to see whether amendments are necessary to address these concerns.[39]

Exemptions to mandatory reporting

The National Law provides for categories of exemption from the requirement for mandatory notification in s 141(4). The current exemptions include health practitioners who are engaged by or providing advice to a professional indemnity insurer and health practitioners who know that AHPRA has been notified.

WESTERN AUSTRALIA'S UNIQUE EXEMPTION

In Western Australia, the National Law was not passed until 18 October 2010. In adopting the National Law, the Western Australian Parliament amended it to include an additional category of exemption from the requirement for mandatory notification of a fellow health practitioner or student where "the first health practitioner forms the reasonable belief" as to the notifiable conduct or impairment "in the course of providing health services to the second health practitioner or student".[40]

This significant issue received only the most modest attention when initially debated in the Western Australian Legislative Assembly. The Australian Medical Association (AMA) had raised concerns about mandatory notification specifically dealing with the knowledge a spouse, a partner or a friend who was also a health practitioner might have about a health practitioner's state of mind or use of medication, and sought exemptions for:

> health practitioners' spouses, treating practitioners and other professional support services including Doctors Health Advisory Services, college and employer performance support and assistance programs and peer review processes.[41]

Despite acknowledging these concerns, the Opposition concluded that, although the AMA raised important points in this regard:

> it is also fair to say that the minister should aim for the highest possible standards. Therefore, we are not in a position to suggest changes to the mandatory reporting requirements.[42]

The Minister did not address this point in his speech in reply and there was no further reference to mandatory notification during the consideration in detail of the *Health Practitioner Regulation National Law (WA) Bill 2010* (WA).

When reviewed by the Legislative Council's Standing Committee on Uniform Legislation and Statutes, the Committee noted concerns raised by the Australian Psychological Society:

> "[T]here are instances where mandatory reporting may actually increase risks to the public rather than decrease it." The society argues that the reporting requirement will result in practitioners being reluctant to seek help voluntarily from their professional peers and other health practitioners for fear of being

[38] Garling, n 21 at [6.47].

[39] Garling, n 21 at [6.49].

[40] *Health Practitioner Regulation National Law (WA) Act 2010* (WA), s 4(7).

[41] Western Australia, Legislative Council, Standing Committee on Uniform Legislation and Statutes Review, *Report on the Health Practitioner Regulation National Law (WA) Bill 2010*, Report No 52 (2010) at [4.89], referring to Submission No 66 from the Australian Medical Association Western Australia (3 March 2010) p 19.

[42] Western Australia, Legislative Assembly, *Parliamentary Debates* (18 May 2010) p 2765, http://www.parliament.wa.gov.au/Hansard/hansard.nsf/0/E13F4B71AE34D03F4825772A001B62C7/$File/A38%20S1%2020100518%20All.pdf.

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> reported. Further, a mandatory reporting requirement may result in a potential breach of professional trust between a practitioner and their patient and might compel a practitioner to act on hearsay information.[43]

The Committee was swayed by the response of the Department of Health that there needs to be "a reasonable belief" and that the provisions deal with "fairly serious matters". The Committee recommended no changes to mandatory reporting requirements in the National Law, justifying it by reference to child protection:

> [I]ncreasingly, mandatory reporting is becoming a feature of this type of legislation and is justified on the reasonable grounds of "protection of the public". For example, similar provisions were included in the *Working with Children (Criminal Record Checking) Amendment Bill 2009* recently passed by the Parliament.[44]

Notwithstanding the original content of the Bill and the report of the Standing Committee, during its passage through the Western Australian Legislative Council in August 2010 the Bill was amended to include an additional category of exemption in s 141(4) as follows:

> (da) the first health practitioner forms the reasonable belief in the course of providing health services to the second health practitioner or student.[45]

The *Parliamentary Debates* show that the amendment, which aimed to "avoid discouraging a practitioner who has a problem from seeking treatment in Western Australia",[46] enjoyed unanimous support, from the then Liberal Deputy Leader (and Minister with the carriage of the Bill), the Leader of the Greens and the Leader of the Labor Party, with the phrase "furious agreement" used by two Members of Parliament. As noted by another member of the House: "We need to debunk the culture that it is an admission of weakness to seek assistance."[47]

This episode demonstrates at least two things. First, there is benefit in perseverance in advocacy. It is improbable that the amendment would have been made but for the perseverance of the AMA Western Australia. Secondly, logically persuasive arguments can indeed result in bipartisan (in this case quad-partisan) support.[48]

While it is true that mandatory reporting schemes are now common, it is appropriate to inquire whether such mechanisms achieve their stated end, and whether they achieve the right balance between protection of the public and the rights of doctors to access the health care they need.

IMPACT OF MANDATORY REPORTING ON PUBLIC SAFETY AND ON DOCTORS' ACCESS TO HEALTH CARE

It is impossible to assess the impact of mandatory reporting over the last three years. The introduction of mandatory reporting coincided with the introduction of other significant changes to the regulatory scheme for doctors. These included the introduction of national registration and the presence of a national health professional regulatory authority. New systems designed to enhance patient safety were also implemented in many health workplaces in response to the various inquiries. These changes to systems and the related discourse around patient safety heightened the medical community's awareness of these issues. It is difficult to disentangle the specific impact of mandatory reporting in this complex environment.

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[43] Western Australia, Legislative Council, Standing Committee on Uniform Legislation and Statutes Review, n 41 at [4.87], quoting Submission No 36 from the Australian Psychological Society (3 March 2010) p 5.

[44] Western Australia, Legislative Council, Standing Committee on Uniform Legislation and Statutes Review, n 41 at [4.91].

[45] *Health Practitioner Regulation National Law (WA) Act 2010* (WA), s 4(7).

[46] Western Australia, Legislative Council, *Parliamentary Debates* (12 August 2010) p 5443 (Simon O'Brien), http://www.parliament.wa.gov.au/Hansard/hansard.nsf/0/2E342CB5AFCC00BE482577930026400C/$File/C38%20S1%2020100812%20All.pdf.

[47] Western Australia, Legislative Council, n 46, p 5443 (Sue Ellery).

[48] In addition to the three political parties referred to above, the Legislative Council at the time comprised five members of the National Party who were in a coalition government with the Liberal Party.

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With regard to doctors' access to health care, numerous groups have raised concerns, including the AMA, the Australian Psychological Society, the Royal Australian College of General Practitioners (RACGP), medical indemnity organisations and the Western Australian Parliament. Even the Garling Report voiced concerns that mandatory reporting provisions in place in New South Wales at that time had the potential to impair a doctor's access to health care.

This is a significant concern because doctors experience many barriers when accessing health care,[49] even when mandatory reporting is not obligated through legislation. Recently, Beyond Blue[50] undertook a National Mental Health Survey of 12,252 doctors (42,492 surveyed, response rate 27%) to explore the barriers experienced by doctors seeking treatment for mental health conditions. In descending order, the barriers were

- lack of confidentiality or privacy (reported by 52.5%);
- embarrassment (37.4%);
- impact on registration and right to practise (34.3%);
- preference to rely on self or not seek help (30.5%);
- lack of time (28.5%); and
- concerns about career development or progress (27.5%).

This finding is striking as it clearly documents concerns related to registration as a serious barrier to health access.

It has previously been suggested that the National Law, with its mandatory reporting obligations, would be unlikely to have had an impact on access to health care because the professional duty to voluntarily report doctors who are impaired has always existed.[51] This recent survey suggests something very different, providing evidence to validate the concerns voiced by experts like Breen (a medical practitioner with extensive experience with the Medical Practitioners Board in Victoria) who stated that "[t]hese new provisions are likely to deter doctors from seeking help".[52]

Breen has identified the wording of the legislation as especially troublesome, "worded in the past tense so that no exception can be made for an impaired doctor who seeks help and voluntarily ceases to practise while receiving care",[53] or arguably if the doctor may have put the public at risk in the past but is no longer a risk, for example, after treatment. Notably, the wording of the New South Wales legislation introduced in 2008[54] and of the Queensland legislation[55] that preceded the National Law used the present and future tense rather than the past tense.

At the very least, the National Law has created the perception of a barrier to health access. The Western Australia amendment removes this added perception, while maintaining the professional requirement to ensure patient safety. The stigma around seeking health care already creates a serious barrier for doctors with mental health issues.[56] Raising the barriers (perceived or real) to health access by introducing mandatory reporting clearly undermines the very purpose of the National Law with its focus on patient safety.

Other measures of the impact of mandatory reporting on the health access of doctors are elusive. It has been suggested that the calls received by doctors' health advisory services could be used as a measure of changes in health-seeking within the medical community. This measure, however, is

[49] Kay M, Mitchell G, Clavarino A and Doust J, "Doctors as Patients: A Systematic Review of Doctors' Health Access and the Barriers They Experience" (2008) 58 Br J Gen Pract 501, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2441513/?tool=pubmed.

[50] Beyond Blue, *National Mental Health Survey of Doctors and Medical Students* (October 2013), http://www.beyondblue.org.au/docs/default-source/default-document-library/bl1132-report---nmhdmss-full-report_web.

[51] Parker MH, "Mandatory Reporting, Doctors' Health and Ethical Obligations" (2011) 194 MJA 205.

[52] Breen K, "Doctors' Health: Can We Do Better Under National Registration?" (2011) 194 MJA 191.

[53] Breen, n 52.

[54] *Medical Practice Act 1992* (NSW), s 71A(1).

[55] *Health and Other Legislation Amendment Act 2009* (Qld).

[56] Beyond Blue, n 50.

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difficult to interpret. It is quite possible for a service to receive the same number of calls, yet the focus of those calls may be very different. Many doctors' health services are voluntary and do not keep databases of this information. Some doctors' health services, however, did report experiencing a reduced number of calls that coincided with the introduction of mandatory reporting legislation. The President of AMA Queensland stated:

> We know the Doctors' Health Advisory Service (DHAS) which provides professional health advice to doctors has experienced a 50 per cent decline in calls since this legislation has come into effect.

He also voiced his concern regarding health access for health practitioners, stating:

> [I]t's understandable that doctors, nurses and allied health professionals are reluctant to seek treatment.[57]

At the Senate inquiry into AHPRA in 2011 a reduction in the number of calls to the Doctors' Health Advisory Service in the Australian Capital Territory was also reported:

> One of the things that I do is carry the phone for the ACT Doctors' Health Advisory Service. I have noticed that since AHPRA and mandatory reporting commenced, there has been a dramatic fall in the number of calls that I have been getting. That troubles me because I worry about my colleagues not seeking help when they need it.[58]

The Senate inquiry also noted concerns voiced by the RACGP:

> This will exacerbate the [doctors' health] issues and drive them underground, rather than decrease the risks to patients, the public, the practitioners themselves, and their colleagues. Only the current system of collegiate support and peer review can ensure that impairment issues will be dealt with in the patients' interest.[59]

The RACGP also recommended that the National Law be amended "to exempt the health professional's treating doctor from mandatory reporting".[60]

The Senate Committee concluded in Recommendation 9:

> [T]his is a difficult area of regulation and the safety of the Australian public must be paramount. However, the committee considers that there is merit in examining the operation of the mandatory notification regime operating in Western Australia.[61]

There is an absence of research into the impact of mandatory reporting on the health of the doctor who is reported to AHPRA. Intuitively, this would be a highly distressing professional event. Previous research has investigated the impact of other medico-legal matters on the health of doctors, for example, a claim for compensation, a complaint to a health care complaints body, or an inquiry such as a hospital or coronial inquiry.[62] The international literature describes the symptoms that doctors experience, including tension, frustration, anger, guilt, distress, shame, a loss of control, depression and, for some, suicidality. For some, this stress is a "major life trauma".[63] An Australian study of general practitioners reported the threat of litigation to be the most severe work-related stress.[64] Nash et al surveyed 2,999 Australian doctors and found that doctors with a current medico-legal matter had a higher risk of having psychiatric morbidity during the medico-legal process compared to doctors

[57] Australian Medical Association Queensland, "Health Professionals' Right to Confidential Health Treatment", Media Release (11 November 2010), http://www.amaq.com.au/gdesign/9351_on/HealthProfessionalsRightto.pdf.

[58] Australia, Senate, Finance and Public Administration References Committee, *Inquiry into the Administration of Health Practitioner Registration by the Australian Health Practitioner Regulation Agency (AHPRA)* (June 2011) at [5.46], http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Finance_and_Public_Administration/Completed%20inquiries/2010-13/healthpractitionerregistration/index.

[59] Australia, Senate, Finance and Public Administration References Committee, n 58 at [5.45].

[60] Australia, Senate, Finance and Public Administration References Committee, n 58 at [5.53].

[61] Australia, Senate, Finance and Public Administration References Committee, n 58 at [6.29].

[62] Nash L, Tennant C and Walton M, "The Psychological Impact of Complaints and Negligence Suits on Doctors" (2004) 12 Australas Psychiatry 278.

[63] Nash et al, n 62 at 280.

[64] Schattner PL and Coman GJ, "The Stress of Metropolitan General Practice." (1998) 169 MJA 133.

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who were not experiencing a medico-legal matter.[65] In addition, when asked to recall their health while the subject of a medico-legal matter, 78% recalled being more anxious than usual, 48% more depressed, 14% recalled drinking more alcohol than usual while 13% recalled having other medical problems during the time of the medico-legal process.[66] This Australian research was undertaken prior to the National Law being passed.

AHPRA's Annual Report for 2012-2013 indicates that there were over 95,000 medical practitioners registered with it during that period.[67] The Report presents the figures for notifications[68] of health practitioners received by AHPRA, including mandatory notifications, during the reporting year and compares the figures to those for 2011-2012. During 2012-2013, AHPRA received a total of 8,648 notifications about health practitioners. Of these, 4,709 (54%) were about medical practitioners, although medical practitioners represented only 16% of registered health practitioners. The figures show that mandatory reporting accounts for only a small percentage of total notifications made to AHPRA. Of the 4,709 notifications about medical practitioners, 299 were mandatory notifications (28.9 notifications per 10,000 registered medical practitioners). Very few notifications (10 per 4,709) were reported as being made by the treating practitioner.[69] These figures are represented in Table 1, which lists the number of mandatory notifications received by AHPRA about medical practitioners by jurisdiction in 2011-2012 and 2012-2013. The Table also lists the total number of notifications by jurisdiction received by AHPRA in 2012-2013 as well as the number of registered medical practitioners with AHPRA that reporting year.

TABLE 1 Number of mandatory notifications, total notifications and registered medical practitioners by jurisdiction

		ACT	NT	Qld	SA	Tas	Vic	WA	NSW	Total
2011-2012	Mandatory notifications to AHPRA	10	4	68	22	8	25	12	72	221
2012-2013	Mandatory notifications to AHPRA	10	4	75	43	13	41	26	87	299
2012-2013	Total notifications to AHPRA*	115	60	1,154	275	108	989	331	1,677	4,709
2012-2013	Number of registered medical practitioners	1,894	992	18,413	7,403	2,128	23,402	9,426	30,333	95,690**

Source: Australian Health Practitioner Regulation Agency and the National Boards, *Regulating Health Practitioners in the Public Interest: Annual Report 2012/13* (2013) pp 139, 150, 234, 246.
* Some practitioners were the subject of more than one notification.
** Includes 1,699 practitioners with no principal place of practice.

[65] Nash L, Kelly P, Daly MG, Walter G, van Ekert EH, Walton M, Willcock S and Tennant C, "Australian Doctors' Involvement in Medicolegal Matters: A Cross-sectional Self-report Study" (2009) 191 MJA 436.

[66] Nash L, Daly M, van Ekert E and Kelly P, "How Do Medico-Legal Matters Impact on the Doctor: Research Findings from an Australian Study" in Figley C, Huggard P and Rees C (eds), *First Do No Self-harm: Understanding and Promoting Physician Stress Resilience* (Oxford University Press, 2013).

[67] Australian Health Practitioner Regulation Agency and the National Boards, *Regulating Health Practitioners in the Public Interest: Annual Report 2012/13* (2013), http://www.ahpra.gov.au/Publications/Corporate-publications.aspx#AHPRA.

[68] Under the National Law, s 5, a "notification" is a mandatory notification or a voluntary notification. The grounds for a voluntary notification are contained in s 144 of the National Law, but essentially relate to concerns a person or entity may have about the behaviour of a health practitioner, but where the behaviour does not amount to "notifiable conduct" requiring a mandatory notification. Total notifications here therefore include mandatory notifications and voluntary notifications made by any person against a medical practitioner.

[69] Australian Health Practitioner Regulation Agency, n 67, p 47.

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Table 1 demonstrates that the rate of mandatory notifications increased in 2012-2013 compared to 2011-2012 (22.3 per 10,000), particularly in Western Australia. Clearly, the presence of the Western Australian exemption has not inhibited reporting.

MOVING FORWARD

Doctors who are unwell need to feel they can attend their treating doctor without the stumbling block of mandatory reporting. The recent Beyond Blue survey into doctors accessing care for mental health problems highlights this concern.[70] Over a third of the participants were concerned that seeking health care could impact on their registration. Doctors have a right to a therapeutic relationship through which care will be provided. They have a right to confidential care without being concerned that they will be reported. The ethical obligation may provide an easier therapeutic space for this doctor-patient relationship. In this environment, the treating doctor and the doctor-patient can consider what is best for the health of the doctor-patient recognising their mutual professional duties to ensure public safety. Even if mandatory reporting is simply a perceived barrier, it needs to be addressed to enable better health access.

As described above, many medical professional bodies have called for the Western Australian amendment to be enacted in all jurisdictions. This would provide consistency across Australia, as envisioned initially when the National Law was written and the national regulatory process was instituted. Beyond these medical organisations, other reports, including the Senate inquiry in 2011 and the Garling Report in 2008, have argued that the Western Australian exemption for treating practitioners is reasonable.

At the conclusion of the Senate Committee inquiry in 2011, Recommendation 10 stated:

> The committee recommends that the Commonwealth Government seek the support of the Australian Health Workforce Ministerial Council to implement a review of the mandatory notifications requirements and in particular take into account the Western Australian model of mandatory reporting.[71]

This was mirrored in Recommendation 4 of the Government Senators' minority report of this inquiry.[72]

The process required to institute this change in legislation was initiated in November 2010, after AMA Queensland called on the "State Health Minister and Deputy Premier Paul Lucas to make mandatory reporting a priority agenda item when he meets with other Health Ministers from across the country tomorrow".[73] On 12 November 2010, the "Ministers agreed to have a serious look at this and asked the AHMAC [Australian Health Ministers' Advisory Council] to commission work from an independent body to further consider these issues".[74] AMA Queensland welcomed this as a positive "step in the right direction",[75] although there was clearly concern at the time that this amendment would not be progressed. To date, Western Australia remains the only jurisdiction in which the exemption for treating doctors exists.

In 2013, the *Health Practitioner National Law Act 2009* (Qld) was amended. The amendment relevant to this article is found in s 141, which states:

> The National Law does not apply in relation to a second health practitioner's notifiable conduct if the first health practitioner –

[70] Beyond Blue, n 50.

[71] Australia, Senate, Finance and Public Administration References Committee, n 58 at [6.30].

[72] Australia, Senate, Finance and Public Administration References Committee, n 58 at [1.82].

[73] Australian Medical Association Queensland, "Health Professionals' Right to Confidential Health Treatment", Media Release (11 November 2010), http://www.amaq.com.au/gdesign/9351_on/HealthProfessionalsRightto.pdf.

[74] Australian Medical Association, "Good First Step but Health Ministers Must Do More on Mandatory Reporting Laws", Media Release (12 November 2013), https://ama.com.au/media/good-first-step-health-ministers-must-do-more-mandatory-reporting-laws.

[75] Australian Medical Association Queensland, "A Step in the Right Direction on Mandatory Reporting Thanks to AMA Queensland", *Online News* (18 November 2013), http://www.amaq.com.au/gdesign/9351_on/spot1.html.

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(a) forms the reasonable belief as a result of providing a health service to the second health practitioner; and
(b) reasonably believes that the notifiable conduct –
  (i) relates to an impairment which will not place the public at substantial risk of harm; and
  (ii) is not professional misconduct.

While this may appear to align more closely with the Western Australian amendment, it does not have the same effect. The wording does little more than restate that a treating doctor does not need to report a doctor-patient if there is no risk of substantial harm or professional misconduct. This amendment does not give the treating doctor an exemption from the mandatory obligation to report notifiable conduct. As it stands, it will not remove concerns raised about the impact of mandatory reporting on health access.

Throughout the last three years, the professional organisations, medical indemnity organisations and AHPRA have provided the medical profession with education around mandatory reporting issues. While this article recognises the argument that the current mandatory reporting obligations reflect the professional duty to report that has always existed, there remains reason to be concerned that doctors have less access to health care since the National Law was enacted. The multiple committees and reports that have voiced opinion on this law have confirmed that it is reasonable to mirror the Western Australian amendment in all States and Territories. They have recognised that this will likely enhance health access for health practitioners, and that this, in turn, benefits patient safety. The authors argue that the time has come for this to be progressed.

CONCLUSION

This article has considered issues associated with the controversial mandatory reporting obligation in the National Law, with special attention given to the circumstances where one health practitioner provides health services to a colleague and the unique Western Australian exemption. The continuing refusal by other jurisdictions to provide health professionals with the same authentic access to care for their own health is unjust. While it may be politically uncomfortable for other jurisdictions to revisit this, delay benefits no sector of society. It potentially compromises patient safety and does not encourage care of the doctor-patient.

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