PANEL DISCUSSION

MANDATORY REPORTING - A HYPOTHETICAL

MODERATOR: MR DAVID BROWN

PANEL: MR MARK LYNCH, Barrister
MR AMEER TADROS, Executive Officer Medical Council of NSW; Assistant Director Health Professional Councils Authority
DR JO KARNAGHAN, Area Director, Medical Workforce

ANDREW TOOK: *This is the first time in the history of the Medico-Legal Society that we have had a hypothetical with a panel of speakers and it should be a rewarding experience.*

Let me introduce you to our speakers. Dr Jo Karnaghan has been a full time medical manager since 1992 and is currently the District Director of Medical Workforce at Nepean Blue Mountains Hospitals.

Mark Lynch is a barrister who has specialised in a number of areas, including professional conduct.

Ameer Tadros is the Medical Council of NSW Executive Officer and Assistant Director of the Health Professional Councils Authority, which provides administrative, financial and other services to the Medical Council.

This is our panel for tonight. I will introduce you to our moderator, David Brown. The format of the evening will be David will moderate the evening and I will take over again for question time.

MODERATOR: Ladies and gentlemen, the title Mandatory Reporting sometimes raises thoughts about children in danger or people who should not be driving but tonight we are specificly concerned with the mandatory reporting of

health practitioners.

Whatever doubts may have existed in the past about the difficult issue of our ethical obligations to report the misconduct or serious impairment of our medical colleagues, with the introduction of a legal regime of mandatory reporting now embedded in the national law, everything became clear and definite - or did it?

Tonight's hypothetical puzzles test out some of the key issues and dilemmas that may arise in practice. In advance I thank in particular Dr Penny Browne, Mr Scott Chapman and Ms Helen Turnbull who have developed these hypothetical scenarios with our distinguished panellists.

Mark, Jo and Ameer are working daily with notifications in their different roles and they bring their respective stores of experience and knowledge to bear on our puzzles.

They will be expressing their own views, not the views of any organisation and we will not be seeking to draw them on any real life situations in which they may have actual involvement.

In two minutes or less, a whirlwind reminder tour of some of the key legal provisions of the legislation that will crop up in discussion tonight. Some of the actual sections of the law are lengthy and have here been stripped down to a few key dot points in the hope that you can actually see them.

The conduct that has to be reported to regulators is so-called "notifiable conduct" defined in section 140. Having stripped out the details, what we are left with is conduct involving intoxication by alcohol or drugs, engaging in sexual misconduct, causing a risk of substantial harm to the public from an impairment and a risk of harm because of significant departure from accepted professional standards - a very simple concept I am sure you will think.

Section 141 sets out that notifications have to be made by health practitioners if in the course of practising their profession they form a reasonable belief that another practitioner has engaged in notifiable conduct. There may also be an obligation in relation to students with an impairment.

There are a few exemptions or exceptions under section

141. For example, a medical practitioner who is engaged by a medical defence organisation giving advice in legal proceedings or under a medical indemnity insurance policy. Again some medical practitioners, as are some members of this Society, are also legal professionals who may be giving legal advice. Some practitioners may be members of a properly authorised quality assurance committee and the law may forbid the disclosure of information. However as you see the range of exceptions is very narrow. Notably there is no exemption for practitioners who are treating other practitioners, except in Western Australia.

Under section 142 employers also have a duty to notify if they reasonably believe that a health practitioner has behaved in a way that constitutes notifiable conduct and under section 143 education providers will also have a duty to notify if they reasonably believe that a student has an impairment that in clinical training may place the public at substantial risk of harm.

Section 237 provides protection from liability for people that do notify, as long as they notify in good faith. Such people will not be liable, civilly, criminally or under an administrative process; will not be in breach of professional etiquette or ethics; will not be held to have departed from accepted standards of professional conduct; and will not be liable for defamation.

Those above sections are some of the key sections that we expect will crop up in discussion tonight.

Scenario 1
How does all this work in practice? We ask you, members of the Panel, to imagine this situation. A young GI cancer surgeon, Dr Younger, tends to take on the complex high risk cases. Several of the cases have had poor outcomes. One of these required the return to theatre of a patient with bleeding and who then spent many weeks in ICU with organ failure. Another patient was re-admitted to hospital one week after discharge with pneumonia. A third patient required a medical emergency team call for what was later found to have been caused by an unsuspected bowel perforation.

There have not been any patient initiated complaints about these events and none of the incidents seems to have involved longer term adverse consequences. However the complications have been picked up in the Mortality and Morbidity (M&M) meetings and has raised concerns,

particularly from one other doctor, Dr Elder, an older surgeon who has always had a bit of a personality clash with Dr Younger. Dr Elder notifies the hospital administration about his concerns after some discussions with colleagues.

The hospital administration requests a written explanation from Dr Younger. However Dr Elder, the older surgeon, feels that the hospital has not done enough, and not quickly enough to manage the problem and he determines to make a notification to AHPRA. He informs the hospital of the steps he has taken.

The notification is made to AHPRA on the basis of a significant departure from accepted professional standards citing the three adverse outcomes that we have mentioned. In the circumstances the hospital administration determines that it has no option but to suspend the doctor pending investigation by the Health Care Complaints Commission.

Ameer Tadros, if I can begin by asking you this: The Medical Council receives this notification, what would you be doing initially? What concerns would you have about this notification?

AMEER TADROS: It is important to state at the outset the fact that the notification has been made as a mandatory notification does not in any way influence or pre-determine the outcome of the assessment. For example, in the last financial year the Medical Council received 87 mandatory notifications and in around a quarter of those 87, the outcome of the assessment was no further action was required. The important thing from our perspective is to assess the complaint on its merits and the complaint will be assessed in the same way as any other complaint would be assessed.

We would invite the doctor to respond to the allegations. We would seek further information in relation to the issues by, for example, reviewing the clinical records. We might seek further information from the hospital in relation to whether there has been any investigation, for example, a root cause analysis report. All this information would be considered as part of assessing the concerns that have been expressed by Dr Elder.

During the preliminary assessment of the complaint the Council would also be guided by the opinion expressed by the Internal Medical Advisor from the HCCC and the

Council's Medical Director who would also have a view about whether or not there has been a departure from acceptable standards.

The final piece of the jigsaw during the preliminary assessment would be looking at the doctor's complaint history. We would be considering whether or not the doctor has a history of previous complaints or whether there have been other concerns expressed in relation to their competence, whether or not there have been previous disciplinary findings or other kinds of concerns expressed around performance.

That would be the immediate response. It would be assessing the complaint, taking into account all those factors.

MODERATOR: While this is going on and the Medical Council is looking at it, Dr Younger obviously is aware that this has happened or becomes aware that a complaint or a notification has been made. Not surprisingly perhaps he goes to see you, Mark Lynch seeking some advice. He is furious because he says that this all relates to a personality clash. Surely this is not a notification in good faith, is it?

MARK LYNCH: Probably not, David. It seems like the grounds on which the notifications are made by Dr Elder lack good faith because it is apparent that his motive for making the complaint is deficient, not a legitimate motive and not based upon reasonable grounds that there has been a significant departure. Everyone knows in medicine and law that adverse outcomes occur in the course of surgery, some are expected, some are not unreasonable, some are. However until some investigation has taken place as to whether or not the adverse outcomes are the result of deficient care or not, as the hospital has initiated the process by approaching Dr Younger and asking him to respond, and until some evidence before a morbidity and mortality meeting makes it clear that Dr Younger's statistical data is out of the ordinary, then it does not seem as if there are reasonable grounds for suggesting that there has been a significant departure. In those circumstances Dr Elder is vulnerable to some action.

MODERATOR: We might come to that action in a moment. Thanks Mark. Jo Karnaghan looking at the hospital situation, these events have all occurred in a hospital, within the north/south, south/north local health diocese.

JO KARNAGHAN: It always happens there.

MODERATOR: The Chief Administrator there is actually an old colleague of yours from the good old days when you both shared responsibility at the east/nor-easterly area health service and one night in a state of some distress this colleague rings you up for some advice. In particular what the colleague is concerned about is the fact that this notification has been made not by the hospital after due process, but by an individual clinician. What do you make about that aspect of notification?

JO KARNAGHAN: I have to say, individual clinicians running off making notifications to either AHPRA or the Medical Council is one of my personal hobby horses. Clearly under the mandatory reporting requirements any clinician can make a notification in good faith, but having said that, these are all incidents which have occurred whilst this doctor has been in the employ or under the control of our district or our area health service. Therefore, the decision really should be made by the employer as to whether or not to make that notification after due process and due consideration.

The thoughts that are going through my mind around this case are that really what we have is a cluster of what I would refer to as clinical incidents that may or may not relate to the performance of this individual doctor. They may relate to system issues. They may relate to the performance of other clinicians or other departments or it might just be a cluster of bad luck. It could also be because this is a young surgeon, new to the hospital; maybe there are some issues around his patient selection; there maybe some issues around the fact that he is obviously a very highly trained surgeon who is being asked to take on cases that his other colleagues are not interested in. In and of itself, I can see three clinical incidents that concern me but I do not see anything that makes me think I need to go making a phone call to the Medical Council or writing a formal letter.

My advice to my colleague would be that although the notification should not have been done at this time it has been done and it cannot be undone. And as Ameer has outlined, once you make the notification there is a cascade of events that occur.

What I would be doing in terms of process is to do some

basic fact finding myself. Is there any substance to the notification? Then the next thing I would do is call the Medical Council and ask to speak to the Medical Director about what she has ascertained about this case, to provide them with some further advice which may help them decide as to whether to refer to HCCC and what level of detail of investigation they need to take.

Then the third thing that needs to happen is that each of those clinical incidents needs to be managed through a proper departmental morbidity and mortality meeting process, but also through a proper incident management investigation process. Each of those incidents needs to be properly investigated with proper clinical review and proper findings and recommendations made.

That is really what I think needs to happen with this case. There are multiple things that could have led to this situation and as it stands, we have got nothing to hang our hat on except someone has gone running off to the Medical Council.

MODERATOR: They have gone to the Medical Council, as you say and there has been a cluster of incidents and there may be all sorts of explanations. At this stage perhaps Ameer it is a difficult question for you to answer, but there are some serious outcomes you think. Do you think this is a matter that would be more likely to progress to a disciplinary matter or could it be a performance sort of matter or something else?

AMEER TADROS: I think based on those facts it is more likely that it would proceed through performance rather than investigation and prosecution. The Council's view is that investigation and eventual prosecution by the HCCC should be limited to circumstances where a doctor displayed a conduct which is either wilful or unethical or criminal or reckless. In this case we are not really sure whether or not there are actually performance concerns, but if there are, it is more likely to result in referral to performance rather than investigation.

Some of the other things to take into account when deciding which path to take are what steps or what actions the hospital has taken to try to address this situation. We do not know, for example, whether this is the first time these concerns have been raised or whether there is a history of similar concerns about similar adverse outcomes to patients. We know that there are no patient complaints but that does not necessarily mean

that there is no history of poor adverse outcomes to patients.

We are not sure, for example, if the hospital has tried to take steps to remediate, to supervise, and to re-train the practitioner. We do not know what the practitioner's response is to those kinds of interventions. If the practitioner is a willing participant and has insight into deficiencies or possible deficiencies in their practice, then it might be more appropriate to refer them to performance where they might be remediated. But if they are not and if they, for example, have been the subject of a previous disciplinary finding, if there has been findings by a Medical Tribunal in relation to professional misconduct, it would not be appropriate to refer them to the performance stream for the same kinds of concerns.

MODERATOR: Returning to you Jo Karnaghan, and picking up from Ameer's comments, one of the things in this case which might seem to limit the possibility of remediation or rehabilitation would be that this hospital has taken the step of suspending the doctor and that is certainly something causing anxiety to your former colleague. What sort of advice would you give about that decision to suspend?

JO KARNAGHAN: She can hop on the hobby horse with me on this one too. This is my other favourite one. Human Resources (HR) practitioners and non-medical hospital administrators have a penchant for suspending first and asking questions later in my experience.

In my view the whole issue around suspension for senior medical staff is actually a fairly complex one given that the nature of appointment in New South Wales relies on two frameworks with two quite separate paradigms. The first part is the doctor's appointment to the health service which is their employment giving them their ability to come to work, to do a job and get paid remuneration for it and having certain rights and responsibilities in regards to that.

The second part of a senior medical practitioner's attendance at a hospital is their clinical privileges. Their clinical privileges, or scope of practice which tends to be the more modern terminology, is what in the past used to be referred to as credentials. What can the doctor actually do? For example, if you are a neurosurgeon, you can do neurosurgery. You cannot do

cardiac surgery at that very basic sort of level. I think suspending doctors, particularly senior medical staff, is probably the bluntest of blunt instruments in managing clinician performance.

What you have also got to remember is these are the most expensive people in the organisation. A senior staff specialist can cost a hospital anything up to about $450,000 per annum. It is an awful lot of money to have sitting on the golf course. For visiting medical officers it is not such a big deal for the hospital because if they do not work, they do not get paid. But assuming this practitioner is actually some sort of staff specialist, it is a very expensive tool to use as well.

Certainly in my experience, I feel very uncomfortable about suspending a doctor's employment unless there are certain conduct issues that fall under the more conduct related mandatory reporting requirements like being drunk or drug affected at work, like sexual misconduct and like severe criminal conduct. In my view matters dealing with clinical performance can often be dealt with in a far more sensitive, professional and mature manner.

My advice to the colleague is that it has been done. The horse has bolted and what we have to do is make a judgment and work out what can be remedied without anybody losing face, without it looking like the district is going soft on poor performance, and without it undermining any potential investigation findings. I have been involved in a situation like this where a very junior HR manager, being the most senior HR person around, had actually suspended a very senior clinician leaving it to myself and the doctor's solicitor to try and retrofit a solution from there.

We can actually use the clinical privileges framework quite nicely to manage clinician performance. What I would prefer to do in these circumstances before anything goes anywhere, is as a senior medical administrator who understands clinical privileges and the sensitivities around it, have a quiet and discreet conversation with the clinician concerned. This gives me an understanding of their insight. Some clinicians do have quite remarkable levels of insight into all of this. Even the young ones who do not will often go along with your advice because of the level of gravitas that you as the senior medical administrator can bring to the situation.

My preferred solution in this case would be to bring the

clinician quietly and discreetly to my office, discuss the matters with him, talk about the cases, get a gauge of what his level of insight into what has gone on really is and then if he is agreeable, seek his formal written confirmation that he will relinquish undertaking certain clinical procedures until such time as the investigation is concluded. The advantage of doing it this way is that it does not have to go to the credential sub-committee of our Medical Appointments Committee and hence he does not run the risk of having his clinical privileges restricted. Having his clinical privileges restricted is a significant issue because if he applies for employment anywhere else, including in the private sector, he has to tick yes in the box that says have you ever had your clinical privileges restricted elsewhere? So again, there are significant implications.

My best advice on this situation is to try and retrofit a slightly different solution which enables the surgeon to come back to work and to conduct safe clinical practice within a limited scope by agreed negotiation whilst we involve his divisional head of surgery and keep him in the workplace. We can keep him productive. We can keep him moving through our waiting lists, which is a not insignificant issue, and at the same time gives the Medical Council something to look at around his clinical practice. Meanwhile he does not feel the need to go off to a barrister and to his medical indemnifier at vast expense to the system.

MODERATOR: But unfortunately the horse has bolted and he has run off to see his medical indemnifier…

JO KARNAGHAN: As he would have, yes.

MODERATOR: To Mark Lynch and he has paid attention to that advice in the first conference with Mark Lynch that there is some possibly of this notification not being made in good faith. In between the first and the second conference with Mark Lynch he has done some valuable internet research looking at section 237 of the National Law about good faith and civil liabilities and there is no doubt about it, Dr Younger believes he has been defamed. He is suspended and defamed. He is determined to clear his name and uphold his reputation. So in the second conference with Mark Lynch, that is his intention, that is what he wants you to do. Are you going to start drafting some defamation pleadings tomorrow?

MARK LYNCH: Probably. There are some riders to that.

Anyone who starts defamation proceedings has to have some counselling because their value for money is not quite shared by most other people and they spend more money on the exercise than they do in recovery - even if they do recover. But that aside, unfortunately this hospital is not administered by Dr Karnaghan. The decision that has been taken to suspend him after they have asked him for an explanation and before they received one, based solely upon the advice or the fact that another doctor has complained about Dr Younger, has exposed the hospital to problems.

However the initial action which I would advise Dr Younger to take would be to sue Dr Elder because the defence available under the National Law, which is a bit like a defence of qualified privilege under the Defamation Act or under the Common Law, is unlikely to succeed providing Dr Younger has not engaged in unsatisfactory conduct or significantly departed from the accepted standards in a way that will expose someone to risk of harm. Accordingly you might want to get an expert opinion from a surgeon to express a view about that before you pursue defamation proceedings with confidence. But assuming you get that and they say these are outcomes which are foreseeable and they are not avoidable. Perforations of the bowel happen in the course of GI surgery on a regular basis not associated with negligence. In this case the patient who had the perforation had a friable bowel for some reason and the outcome was unavoidable, without negligence. There is now no cause for asserting and no reasonable basis for a belief to assert that there were reasonable grounds to make the notification. The defence under the National Law is not available and the issue of good faith does not arise if there is no reasonable basis for belief in the first place. But the issue of good faith is open to debate and that would depend on the evidence at trial.

However it seems that Dr Elder has got some personal resentment and part of his rationale for bringing the notification is to pay out the junior doctor. If that can be sustained, the good faith defence would fall away. Again you do not get to good faith unless Dr Elder has a reasonable foundation for believing that significant departure from accepted practice existed in the first place.

What is likely to happen so far as my client is concerned is he would issue a writ in defamation suing Dr Elder. Dr Elder would know that the economic loss that my client

is likely to be exposed to as a result of a suspension, assuming he is losing income as a result of the suspension as he would if he were a VMO, would be significant and Dr Elder would therefore possibly be exposed to a substantial award for economic loss if Dr Younger is suspended for months or a year or more until the issue is resolved. Dr Elder would inevitably, if he is properly advised, be making a cross claim against the local health district to seek contribution or indemnity from the hospital because it is the one which suspended Dr Younger. So now it is on for young and old with at least three barristers involved and potentially more.

The action that Dr Younger would bring would be restricted to an action against Dr Elder but the economic losses and actual and probable consequence of Dr Elder's notification, are easily proved because they are a fact. The hospital was very imprudent in peremptorily deciding to suspend Dr Younger simply because somebody had made a notification. Ameer will tell you that notifications are made all the time and many of them are without foundation and they don't warrant performance assessment or investigation or any action. That is what should have happened in this case but because the notification was made and others responded to it as if it had a foundation, then trouble follows and it is expensive.

Scenario 2

MODERATOR: Ladies and gentlemen, we might leave that situation bubbling away, as it certainly is in north/ south, south/north. We might move about 150 miles further west to a small rural General Practice owned by a husband and wife, Dr H and Dr W who employ an older practitioner, Dr Oldman. However, Dr H and Dr W would like Dr Oldman to leave the practice because he is pretty slow to adapt to changes such as computerised records and he has some old fashioned treatment approaches. Some of his methods that seem to be a bit out of date include testing for diabetes using urinalysis only and no blood test, therefore missing some diagnoses of diabetes; using digoxin for atrial fibrillation and not commencing anti-coagulants, with apparently one patient having had a CVA; and using tricyclic anti-depressants for depression in patients who may be a suicide risk and in fact one patient has committed suicide. Dr H and Dr W are also very concerned that his records are inadequate, particularly because he cannot use the computer adequately. Dr H and Dr W have also received and seen some correspondence from the local hospital about Dr Oldman. The hospital been very concerned about some

admissions and referrals to emergency where there has not been proper assessment previously by Dr Oldman.

The doctors believe that current employment laws will make it very difficult for them to get rid of Dr Oldman, so their minds turn to whether perhaps they should make a mandatory notification in these quite serious circumstances.Mark Lynch, just following up with you, do you think that these circumstances are enough to warrant a mandatory notification? Do you think there is reasonable belief and there is a real risk of harm to the public as required under the legislation?

MARK LYNCH: I think so, without any qualifications. I understand that the prescription of old fashioned anti-depressants to people who are suicidal is so contra-indicated that it is a significant departure and exposes patients to the risk of harm. On that basis alone it would seem justified to make the complaint. The issue then arises as to has it been made in good faith? Well, that is uncertain. However if the motive for making the complaint is one that is based on the overall objectives of the National Law for the protection of the public you would probably establish good faith, providing that motive is the dominant one. This would be so even where there is perhaps another motive lurking in the background that the young doctors want to get rid of the older doctor and the normal industrial relations mechanisms are unsatisfactory to achieve that end. As long as the motive is predominant, the good motive if you like dominates then I believe you would be able to establish good faith. In any event, you would probably be able to establish a defence under the Defamation Act of qualified privilege providing your motive is proper, even if it is infected with some improper motive. Accordingly I would not be encouraging Dr Oldman to issue a writ.

MODERATOR: Ameer Tadros, the information comes into the Council and certainly some of these treatment methods seem a bit old fashioned, but surely some of these clinical issues about how you test for diabetes, whether or not you use digoxin are things which are open to debate and presumably not black and white. Do you regard these as proper matters for mandatory notification and how would you be looking at dealing with this kind of issue?

AMEER TADROS: Again, the fact that something is expressed as a mandatory notification of a fact that somebody says that they have formed a reasonable belief

that there has been a departure from acceptable standards does not in any way influence or pre-determine the assessment of the complaint. From our perspective we would be looking at the issues raised with the complaint. We would be seeking further information during the assessment. That would involve the practitioner's response to these concerns. We would want to look at the medical records. We would not only want to look at the specific allegations and the circumstances arising from the specific concerns, but also look at the practitioner's long term management of these patients to determine whether or not it has been appropriate.

We would also look at the practitioner's prior history and that would help determine what to do with the complaint. If this is the first complaint in an otherwise unblemished career, and the assessment of the concerns is that there has not been a departure from acceptable standards then the likely outcome will be no further action. If this is one of a number of complaints, and if these complaints have all been received in a relatively short period of time from different sources, all raising similar concerns about the doctor's performance, and if during the assessment of the complaint the medical opinion from both the HCCC and also the Medical Council suggests a departure from acceptable standards, then more likely than not the complaint will be referred to the performance stream. I do not think there are indicators to require investigation by the HCCC. If it is referred to performance, then it might be something which is dealt with quite easily by an interview and talking to the practitioner about further education, about up-skilling, about being involved in professional development et cetera.

There are some occasions where a practitioner's health might contribute to their poor performance. We cannot say at this stage whether or not health is a factor but it might be a factor and if health is a factor, then we would want to assess the practitioner's health and determine whether or not we might require the practitioner to undergo or seek treatment for a medical condition. It might even be necessary to impose some restrictions around their practice for public protection.

MODERATOR: Mark, just reverting to you and picking up on that point about what the factors really are in all of this. Dr Oldman has certainly got a view. He tells you that it is obvious he is about to be dismissed and it is just pure ageism. In particular he says there was nothing

wrong with his handwritten records, which are very comprehensive and he wants to be ready to commence legal proceedings immediately if he is fired. Is this in fact pure ageism? Could this actually be an unlawful act of discrimination?

MARK LYNCH: I think not. It does seem that the clinical deficiencies in his care such as the prescribing of outdated anti-depressants for patients who are vulnerable to suicide is a more serious problem. The record keeping is not a problem, whether handwritten or computer written, unless the records are deficient. It is hard to see that a risk of harm arises from poor record keeping, unless it is persistent and significant or there are no significant records retained by the practitioner at all. It is not the record keeping so much, but the other three or four matters that are identified in the scenario that suggest his practice does need some rehabilitation from a clinical perspective and there is some risk of harm. That is a ground that is acknowledged in the legislation and there are means to assist in the remedying of it. It probably would not affect or achieve his dismissal from employment. If that is the aim of the couple who were employing him, they might be frustrated by that in any event, unless there is an adverse finding and even if there is, it is not likely to be of such a significant kind that dismissal would follow.

MODERATOR: Picking up on dismissal, Ameer Tadros, there may be good reasons for notifying about this particular doctor but a bit more generally, one fear that people may have is that employers will use mandatory notification as an excuse or a device to help remove an unwanted person. Have you observed any changes in notification behaviours since the introduction of mandatory reporting along these lines?

AMEER TADROS: The short answer is no. I think there is a lot of fear and certainly around the commencement of the National Law there was a lot of fear. There was a lot of uncertainty as to how it would actually impact on the practice of medicine. Mandatory notification obligations had been in existence in New South Wales since 2008 before national registration. This was in response to circumstances arising from Graeme Reeves and alleged regulatory failures which led to the introduction of the mandatory reporting obligations in the Medical Practice Act. On the commencement of national registration the scope of the obligation was extended to include all health practitioners who are registered under

the law and also to employers and education providers. Once that obligation was extended, we saw an increase in the number of mandatory notifications that were made but since the commencement of the National Law it has remained relatively consistent. The last financial year we received around 80, which is about five per cent of the total number of complaints that we and the HCCC receive in a year. My view is that is not statistically significant, five per cent. Of the 80 that were received, around 30 per cent or 26 were from employers. So again, my view is that it is not statistically significant that twenty six mandatory notifications were made by employers in one financial year. From our perspective, we have not seen any changes or trends because employers have for a long time been under an obligation to notify certain conduct to the former Board and now the Council under the Health Services Act. A chief executive officer of a public health organisation is required to notify the Council of instances of unsatisfactory professional conduct or professional misconduct. That obligation has existed for a number of years. What is now happening is employers are reporting very similar conduct but expressing it under the mandatory reporting obligations.

MODERATOR: Jo Karnaghan, this is a situation which primarily concerns general practice rather than a hospital environment. However there is one little twist in there which could be relevant to you, that is you have in your hospital some emergency doctors who have some concerns and they approach you about these unwanted referrals to emergency. They give you some history. Is this the sort of thing you would be prepared to get involved in personally? For example, would you contact Dr Oldman yourself in a rural setting?

JO KARNAGHAN: In this situation there are to me two potential obligations for the medical administrator. Firstly, when you are in the bush any doctor working as a VMO in a small rural hospital is like gold dust. Their concerns have to be seen to have been addressed and by an appropriately senior person. Thus sending the nurse unit manager from the ED to talk to Dr Oldman is not going to do it for doctors in his position. We have circumstances where there are inappropriate referrals, with improper clinical work up, to the emergency department, where there are GP VMOs who are themselves very, very busy trying to combine hospital and private practice in their towns. None of them actually need the money, they would rather the time to themselves. They work in the ED out

of obligation. Hence there is a need for some sort of action from the district medical administrator.

Secondly I will talk to one of the things that I feel very passionately about, because it is something that I think we do very well in this profession and that is the proper management and pastoral care that we provide to some of our senior colleagues. These colleagues are very, very good as they enter their more mature years of practice at beginning to restrict their own scope of practice, their hours of work, the types of patients they see and the activities they can do. The issue with rural GPs in particular is that what often burns very bright for them is whilst they have this insight it is overridden by a concern for their community and an obligation to serve their community. I think there is a real opportunity for somebody who is not connected with the practice but who is sensitive to the concerns that Dr Oldman may have, to actually involve themselves. I think there is an opportunity to get a real win/win out of this situation.

So how to get my emergency department "tidy", which is always a good thing and to win some brownie points with the GP VMOs, which is not always an easy task to achieve? I think there is a real opportunity for an independent doctor, someone who is not involved in the practice and does not know this doctor, to come in as a concerned colleague and have the conversation to try and tease out some of these issues. How much insight has he got? How much of it is a sense of obligation? How old is he? In reality in the country he could quite easily be 80 years of age. We need to try and sort out what is the employment issue versus what is the clinical issue versus what is the insight issue.

If I, having spoken to Dr Oldman, did have concerns about his level of insight, I would have the sensitive conversation with him about maybe self-reporting to the Medical Council as an older clinician, asking for some assistance, being involved in some sort of program and letting them know I have these problems with my practice and all of those sorts of things. I would give this advice because in my experience by self-reporting the Council tends to take a very different view.

What should I do if I felt sufficiently concerned about his lack of insight and I genuinely felt there was some clinical deficiency with in older clinicians some associated cognitive impairment. In this situation their

brains just do not function as well as they did when they were 50 years of age and they are just not making good decisions like they used to make when they were younger. Should I as a doctor who has seen this person and had a serious conversation with this person, make a notification, not as an impaired clinician per se or even on a performance issue, but out of concern that this is an older clinician who lacks insight and is not adequately restricting his practice?

Scenario 3

MODERATOR: On the question of insight and making good judgments, the problems are not limited to older practitioners of course. I want to now swing, ladies and gentlemen, to someone nearer to the other end of their career. This is a fairly young female anaesthetist who has been working in a large public hospital for only a couple of years. She is a reserved sort of personality, keeps to herself and is not very well known by theatre staff. Lately she has been leaving theatres frequently during operations to go to the bathroom. She seems a bit vague and a bit less focussed on her patients. She requires some prompting in some of her clinical work.

A theatre nurse notices that often when she has been in the anaesthetic bay after this doctor, the anaesthetic drawer is open. One day the doctor excuses herself during an operation to go to the bathroom, ensuring that the patient is stable and being monitored. She does not return for about 10 minutes. A nurse is sent to find her. The nurse finds the anaesthetist collapsed on the bathroom floor. The doctor apologises, stating that she has had the flu and arranges someone else to complete her list and she goes home. The nurse is concerned about possible drug use and reports the concern to nursing administration. There is the possibility that some ampoules of propofol are missing but the nurses are not certain about that. Notification is made to AHPRA by the nursing administration of the hospital on behalf of the nurse.

Ameer Tadros, it sounds as though this doctor may have some sort of impairment issue related to drug usage. If that is the case, how would that be managed in New South Wales?

AMEER TADROS: These kinds of situations unfortunately are not uncommon and it really is on one level the pointy end of what we deal with in regulation. It is the most difficult aspect where there is a presumption of

innocence and an obligation to protect the public. In this case you would hope that following receipt of the notification it would be assessed and referred to the Council and hopefully dealt with through the Council's non-disciplinary health program. In doing all of that we would need to consider whether or not we needed to take some immediate interim action against the practitioner for the purposes of public protection. Such action might involve suspension or imposing some conditions on the doctor's practice.

However the first step is to contact the practitioner. We would want to talk to her about our health program. We would strongly advise her to get some assistance from her medical defence organisation. If she was not insured, we would try to refer her to or at least get her to make enquiries with other kinds of providers such as the Medical Benevolent Association or the Doctors Health Advisory Service. It is really important to try to get her in contact with somebody who can provide her with some advice. In this kind of situation it is likely, so long as interim action was not required, we would probably have the practitioner assessed, usually by a psychiatrist and by somebody who specialises in drug and alcohol medicine.If she has a drug problem, she will probably need some conditions around her practice. The conditions will be related to employment, so you would look at limiting her access to Schedule 8 drugs. You might require her to be supervised by her employer if there are concerns around clinical performance as well. The conditions would require her to engage in treatment. You would also want to be satisfied that she was abstinent from drug use so she might be required to undertake urine drug testing for a period of time.

In New South Wales we have a slightly different health program in that the Council would then review the practitioner once the conditions were imposed. She would then be subject to regular monitoring and review by the psychiatrist who first assessed her and then by the Council on a three monthly basis. The Council is a little bit different compared to the other states and territories in that the Council does review impaired doctors and we are guided by the reports that we receive from the independent practitioners. They will provide us with recommendations in relation to whether or not over time those conditions can be eased or varied and then whether or not that practitioner can eventually exit the program.

MODERATOR: Jo Karnaghan, you have said a number of things about the various responsibilities of people in hospitals, but just by way of a brief additional comment, in this case surely nursing administration on the basis of what they have observed had a responsibility to make a notification?

JO KARNAGHAN: I would beg to differ with respect. My feet would not touch the ground in getting to the Director of Nursing's office to have this discussion with her. She would not like it if I did the same. In fact she would not – I am assuming it was a she - her feet also would not touch the ground.

What I am seeing in this case is actually very similar to the first case we discussed except rather than it being a clinical performance issue we have what I would describe as a conduct issue.

What we have is absolutely correct, any health practitioner can make a notification where they have reasonable grounds. However what I am seeing in this case is a set of observations from which a conclusion has been drawn without any discussion with the doctor, without any discussion with anybody else in the department and without any fact finding having appeared to have been carried out.

What we need to be careful of in this case is that anaesthetics are a very high risk speciality group for impairment, particularly impairment relating to drug addiction. Anaesthetists have the opportunity to access drugs that most other clinicians do not have in an environment which is regulated but less so than in the general ward setting. Another comment I would make about anaesthetics is that as a personal observation anaesthetists tend to have a certain personality type. I am aware this is a very broad and sweeping generalisation. However anaesthetists have personality traits plus opportunity making them very high risk.

MODERATOR: Mark Lynch, would you like to cut in?

MARK LYNCH: High risk, what were you referring to?

JO KARNAGHAN: What I was going to say was though this young woman may be an impaired clinician she may also be pregnant. She might also just have a physical illness. We do not know any of that and it all needs to be teased out. In my opinion any referral to the Council is quite

precipitous in this case until we know what we are dealing with. For example anybody working in that theatre could have stolen the propofol, including the nurse who alerted nursing administration, a situation I have personally observed.

MODERATOR: I can imagine. But let us just assume Mark that the doctor does indeed have some kind of drug problem. We will assume that for a moment. What sort of medico-legal advice would you be giving to her and would your advice be any different if in conference with you she discloses that she has been seeing a respected drug and alcohol specialist regularly for the past 12 months.

MARK LYNCH: If I did not know that bit of helpful information, I would suggest to her that the first thing she should do was cease working as an anaesthetist for a while and at least to see a drug and alcohol specialist and perhaps a psychiatrist. Depending on the nature and depth of her habit, if she has one, she might consider surrendering her authority to prescribe narcotics, if that were her drug problem.

She might want to consider enrolling in the impaired registrants program, because if it operates as it is supposed to, it is meant to be a helpful means by which doctors suffering illness can be assisted in their recovery and rehabilitation. It does not always seem to operate like that and it depends upon the voluntary co-operation of the doctor to adopt all of the recommendations that might be made by the impaired registrants panellists. However if it operates as it should, it is a helpful and productive way of assisting someone to rehabilitate themselves if they have a drug problem.

If she told me she was already seeing a Drug and Alcohol counsellor then she has obviously commenced to address the problem and depending on what the drug and alcohol specialist says, it may be unnecessary to do any of those things. This would depend upon how far her rehabilitation has advanced, whether she has had any relapses and whether there are recurring problems of her having to leave theatre in the course of surgery. That is a problem that raises some other areas of concern. However if she is coming to me and acknowledging that she has a problem, then what I have discussed above are the sorts of things that you would consider. You might also explore whether working in anaesthesia is the best place for her for the time being because of the problems that Jo has

identified, in particular the ready and easy availability of narcotic medication. She might want to do a stint working in an area where those temptations do not arise so readily.

MODERATOR: Ameer, just picking up on something that has been touched on by Mark and in more detail by Jo, would you be satisfied that enough has been done to investigate this matter before the notification?

AMEER TADROS: No and it is unlikely that we would receive a notification in those circumstances. Usually the hospital would have carried out some kind of investigation into the matter. As Jo has said, there might be a number of reasons why the doctor is displaying this kind of behaviour. She might be pregnant. She might have fallen off a ladder and taken a knock on the head. She might be a drug addict. All those reasons are plausible but the hospital needs at least to carry out some kind of enquiry, to put the allegations to the doctor and to get her response. The issue of the possible missing propofol is also a concern. You would want the hospital to carry out an investigation into that. As Jo has pointed out, it might not be this doctor but the nurse who has a drug problem and is trying to blame the doctor. But either way, there are concerns from a patient safety perspective and there are concerns for the practitioner's welfare in terms of trying to manage her impairment.

MODERATOR: Mark, Jo and Ameer have guessed at one other possibility and in conference the doctor actually tells you what they guessed, this is all a load of rubbish, I am pregnant and I was just too embarrassed to tell my colleagues, I am a shy sort of person. What would you advise her now?

MARK LYNCH: I expect the notification may well have been justified because an anaesthetist leaving theatre for 10 minutes at a time is a cause for alarm. It probably gives grounds for reasonable belief that there is a risk of harm. However if she was pregnant and nobody asked her why she was visiting the toilet so frequently and simply assumed that she was going off to self-medicate, then it highlights the lack of wisdom of people who make notifications but have failed to enquire as to why somebody is doing something untoward in the first place. By making a simple enquiry they can commonly ensure that a lot of people's time is not wasted as there is a simple and straight forward explanation that can be exposed if

only somebody enquires about it.

What this scenario highlights is probably as a general rule before you make a notification, unless it is an obvious intoxication or similar outrageously obvious scenario, you ask the person. In defamation law the defences of qualified privilege often expect you to enquire of the person whom you have defamed before you defame them. Then depending on the answer they give, you might find a defence is available because you enquired and got a response and you either knew it was false or you knew it was impossible so you went on to make the defamatory publication by way of a notification. If you ask, then you can better defend yourself if you are challenged or sued and you probably avoid wasting a lot of time by unnecessary notifications thereby making Ameer's task in life easier.

MODERATOR: Ladies and gentlemen, there you have it, a veritable cavalcade of practitioners, administrators and employers, some well-motivated, some not well motivated, the competent, the incompetent, the impaired, the impaled, those that are exiting the profession, those who are expecting.

It has been my privilege to ask a whole bunch of questions to these very expert people and to receive their frank and fascinating responses. You, no doubt, may have some other questions you would like to raise and I will hand back to Andrew Took to help with that process.

ANDREW TOOK: We have a few minutes for questions.

QUESTION: Thank you very much for that very interesting presentation.

I would like to ask a question based upon something being added to the first two scenarios and whether or not that would influence the judgment call of the health administrator and the advice of the lawyer.

In the first case related to Dr Elder and the second case related to Dr Oldman. What if one of Dr Elder's friends happened to be having a drink down at the hotel with a medical reporter from *The Daily News* and said "did you know that in this particular hospital there is this complaint being made and it is a serious one?" It gets into the paper. Would that influence the way you give your advice or the administrator would handle it? In the

case of Dr Oldman, and I have seen this happen in a small rural community where a very elderly doctor hangs on and on and on, has a lot of support because he/she has delivered every baby in the area for about 30 or 40 years and organises a public meeting to say that I have helped this community and I like this community. Both the press in the first case and the public arena in the second case bring politics into the situation and who knows where that could finish up. If it was out there in the public arena would it influence the health administrator and how would it influence the lawyer and the advice that he gives?

JO KARNAGHAN: Noting that I come from a local health district that had the unenviable recent publicity around the ladies who insisted on giving birth in our car park and then being told to suck it up princess, we are somewhat sensitive to publicity. The thing around the publicity to me is it does not impact on what you do. What it does is impact on the level of pristineness of process, for want of a better term, that you use and also the pace at which you manage.

With a scenario like the Dr Elder/Dr Younger one, there are obviously a lot of privacy issues that we would not wish to share with the press. What we would do internally is make sure that our media and communications team are well briefed on the situation with regards to the individual matter. We would also do an "environmental scan" to see if there was anything else hanging around, for want of a better term, that young journalists out to make a name for themselves might go on a hunt for. In reality what we would do in terms of practice as a medical administrator and practice as a bureaucrat is not that different. It is how we manage the potential collateral damage to the reputation of the clinician and the reputation to the organisation that becomes different.

MARK LYNCH: To answer the first part of your question, I am reminded of a recent interview that Barry Cassidy had with the Federal politician, Mr Windsor, who was retiring from politics. It was suggested to him by Barry Cassidy on the ABC that the reason he was retiring from politics was because Barnaby Joyce was bound to win the seat that he used to hold. The *Daily Telegraph* had said as much. His response unhesitatingly was, Barry, we are a Sorbent family.

The *Daily News*, whether it published the story before or

after Dr Elder conveyed the information and was it Dr Elder telling *The Daily News* or the reporter from *The Daily News* telling Dr Oldman that this issue was alive? In either case, if *The Daily News* had published it, then Dr Younger would have an action against *The Daily News* if it was based on the same spurious grounds as the earlier scenario. That is probably all I can offer by way of addition.

JO KARNAGHAN: I think the thing with the older GP Dr Oldman in the whole scenario that you outlined, is why it is really important that good pastoral care occur around this doctor. If it is well managed the doctor will actually manage the community and there is no need for the hospital to do so. If the doctor forms the view that he needs to retire and accepts the view that he needs to retire or restrict his practice, he then actually manages it all. This dissolves a lot of the problem and can be quite a powerful tool to use.

ANDREW TOOK: Ladies and gentlemen, it is time as they say. Can you join with me in thanking the Panel.

PANEL DISCUSSION CONCLUDED