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"A new era in medical regulation – for better or for worse"

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Tonight I am here to talk about a new era in medical regulation and try to explain to you a little bit about where it came from and what it is and then talk a bit about medical regulation in general and how that might develop what I see the challenges as being.

I want to start by telling you a brief story of an experience that I had in Oxford in 2000, the year 2000 when I went to the International Association of Medical Regulation Authorities which is a group that meets every two years which Australia has played an important part in.

The meeting that year was in Oxford. It was hosted by the General Medical Council under its then President, Sir Donald Irvine and the welcome evening reception on the first night was held in the Museum of Natural History in Oxford which is a very interesting place.

Sir Donald got up and made his opening remarks welcoming everybody to the conference and speaking a little about medical regulation and he was literally standing between a dinosaur and a dodo and I thought that it was unfortunate that nobody had pointed out that this perhaps was not where he would want to stand.

As I said, I am going to talk about the new era, where it came from, what it is to do and how we might respond, but I think it's important because this is an important transition, to recognise the history of medical regulation in Australia.

Some of you would be aware that the first registration that anybody is aware of was in Australia in Tasmania. The Council of Medical Examiners of Van Dieman's Land was established in 1837 to determine who

could perform autopsies and give evidence at coronial inquests.

In New South Wales in 1838, remembering of course that New South Wales was the colony, apart from Tasmania, other States, so in 1838 New South Wales had a Medical Act and other States and territories came on board as they were formed and the General Medical Council of the UK was only formed in 1858, so 20 years later than Tasmania.

In the beginning the powers of registration authorities were about putting people on the register. It didn't become apparent until later that perhaps it was necessary to take them off the register at times and so it took some time for those powers to be built into the system, and progressively the system of medical regulation as we know it has built up from there so that there are investigation and disciplinary procedures which came earlier but then more recently, procedures to deal with practitioners who have health impairments, to deal with people who are poorly performing rather than engaging in misconduct, and a more proactive form of regulation which includes boards issuing more in the way of guidance and codes and trying to educate and to some degree lead and shift the profession in positive directions.

It has been a trend also to have much more involvement from the community in regulation of the profession and to change Medical Acts from being single profession Acts to being cross-profession Acts. That is the background.

The National Registration and Accreditation Scheme known as NRAS is a national registration and accreditation scheme for the regulation of health practitioners and the

registration of students undertaking programs of study that lead to qualifications in their health profession. It is important to recognise it is not just about registration of health practitioners, it is about regulation.

Where did it come from? In 2004 Peter Costello as Treasurer commissioned the Productivity Commission to do a report into Australia's health workforce. This was in the face of concerns about the shortages of workforce in a number of key areas - medicine and nursing in particular but many others - and a belief that there was too much rigidity in the professions as they were then regulated, that they were too busy looking inwardly rather than outwardly and too busy protecting the way they understood the world to be and the health workforce to work in relating to each other. There was also through the late 90s and into 2000 concern I think, about the regulatory processes for all sorts of reasons, some of which I will come back to.

In February 2006 the Productivity Commission released its report which was called Australia's Health Workforce, and recommended a single cross-profession accreditation and registration scheme with a single accreditation board and a single registration board for each of the 10 professions involved in the scheme. That wasn't warmly welcomed and I think, as I will say shortly, it was very very important then that there was a great deal of consultation and a great deal of agitation because people recognised that that wasn't what we thought was going to work best for the professions and particularly for the community in Australia.

The aims of the scheme that COAG announced were to facilitate workforce mobility, to improve safety and quality, to reduce red tape and to simplify and improve consistency in accreditation of health education, so in July 2006 COAG announced that it would happen and said it would start in July 2008. It took them until March 2008 to actually have all the States and Territories and the Commonwealth Government sign the inter-governmental agreement that was necessary to get the scheme up and running, and at that point they changed their time frame and said it would start on 1 July 2010.

I think it is important to acknowledge that there was vigorous debate and there was genuine consultation and the people who were responsible for developing the scheme an developing the legislation did listen to the feedback that they got and so we went from that system of having one national board for 10 professions to having 10 separate boards, one for each profession, all in the one scheme, and some other changes that I will talk about.

Taking part in those consultations was always a really interesting exercise from my point of view because it seemed to me that the bad guys were always in the other room. Whichever room you were in, we were the good guys and we cared about standards and about good things for the profession and good things for the Australian community. It was the other people who didn't, though there was a view amongst the government that they needed to make these changes because we needed to be brought up to higher level of standards and the boards of their own devices would go to the lowest common denominator. There was a view amongst the boards that the governments were trying to drive

things to the lowest common denominator and that the boards would protect the standards and I think there is some truth in both of those. It depends which way you look at things, and the track record of either government or in fact all of the health regulation boards isn't perfect in these regards.

It was very interesting for me, having been involved as Terry said, in medical regulation and the Medical Board for a long time, suddenly to be everybody's friend. Everybody wanted the medical boards as they currently existed to stay. The Australian Medical Council was the best thing that anybody had ever heard of so it was actually nice to get some positive feedback, even if it was in a crisis.

What happened then? There was a long process of developing legislation, and frustrating in many ways because if any of you, and I am sure many of you have, who've been close to developing legislation recognise a lot of it goes on behind closed doors. There are these people called Parliamentary Council - I hope there aren't any of them in the room - who seem to do mysterious things and don't always seem to take notice of what seems to be blindingly obvious that people are trying to tell them about the schemes they are dreaming up.

Nonetheless we have now the Health Practitioner Regulation National Law which was passed in Queensland and is in force now and enables the establishment of the National Boards and the Agency which I will come to.

We have the Act A, the first piece of legislation which went through in 2008 and it was set up so that boards could be appointed and the next lot of stuff would

happen. Then the Health Practitioner Regulation National Law Act (2009) has got all the provisions in it about how the scheme will work.

New South Wales being New South Wales, and I am not sure if there are any New South Wales people in the room, decided to do something different so those of who are involved in health law would recognise that New South Wales has a different system of health complaints investigation in New South Wales where it is what they call a co-regulatory framework between the Office of the Health Care Complaints Commissioner and the Boards in New South Wales and they deal with things in different ways, and they have decided for the complaints piece of this to go on doing that. It will be very interesting to see as we get a bit further down the track, what emerges in having one model in New South Wales and different models in the other States.

They chose Queensland quite simply because it is a unicameral parliament and it was going to be easier to get stuff through one parliamentary process than getting it through two. The piece of legislation that went through was signed off by all of the Health Ministers and there is an agreement between the Health Ministers' Council which has wavered a little bit but is still there, that legislation won't be changed unless all of the Health Ministers in all of the jurisdictions agree.

In order for that piece of legislation to then be taken up in each State we need the third part which I call Bill C. In Queensland, Victoria and New South Wales those have passed. They have been introduced in the ACT, New South Wales and Tasmania. We have got a State election in

Tasmania, we have got a State election in South Australia. Western Australia is still sort of making up its mind what to do, so this notion that we are going to have a national scheme by 1 July tests our confidence a little but we are hoping for the best.

What are the key features? It is a national system for health practitioner regulation. There is one law covering all of the 10 professions involved and I will talk to you in a minute about what they are. There are 10 national boards which will exercise the regulatory functions and there is a thing called AHPRA which is the Australian Health Practitioner Regulation Agencies. The role of AHPRA is to support the boards.

I am going to show you a diagram which may or may not make it more confusing. At the top is the Ministerial Council. They appoint the national boards. That group that is there on the left which is called the Advisory Council which has not yet been appointed but is supposed to be a sort of referee for some of the things that perhaps boards and ministers can't agree on, and on the right is the Agency Management Committee which has got the responsibility of managing and oversight of the staff and all that part of the operations.

You can see that there are a lot of arrows going in different directions so this is a very different model from the model that we have had in Victoria for a long time but not that dissimilar from the models that have operated in Queensland and the Northern Territory where the staff of most boards who've been in the one office have been essentially government employees but they have been doing the work of the boards.

AHPRA is an independent agency but it operates by sort of general public sector rules around how it operates, standards of work and accommodation and contracts and all those sorts of things.

At the moment we are in a situation where medicine has decided that it will have a board in each State so the currently existing State and Territory Medical Boards will become committees but called Boards of the Medical Board of Australia so that the Medical Board in Victoria will be the Victorian Board of the Medical Board of Australia and the Western Australian one will be the Western Australian Board of the Medical Board of Australia. Medicine, Nursing and Physiotherapy are going to have that sort of structure and some of the smaller professions are just going to operate with a National Board and have a Registration Committee and a Complaints Committee and so on but not State-based Committees and some poor unfortunate boards, in my view, have created or encouraged to create - I am not quite sure which of those it is - cross-regional boards so there are some cases where it's Queensland and the Northern Territory and some cases where it is across State boundaries which I think is actually quite a difficult thing to manage.

So what is this all about? The legislation, as I said, establishes the national boards and establishes AHPRA. The role of the national boards is to approve standards, codes and guidelines for the profession, to determine the requirements for registration and register health practitioners who meet the requirements, to approve accredited programs of study and in fact for medicine particularly, the Australian Medical Council has been

appointed as the designated accreditation agency for Medicine so the AMC will go on doing its accreditation work and report back to the Medical Board. It will oversee the assessment of overseas-trained practitioners, oversee the receipt and follow-up of notifications which is the word for "complaints" which we are used to in Victoria which is about people actually not complaining, but notifying the regulatory authority that there might be a problem with a practitioner, and to maintain the registers.

The role of AHPRA the Agency is to function in line with the objectives and guiding principles of the scheme which I will come back to, provide support and administration services to all the boards and each board will negotiate what is called a Health Professions Agreement with the Agency which will include what are the fees to be paid by the registrants in that profession and what are the services which AHPRA will provide to that board.

There are some very important things in the legislation about the guiding principles. It says that the scheme is to operate in a transparent accountable efficient effective and fair way, that registration fees are to be reasonable having regard to the efficient and effective operation of the scheme, and that restrictions on practice are to be imposed only if it is necessary to ensure that health services are provided safely and of appropriate quality.

It is also important that there are a set of objectives for AHPRA which are different from the objectives or purposes of the legislation that we have

been used to in the regulation of the profession so there are three or four parts of it which are - what we would understand - which is about protecting the public by ensuring that only health practitioners who are suitably trained and qualified to practice in a competent and ethical manner are registered, to facilitate the provision of high grade high quality education and training and to facilitate rigorous and responsive assessment of overseas trained practitioners. But there are some other things in there which are important. One is to facilitate workforce mobility, one is to facilitate access to services provided by health practitioners in accordance with the public interest, one is to enable continuous development of a flexible responsive sustainable Australian health workforce and to enable innovation in the education of and service delivery by health practitioners.

So that is a set of things around how this scheme is supposed to work to ensure some changes in workforce in Australia. Whether they are good things or bad things will remain to be seen. I think like most things the ultimate answer about whether the glass is half full or half empty is that it depends on how we do them and how wisely we do them.

I have been in forums on Medical Boards many times where people have said when questions have come up, "Workforce is nothing to do with us, we are about standards." My own view is that in a population like Australia with the health workforce like we have got, that is completely burying your head in the sand. It is not our role to change workforce or to fix workforce problems but you can't have quality health care if you don't have any

people to provide the health care and there are some issues around how we are going to address that in the future which I think we have got nowhere near touching. As I said, we will have to be very careful because as everybody would know there are a lot of agendas potentially running there and we have to work our way through them.

The health professions that are in the scheme from July 2010 are chiropractors, dental care, so dentistry is quite a complex profession with several sub-sets, medical practitioners, nurses and midwives, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists and psychologists. Then from July 2012 some other smaller professions come in.

I didn't realise until I read it in a report to the Board this week that once this Register is up there will be 500,000 people on it, half a million. That means about one in every 45 Australians will be registered - and is now - because all the people who will be on it are currently registered health professionals but it is an enormous number of people.

The Medical Board of Australia was appointed in September. Essentially there are 12 people on the Board. There is one practitioner member from each jurisdiction and four community members. All of the people except me are current members of their State and Territory Medical Boards and most of the medical members are the current Chairs of the Medical Boards.

I think that that was a very very wise decision by people who made the appointments or who made the recommendations to the Ministerial Council because in

medicine we are going to have to try to make the process of having a National Board and State Boards as seamless as possible and I think keeping current people who have got the expertise and know their local people and know their systems and are experienced in the work is the only you could start this system up safely.

I just want to divert a little bit to medical regulation because at some levels all of this stuff that has been happening has distracted us from thinking about what do we actually want in medical regulation because we have been busy trying to think about how this works.

Doctors still think of themselves as being self-regulating. In the sense of the system of regulation that we work with now that is actually probably not true. It is a statutory regulatory model or possibly a co-regulatory model but self-regulation in the regulation industry is a term that is used referring to people who don't have any pieces of legislation and who do set their own standards.

I actually think that the most important form of regulation in the profession and the thing that most upholds the standards in the profession is the regulation that each individual professional does of themselves, and the General Medical Council have articulated what they call a four layer model of regulation which starts with personal regulation and that is how each of us who is in practice decides every day what we are going to do.

There is the notion of team-based regulation. Most people work in teams and learn from and are - their behaviour is modified in various ways in those teams and they learn what works and what is acceptable. There are formal systems - more in the UK than here - of workplace

regulation through clinical governance and performance and there is professional regulation through colleges and professional associations and then the statutory regulation through the regulatory authority.

I think it is always important to recognise that the Medical Board for most people is still and will still continue to be a somewhat distant and remote structure because that is not how they make their decisions about what they are doing. I hope that the guidance that boards have offered and will continue to offer to people is helpful when they get to difficult decisions. Mostly people are well-trained and they continue their professional development and they work out what to do.

I think it is also important to think about why we have regulation. In the UK in February 2007 a White Paper was released called "Trust Assurance and Safety" and it defined professional regulation as "A framework to maintain trust based on safe and effective clinical practice and effective relationships between patients and health professionals." I think that is a good definition. They made the point that is all too easy to focus on the incompetent or malicious practice of individuals and seek to build a system from that starting point.

In their White Paper they placed a lot of emphasis on trust, the fact that the regulatory system is there to underpin or ensure that the trust that patients place in their health professionals is well founded, that the safety and quality of the health care that people receive is the most important part of it. Professional regulation needs to sustain the confidence of both the public and the profession's very demonstrable impartiality and it is

about sustaining, improving the standards of the majority as well as about action on poor practice and behaviour, and last and very importantly, that it is not burdensome, that it is proportionate to the risks and benefits. I think that that was a very reasoned and sensible discussion and there were a lot of really important points for us there.

So what are we going to gain with this new scheme? It will be national registration, so pay one fee, practice anywhere. It is essentially a model though like driver's licences in Australia. You can drive in any jurisdiction with your driver's licence but you do need to know what the law is in that jurisdiction and if you run foul of the law in that jurisdiction you will be prosecuted in that jurisdiction, so there are all sorts of things which are not anywhere near being addressed yet around anomalies in all sorts of Drugs and Poisons Regulations, intersection with lots of State laws which are still there, and it is a bit like eventually we learn whether you still give way to the right in every jurisdiction in Australia and they try to harmonise the road laws. They still haven't got that right yet so I imagine it will take a long time to get all those other bits of legislation that fit around this into some more coherent framework.

I think there are some important things about national consistency and standards in policy and procedures. I think there are some important things to be gained because we are sort of leaping up a layer. There is more critical mass. There is an opportunity to revitalise, to re-examine, to think about how we do things and to learn from each other.

And the medical boards I think more than perhaps some of the other professions have had quite a high level of exchange over some years, but all the same we have tended to sit around tables and talk about things and then go home and do it our own way. There will be some pressure now to really debate seriously what is the best way of doing things and trying to get a bit more consistency about that.

I think the national register will be a big asset. The situation at present is that the government put up $20m for the establishment of this scheme. Some of that was for the IT system and some of it was for the work that needs to be done while our registration fees for this year are supporting our current boards.

The $20m has long gone. They have committed to keeping funding the IT system until the IT system is right and I think that that is a very important thing. Hopefully that will be a straightforward process, but what would lead you to think that?

I think it is important that we now have a Medical Board of Australia and across the other professions too because a lot of things within our profession and within our country are organised nationally and so we can relate to them nationally.

I think there is less risk of influence of sectional or local interests, not that I think that is a big problem, but potentially in the little States it may have been, and I think there are opportunities to learn from each other across the health professions and to engage with each other.

There are a whole lot of new things. There are

mandatory features in the national law which health ministers decided would be part of it. All new registrants will have a criminal history check and an identity check. There is mandatory continuing professional development for all practitioners. Essentially what will happen is when those of you who are health practitioners renew your registration it will be done on line and you will just fill out this declaration box by box saying, "I have met the CPD requirements required" according to the category of practice you are in. "I do have professional indemnity insurance that covers the practice that I am doing" and so on, so it is a straightforward process if the answer to all those questions is "Yes."

There is a question on the form prescribed by the law which says, "I have an impairment, yes/no." or "I do not have an impairment, yes/no" whichever, which I think is an unfortunate and very stark sort of question. We don't have any choice about whether it is there. God knows how people are going to decide how to fill it in, but that is another question.

The way the complaints processes work within this legislation is not too different from the current Victorian legislation. In theory it will give us what we need. I am not sure how many redo's of the Victorian legislation I have lived through, but two whole new Acts anyway, and some amendments, and I can tell you that it never works the first time so I guess we will work our way through that.

There will be student registration for each profession. That is an easy matter for Medicine but it is not easy for Psychologists or lots of other people who

have much more diverse sorts of training systems and the accreditation functions are by legislation independent although nobody is quite yet sure what "independent" means.

I don't want to make you think I know everything about this. I am just telling you what I know. There are mandatory notifications. Now that is something that has been in New South Wales and Queensland now for a year or so. According to the people who work in the Queensland and New South Wales boards it hasn't made that much difference but it is something that people feel anxious about. There are a whole lot of things which are called notifiable conduct which practitioners and employers need to report. There are some exemptions including important exemptions for people who work for professional indemnity insurers. The notification has to be made on the basis of a reasonable belief formed through the practice of the profession and there are a series of things that are notifiable conduct which are about, the practitioner has practised while intoxicated, either drugs or alcohol, engaged in sexual misconduct, placed the public at risk of substantial harm through an impairment or placed the public at risk through a substantial departure from accepted professional standards.

I think that there are some interesting interfaces. How this might interface with the legal profession? I guess the first question is, is the legislative framework that we are going to have any good? Is it going to be workable? Is it sound? Is it robust?

There is no doubt it is going to be challenged and I would imagine it will be challenged by some practitioners

who are not happy about something that a board tries to do. I suspect that the board that will be trying to do it will be Medicine because all the other professions, whenever there is an uproar about medical regulations say to Medicine, "It's all your fault. We were doing fine, it is you guys who aren't."

It is interesting that the composition of the boards does not require in the legislation that there is a lawyer on the boards but in fact there has been a lawyer appointed to all of the boards as a community member. I think the ways in which we work together as this evolves are going to be really important.

One of the things that is difficult for Medical Boards is that when either a complainant or a practitioner - well for all registration boards - wants to take things to the ultimate legal limit we have no choice but to go there and the Medical Board in Victoria has been challenged a couple of times by people who over what are essentially not very major matters have pursued them through all the avenues of appeal and cost all the registrants in Victoria a lot of money but you can't once you have made an adverse finding about a practitioner, if they don't like it, just drop it because they are appealing. You have to keep going and so we have to think through how that is actually going to work.

There will be an enormous set of challenges about multiple jurisdictions because what will happen with the serious disciplinary matters is that they will be heard by tribunals in each State so VCAT in Victoria, different tribunals of similar ilk in the other States. Those people won't be bound by the decisions that the other

tribunals make. To what degree they will be aware of them I don't know so it is hard - we need to try to run a nationally consistent system and there will need to be a lot of discussion about how to make that work.

There are considerable risks in this scheme. One of them, as I said before, is if the Bill C's aren't passed and we don't have a national scheme on 1 July. If the IT system is inadequate, if it turns out that we are under-resourced, so it is quite a challenge to figure out what the registration fees should be for the first year because from now on the whole scheme is funded by registration fees of practitioners.

It would be very easy in a complex structure like this to get bogged down in bureaucracy. The National Board has the responsibility of deciding what it can delegate. It has got very flexible delegation powers. It can delegate to State Boards, to committees or to staff of AHPRA, the Australian Health Practitioners Regulation Agency, all of its functions except the capacity to delegate so the Board is going to have to be very wise about what it keeps and what it delegates.

As I said, there are significant risks of major legal challenges. Some of those will serve to make the law better. There are risks that the costs will blow out and there are considerable risks if we don't actually operate as a national system.

I think practitioners probably won't notice the difference all that much at first except that there are different names. The money - I can tell you it will go up, I can't tell you by how much.

We have specialist registration in the new scheme

which hasn't been part of the Victorian scheme in the past so for the one fee everybody will get general registration and specialist registration. That will be managed by a process essentially of the colleges telling the boards who are recognised specialists.

All practitioners will get a letter in April saying, this is what we understand about you. These are the categories of registration we think you will have and this is the fee we expect you to pay. Please let us know if we have got that wrong. I think I will take April off.

There is a set of questions that are important about how will we know if it's working, whether it is better or worse than what we have now? We don't yet know what we should be measuring or monitoring. I think there are questions about how much variability is desirable or tolerable. Hopefully we can learn from each other. We don't need to be completely rigidly the same and in fact the States and Territories in Australia are all different in many ways.

I think it is going to be pretty important that we have similar standards and procedures. Whether we will get the same outcomes I don't know. As I said before, it will be interesting to look at the comparison with New South Wales, and we don't yet know how we should be reporting this. How will a National Board oversee all of this? What will we report to the community and the profession about what we are doing and how long will it take for us to know whether it is working or not?

From my point of view I think that there are some things that this doesn't really make it any easier for us to address which are still the big issues in medical

regulation. There is a really big issue in maintaining credibility. I read out the thing from the GMC about the confidence of the public in the profession. I think it is hard for regulatory authorities to get that confidence. It is very easy for it to be damaged. It is not the 80/20 rule. It only takes one or two or three really bad situations that get a lot of publicity to take a very long time for a regulatory authority to recover its credibility.

I think there is still a problem in terms of people entering the profession, and at least until the new wave of students come in, the way in which we register people who come in from other jurisdictions, from other countries. We try to make the assessment process of those doctors sufficiently robust to ensure that they will be safe to practise wherever they go so if they are going into a relatively supported hospital system the assessment process is less detailed than if they are going into a less supervised position where they will be taking on more responsibility but it is still not the same as doing a full medical education and a full assessment at the end of that and a full vocational training program and it is still a risk, and there is still a belief in some places where Medical Boards take time to make those decisions and require people to have more assessments, that they are being too fussy and for this community this doctor would be better than no doctor.

That is always a question. Is it true that this doctor is better than no doctor? That is one of those things if you get it wrong, again it has an enormous impact on credibility.

I think that there is always still a problem for medical boards in terms of being seen as being out of touch. I guess that is a challenge which to some degree I think this system will help us get around. I don't now how many of you are cricket fans but there was an interesting incident three or four weeks ago where somebody bit a ball, one of the fast bowlers, and that was obviously not acceptable. I think it might have been Geoff Lawson wrote a column in the Age saying that he thought a bit of ball-tampering was really okay - maybe not so far as biting the ball but maybe picking at it. And I guess that might be what you think if you are a fast bowler, but it is probably not what the rest of us think. I guess this is the challenge about trying to make sure that we don't think to narrowly about what is acceptable in medical practice. We have got to be informed by people who understand practice. We have got to be based in the real context of everyday practice but we need to recognise what the community thinks too and recognise what other people think and try to make wise judgments taking all that on board and not say it's okay for fast bowlers to bite the ball.

I think assessment and supervision of international medical graduates, trying to make sure that we have got really good quick responses to really serious problems, but for things which are reported to medical boards which really are not major, we need to be able to deal with them quickly and effectively and I know all the boards around Australia have been working on that, but it is going to be a challenge.

We might think that six months is a reasonable

target if you have a less serious complaint to the board but for the practitioner involved, that six months is an awfully long time and a very very stressful experience so I don't think we have quite got it right yet in terms of really quickly dealing with stuff that is not about professional standards, it is not about safety of the public, it is about somebody was upset that day for some reason. It needs to be addressed, recognised, acknowledged and dealt with but not leave somebody subject to a protracted and very stressful experience because we do have a problem with workforce and one of the things that drives people out of work or at least threatens to is if they feel, having worked really hard that some minor incident on a bad day is what has totally hung up their career, and most people don't want that sort of interaction with their board.

I think there are issues about whether the system can remain entirely self-funded so part of the question about New South Wales - New South Wales Government actually put money into that model.

I don't think it is a great model and I don't think they are very effective but it seems to me to be a bit unfair that doctors have to keep stumping up to fund the activities of the board when a lot of them are for the good of the community.

As I said, if it was really self-regulation there would be no doubt that that is what we would do but it is not so clear into the future that that will be what it will be. Maybe it is still important that we completely fund it because that way the medical profession and all the health professions can say and feel more that this is

their system of regulation, albeit with the input from the community and an open forward looking attitude, but I think it is there as a question and it depends really how much it does cost.

So what of the future? Well, firstly I think it is really important to acknowledge the past. There has been 160 years of good work in medical regulation in Australia. There have been a lot of really dedicated people who have worked on the medical boards. There has been a fierce professional pride, wisdom, intellectual rigour, compassion and altruism put into that, and effort, all the very best things of professionalism. I think Aristotle said that the whole is more than the sum of its parts and I am a bit afraid that once we dismantle that system we will find that there were some parts that we didn't recognise and part of my responsibility and the Medical Board of Australia's responsibility is to try and carry what is good in that whole system and that history into the future.

I would hope that we might be seen and be a fair, independent and effective regulator, that we might be a respected source of advice and guidance, a responsive and adaptive and accountable organisation with financially sound but reasonable fees, and indeed that the regulatory system would be, as the UK White Paper said, a framework to maintain trust.

DR HACKER: Thank you, Joanna. Sandra Hacker, Psychiatrist. As somebody who has had a considerable investment over more than 20 years in looking after sick doctors and having been part of a scheme that established the Victorian Doctors Health Program here to look after

psychiatrically ill medical practitioners and other sick doctors and knowing that those systems don't exist elsewhere, can you tell us something about how the new medical board sees itself as managing these issues and at what level of disability will people have to tick the box that says, "I have a disability," because quite clearly the concern amongst the mental health professionals is that this might discourage people with various sorts of illness from actually seeking help.

DR FLYNN: I think that that is a real concern, Sandra. That is not the way we would have worded the legislation if it had been up to us. That is the way it is worded.

What the board is currently doing - we started work in September. We have developed all the guidelines about what's required for professional indemnity insurance, continuing medical education, professional development, recency of practice. We are now starting on a set of guidelines, the first one of which is about mandatory reporting and about where the thresholds ought to be for mandatory reporting.

What you are raising is what sort of guidance should we give practitioners about when they should tick that box and I think that that is an important question to ask and we need to think about that.

I mean what you would hope is that we could get to a situation where we make it clear to people that if there is no current or future risk that there is no need for them to do that.

The question about the Doctors' Health Programs is one that is not something - I mean my personal view would be that ideally we would have the equivalent of the

Victorian Doctors Health Program in all jurisdictions. It is not something that we are going to achieve in the short term so as you know, the program here is going to continue with funding for the next two or three years and during that time hopefully we will figure out what should be happening nationally.

I agree with you it is an issue, and I think it is something we should look at.

QUESTION: Who will be on the Boards?

DR FLYNN: Well, directly each board - the bigger professions have boards of 12 of whom 4 are not practitioner members, and one of those is a lawyer. The Medical Board has Belinda Bennett who is a Professor of Medical Law at Sydney University. The other three community members come from diverse backgrounds, highly experienced people, have had experience in tribunals and regulatory matters and come from different states, on the Medical Board. That is sort of at that level.

Obviously the community has input in lawmaking; that is part of how they have input. In Victoria the Medical Board in Victoria, the Medical Practitioners Board has had a very successful model for a few years of a community consultative committee, having a group of people that it brings in to look at policies and language and letters and issues and get feedback about how the community might look at that. I think that that is a really good model, an easy way of getting some people who become reasonably informed about the issues and can provide input so I think there aren't a lot of models around the world about how to engage the community. As you would know from College experience it is important to have the right people but I

think the experience across medical boards, all of which have had community members for some years, is that it is a very positive influence on the decision making. It brings in a diverse range of experience.

As you know, doctors can get a bit narrow and some of us don't have great records of - we are not terribly good at employment law or all sorts of things. We only tend to focus on what we are doing so it is great to have some more diverse input.

DR PRAGUE: Jenny Prague, Psychiatrist, Victoria. Thank you, Joanna. I have got two questions. The first one is, I understand that the Australian Medical Council will be in place for at least three years. After the demise of the Australian Medical Council who will be responsible for the standards in the Australian medical profession? That is the first question.

DR FLYNN: Yes. What you are saying is partly correct. So health ministers have decided that the Australian Medical Council will be the accreditation agency for medicine for the first three years and then the Medical Board of Australia will appoint the accreditation agency beyond that time so I would assume it will be the Australian Medical Council unless there is some reason why it shouldn't be.

DR PRAGUE: okay. Let's hope so. The second question is, you have described a huge what may become an amorphous mass of health professionals. How will members of the general public know who is who when one in 45 is a part of this mass. How will they know who they are seeing and what titles will they have?

DR FLYNN: I think from the point of view of members of the

public in terms of clinical interactions it will be just the same. They will know that they are seeing a doctor or a chiropractor or a podiatrist or a pharmacist or whatever. That is what those people will be. The Register will be the Register of Medical Practitioners, the Register of Podiatrists, the Register of Chiropractors and so on. They are not all on the one register so if you want to look up a doctor you go to the Medical Register and enter the suburb or the name or whatever you are going to enter.

The thing that is a little bit more complicated and not yet clear is if a person wants to make a complaint about a practitioner, where do they go, because AHPRA, the Australian Health Practitioner Regulation Agency doesn't really roll off the tongue, or at least it doesn't yet, and so there will be a website for the Medical Board of Australia which they might look at which will link them back to AHPRA which will tell them the address of where to send the complaint because it will be the AHPRA staff who - 70 to 80 per cent of them are the existing staff of State and Territory Medical Boards across the profession who will be dealing with it.

QUESTION: Will the Board deal with disputes over fees?

DR FLYNN: My own experience of getting into fee regulation was once when we were foolish enough to bring a neurosurgeon to an informal hearing believing that the fee that he charged for a two-line report was unreasonable and he told the members of the medical board who were sitting on the panel at the time that they should get out into the real world.

I mean the short answer is no, it is not the role of

medical boards to regulate fees. If people - it is a free system. The only ways in which it becomes part of the medical board is if there is something dishonest and fraudulent. In this particular case the board did feel, and decided to hold an informal hearing, that the fee was outrageous. The practitioner, as I said, told us we needed to talk to more neurosurgeons.

MR STOREY: Thank you, Dr Flynn. Rowan Storey, Oral Surgeon and Lawyer. I am particularly concerned about the disciplinary actions that you discussed. I have been aware through a number years dealing with disciplinary procedures, not as a participant but more as a tribunal member, it seems really unclear how this will happen in the new system and I don't know that it is yet clear for both practitioners and the public how they will access it because I think the current systems work well across a number of our health professions.

DR FLYNN: That is an important question. I mean obviously it remains to be seen. What will happen is that a person who wants to make a complaint or notification will send it to the agency. They will be able to ring up and talk to somebody about the issue and be advised about how to make a complaint.

If we are talking just about medical - the medical board in that State will continue to have committees which look at complaints and make recommendations about what pathway in the legislation, is this not really a matter that needs further investigation? Is it a matter that needs a panel hearing? The panel will run in the same way as they currently do with members of the boards and external panel members hearing them. More serious matters

will be referred to the VCAT type situation, so that part of it, although it will go in under different titles, the pathways once it's there are the same, the penalties are essentially the same. I would imagine it would be quite similar to the way it currently is.

MR McRAE: Roderick McRae, anaesthetist and also a lawyer. Dr Flynn, thank you for your very eloquent presentation. I am interested if you could give a little bit of an insight into what communication there will be between the various boards - there are 10 coming on in a few months' time and then four and perhaps even more into the future. Is it possible that the practice that everybody in the room would say, (indistinct) profession might contain that, but another group sort of chip away and they are doing a little bit on that, and that is okay because that board regulates and - yes, that is acceptable, that is acceptable, and yet a person on the street, the famous omnibus perhaps, or the tram, just turns up and sees the doctor and doesn't necessarily read whatever might be in the brackets. What is the communication going to be between say the standard regulations in medicine as you have outlaid, and another group who might just be busy doing their own thing?

DR FLYNN: I can answer that on a number of levels and I think everybody is probably ready for their dinner so I won't do it at great length, but the Board Chairs across the ten boards meet by teleconference once a month and face to face two or three times a year.

The standards that any of the boards - or codes or guidelines that any of the boards issue must be circulated to all the other boards and the boards have an opportunity

to comment on those standards and in fact if one board wants to make a comment about the other boards' standards those comments have to go to the Ministerial Council that signs off the standards.

So if a board felt very strongly that there was something that caused a significant risk for the public, because that would be the only justification for objecting, then they can make that point.

The other thing is that it is important to recognise that the model of regulation is protection of title. There is no scope of practice essentially. This not a scope of practice model, it is a title model, so the questions about what people ought to be doing are a different set of questions. Some of them are coming up in terms of prescribing from other groups and that is being looked at across the professions who are looking at prescribing access for their registrants, in a reasonably sensible way I think.

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