Australian Nursing and Midwifery Federation submission

Proposed reforms to the Health Practitioner Regulation National Law for the management of professional misconduct and strengthening protections for notifiers

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INTRODUCTION

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 320,000 nurses, midwives and carers across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

The ANMF welcomes the opportunity to provide a national response to Health Minister's on the proposed reforms to the Health Practitioner National Law for the management of professional misconduct and strengthening protections for notifiers.

Part 1 – Expansion of the information available on the national public register of health practitioners

1. Do you support the publication of practitioners' full regulatory history where there has been a finding of professional misconduct because of: • sexual misconduct; or • sexual boundary violations. or where there has been a: • conviction or finding of guilt for a sexual offence. Yes / No / Unsure. Please explain why.
No. The ANMF believes this proposed reform is reacting to critical media reporting, long overdue inquiries, and royal commissions and is unnecessary. Those inquiries examined gaps in now-defunct regulatory systems and failures of individuals to comply with their reporting obligations under the National Law. **Practitioner context** The proposal involves a fundamental misunderstanding of the different contexts in which nurses and midwives primarily practice from that of medical practitioners. Nurses and midwives are overwhelmingly employees of hospitals, health services, aged care facilities and medical practices. As such, people seeking care do not engage them as individual practitioners, rather they engage with the organisational provider. This is distinct from medical practitioners, to whom this proposal is plainly targeted. Medical practitioners are primarily in practice as self-employed, independent contractors. The proposal is advanced on the premise that members of the public choose their health practitioner. That is overwhelmingly not the case in respect of nurses and midwives, who constitute the largest component of the health workforce. In the case of nurses and midwives, the organisations employing them subject any prospective employees to a range of applicant screening and reference checks, for example an NMBA registration status check (including already hyperlinked tribunal findings under s225(p) of the National Law), working with children checks, NDIS worker screens, and Police criminal records check. Nurses are already prohibited from working in aged care if they have a history of sexual assault offences under Part 6 of the Accountability Principles 2014. There are already sufficient structural and organisational controls in place to protect the person receiving care from employee nurses and midwives. There would be little if any added protection in the publication of regulatory history in the case of nurses and midwives while adding further bureaucratic burden to already highly regulated professions (nursing and midwifery). The publication of such information, however, would cause immense reputational damage, embarrassment and professional and personal humiliation that would be grossly disproportionate to any benefit that is stood to be gained by doing so and have the effect of unreasonably amplifying any sanctions. People whose sex offences are published on publicly available databases have expressed fear for their safety as a consequence of this type of publication.[1] Moreover, the information, if published would render many nurse and midwife employee's unemployable, not because they posed a risk on any fair assessment, but because their employers would face reputational damage if such details about their employees were made publicly available.

Such an approach would inflict an economic punishment on a registrant in addition to any other regulatory sanctions.

The material advanced in support of the proposal, insofar as it concerns nurses and midwives, is scant. Reference is made to a media report (involving a medical practitioner) and to the recent Tasmanian Commission Inquiry. As to the latter, the case study involving Nurse Griffin described circumstances unrelated to the present proposal. The ANMF considers the information in the Report makes disturbing reading. Nonetheless, the facts remain that Griffin was reported to Ahpra on 1 August 2019, was suspended on 7 August 2019 and resigned his employment and surrendered his resignation on 8 August 2019. The case provides no support for the proposal. Furthermore, the material referencing Footnotes 18 and 20 in Background Paper Part 1 page 7 misrepresent the Tasmanian Commission's Report. The Background Paper also presents confusing data of reports from different time frames involving different reporting in support of a thesis of widespread sexual misconduct (Part 1 page 6).

The proposed change is a punitive response to media commentary rather than a considered public policy initiative. As discussed below, Ahpra already has the tools and powers to achieve the necessary outcomes sought without the adoption of this proposal. The ANMF recommends that where Ministers have concerns about medical practitioners, then the Medical Board should be engaged to deal with those concerns rather than involving nurses and midwives as potential collateral damage.

In addition, this proposal also places practitioners at greater risk of having vexatious or fabricated complaints made against them. It allows access to information, which may subject them to an unacceptable risk of psychological and/or physical harm in their work or potentially in their personal life.

Concerningly, this proposal relies on definitions that were constructed specifically for the context of practice of a medical practitioner, which should not be applied to nurses and midwives. These definitions do not translate appropriately to all health professions and do not consider the nuances and complexities of the professional practice of other health professions or communities.

The definition of 'sexual boundary violation' includes 'flirtatious behaviour' which is not further defined. What is 'flirtatious' can be incredibly subjective. Nurses and midwives spend significant amounts of time with the people for whom they provide care (compared with medical practitioners) and their therapeutic engagement may be reliant on developing a rapport with the person and establishing trust. Strategies that health practitioners may employ to develop an effective therapeutic relationship are often misinterpreted and that should be something that can be resolved without regulatory action. The ANMF contest that when such definitions are applied or adopted, they can result in misguided or inappropriate regulatory action being taken particularly when definitions are open to interpretation.

We are strongly concerned that where a practitioner has an impairment that information would be published, and the onus would be placed on the practitioner to seek an exemption. The fact that there is no clear entitlement to the personal health information of practitioners remaining confidential is alarming. The ANMF is also concerned about the impact on those practitioners who have experienced domestic violence, coercive control and/or abuse of systems – including from people receiving care who may have been the subject of the boundary violation. Although information may be removed on request, once it is published it can be saved and stored.

Publication of information could inadvertently disclose the identity and type of treatment of the person receiving care (for example, mental health) where there is a relationship known in the community, and even more alarmingly children of a relationship which is the subject of a tribunal proceeding could have their identity inadvertently disclosed and the onus would be on a practitioner to apply for this not to be the case. The absence of any reference as to how non-publication orders that are made by a tribunal will be treated or enforced under the proposal, provides further evidence that this proposal has not been sufficiently considered.

Information on page 18 of the consultation paper highlights the difficulty that exists for practitioners in remote settings that is acknowledged with reference to the (now rescinded) NMBA's *A nurses' guide to professional boundaries*. Whilst this is acknowledged, there is no clear consideration of the impact this will have on someone who is unfairly put in this category due to their geographical proximity.

The ANMF is aware of instances where people in rural, regional, and remote areas have had relationships with former patients and are investigated and/or prosecuted for this. The circumstances of each of these matters is unique and where a complaint is brought to a tribunal, they have an obligation to make a finding and do not have discretion where the complaint is admitted.

This highlights that there are many matters which may be able to be put into a box of 'sexual boundary violation' even if such a phrase is not referenced by a tribunal.

The ANMF considers the proposal for this to apply to people who have been deemed safe to practice (with or without conditions) by their National Board, does not provide protection to the public. It is egregious to suggest that publication of this type of information will protect people receiving care from sexual misconduct (page 6). Not only is there no evidence to support this, but it is also victim blaming at its worst - inferring that an individual accessing publicly available information could have prevented them being sexually assaulted by a health practitioner.

The only effect this reform would have would be to deliver lifelong inequitable punishment for conduct that has been sufficiently remediated for the practitioner to be able to remain on the Register. Research shows that publicly available sex offender registries do not reduce recidivism. Further to this, there is some evidence that publicly available sex offender registries increase recidivism.[2]

Summary of ANMF's Specific Concerns

The ANMF opposes the proposal and in particular the following elements of the proposal:

1. The proposal to publish **the full regulatory history** of practitioners. The absence of any rationale for a sexual misconduct matter to trigger the publication of an entire regulatory history unrelated to that misconduct is notable and alarming.
2. The proposal for the **full regulatory history to remain indefinitely.** This element of the proposal is despite the intervention becoming stale or irrelevant. This aspect of the proposal is punitive and undermines the exercise of the disciplinary jurisdiction to time limit certain practice rights.
3. The continued **publication of expired sanctions** except in what are confined special circumstances. This is proposed in the absence of any rationale (beyond an informed public) in respect of sanctions unrelated to any issue of professional misconduct of a sexual kind. The elevation of sexual misconduct in this way has the unintended effect of diminishing other behaviour involving professional misconduct.
4. The inclusion of "sexual boundary violations" as explained in the **Medical Board guidelines.** This proposal is for practitioner guidelines to be the foundation of legislative criteria for a finding of unprofessional conduct triggering publication of full regulatory history. As discussed below the proposal is confusing, contradictory, and involves unnecessary complexity to the primary task of determining professional misconduct.
5. The **reinstatement of previously removed regulatory history.** This is proposed in circumstances where there was necessarily good reason for the regulatory system's prior removal of the regulatory history. The revival of expired conditions, etc., involves an infringement of the legitimate interests of a practitioner who has in good faith complied with and "served their time" in respect of a matter unrelated to sexual misconduct.

6. The **retrospective application of full regulatory history from 2010.** This proposal for retrospective publication is advanced in circumstances where the past regulatory intervention took account of the regime of publication in force at the time. Now, a further punishment is to be imposed, namely publication of past history, a history including that unrelated to the issue of the professional misconduct involved.
7. The **expansion of the scope of regulatory history.** This proposal is to expand the history from conditions imposed, reprimands, undertakings, and suspensions to include "other direct action". The reference has no definition but would include a range of matters involving no finding of misconduct at all, no finding of unprofessional conduct, but merely an investigation and suspension on the basis of belief.
8. The unreasonably limited conditions under which a **Board is required to remove regulatory history** from publication. The proposal unreasonably limits the conditions under which regulatory history must be removed.

These shortcomings render the proposed reform contrary to the public interest rather than in support of that interest.

2. Is a tribunal finding of professional misconduct because of sexual misconduct or, sexual boundary violations or criminal convictions for sexual offences the appropriate threshold for prompting publication and retention of practitioners' regulatory history?

   Yes / No / Unsure. Please explain why.

No.

It is noted that the proposal involves the publication of the practitioner's entire regulatory history. Currently, in instances where a tribunal finding has been made (in satisfaction of the *Briginshaw* standard of proof), Ahpra publishes a hyperlink to the decision on the practitioner's public register profile under the discretion to publish information that the Board's think fit provided at s 225(p).

This current practice provides the public with sufficient information about the practitioner's professional misconduct. This means that already, where a practitioner had been deemed guilty of professional misconduct because of sexual misconduct, sexual boundary violations or sexual offences, the information is retained and available via hyperlink to a member of the public who wishes to access it.

It is the view of the ANMF that there is no justification for further information to be available on the public register. The focus on sexual misconduct such as to elevate the need for publication of all regulatory history is without merit. Under existing arrangements Tribunals' professional misconduct findings are already available.

3. A practitioner's regulatory history could include any undertakings, conditions, reprimands, and prohibitions orders. The National Law does not currently allow this history to remain on the public register when they are no longer in force.

   Do you support publication and retention of these elements if the circumstances for publication are met?
   Yes / No / Unsure. Please explain why.

No.

The retention of other regulatory history on the website such as any past conditions, reprimands, or undertakings on a practitioner' registration would be unreasonable, because this previous regulatory action would commonly have been taken as a result of a Board having formed the **reasonable belief** that the practitioner's practice was unsatisfactory under section 178 of the National Law. A reasonable belief is a low standard of proof upon which to continue to publish prejudicial material about a

practitioner on the public register, particularly when the conditions have been met or restrictions revoked.

If a National Board has determined that a practitioner is safe to practice with or without conditions, then they should appear on the Register and information that is no longer relevant at best and harmfully prejudicial at worst should not appear. If the practitioner is not safe to practice without what is essentially a 'public warning' then a National Board should reconsider whether they are a fit and proper person to hold registration.

The absence of any rational relationship between the professional conduct involving sexual misconduct and unrelated expired regulatory history illustrates the further disciplinary and punitive underpinnings of the proposal.

The proposal degrades the necessary trust and confidence the public are entitled to have in government and regulators to make decisions about health practitioners that keep them safe. It undermines the role of Ahpra and the National Boards. This is what protects the most vulnerable members of our society.
The desired 'transparency' does not extend to those whose knowledge does not include the regulatory framework for regulating health practitioners, and so any 'protection' is likely to only extend to those who have a particular level of education and English language proficiency.

The National Boards and Ahpra cannot abrogate their responsibility for ensuring protection of the public. This proposal is not genuinely aimed at public protection – it is aimed at protecting the National Boards and Ahpra.

Attention is again directed to the prejudice to employment certain to arise from the proposal because of employer reputational fears referred to above.

Subsections 225(a) through (o) mandate what information is to be included on the Public Register. In addition, subsection 225(p) allows the Boards to decide on any other information they consider necessary. Under this provision hyperlinks to tribunal findings are currently published. In respect of reprimands, sub-section 225(j) provides that reprimands must be recorded, and the requirement is indefinite.

The rationale for the proposal is absent.

4. It is proposed to use the guidelines in the Medical Board of Australia's *Guidelines: Sexual Boundaries in the Doctor-Patient Relationship*[3] to define the scope of behaviours covered by these reforms.

    a) Does this sufficiently encompass all conduct which should be considered in scope for this reform?

    b) Should other specific conduct, such as grooming, be included?

The proposal to use the Medical Board of Australia's sexual boundaries guideline demonstrates that medical practitioners and their practice arrangement are at the heart of the concerns that have given rise to the proposed expansion of information on the national Public Register.

The use of Guidelines designed for medical practitioners as the basis for legislative reform to define unprofessional conduct of a sexual nature by all health practitioners is misplaced and fraught. In any event, the task of defining the concept presents more difficulties than it solves.

The question for the relevant Tribunal is whether the conduct concerned constitutes professional misconduct. The description of the Guidelines as the foundation for "the legislative framework to prompt publication of practitioners' regulatory history with respect to sexual boundary violations" is impossibly confusing. Elsewhere in Background Paper 1, it is said that a finding of professional misconduct is the trigger for publication and that the full regulatory history is to be published.

The introduction of some secondary legislative guideline, specific to sexual misconduct, as to the well-established meaning of professional misconduct is opposed as confusing and unnecessary.

5. Are there any other initiatives or actions which could improve public protection and transparency regarding practitioners' regulatory history?

Being able to access historical information about a practitioner's regulatory history does not protect the public, rather it undermines public trust and confidence in health practitioners in circumstances where the regulator has determined that it is safe and appropriate for them to practice (with or without conditions). This situation could potentially have disastrous effects for people trying to access care where there are geographically limited options available, or in situations where they have no choice over their care provider, such as in accessing practitioners with limited specialties.

To improve fairness and transparency, amendments could be made that provided for Tribunals determining misconduct matters to consider the extent of information to be published on the Public Register, and the length of time that information would remain on the Register.

This would allow parties to misconduct proceedings to make submissions and for the balance between public protection and the practitioner's privacy and reputation to be considered.

If a health practitioner has a criminal finding of guilt or conviction it is open to a National Board to prosecute a complaint against that health practitioner on that basis and for their registration to be cancelled if appropriate.

The reforms proposed in Background Paper 1 are at odds with the legitimate interests reflected in amendments of this kind.

6. Do you have any further comments or suggestions?

No further comments or suggestions.

Part 2 – Establishing of nationally consistent reinstatement orders

1. Do you support a nationally consistent requirement for practitioners to seek a reinstatement order from a tribunal before applying for re-registration after being disqualified or cancelled?

   Yes / No / Unsure. Please explain why.

No.

The policy purpose of this proposal seems to be confined to consistency with the New South Wales system.

In the absence of any explanation can it be assumed Ministers consider the Medical Board is reinstating unsuitable applicants following disqualification/cancellation by a Tribunal?

Tribunals, when they cancel a practitioner's registration, already set a period of disqualification. This period is based on, inter alia, Tribunal's consideration of the need for specific deterrence. Requiring a further hearing, in effect, would involve a Tribunal revisiting the original determination about the length of the period of disqualification.

The considerations relevant to the Tribunal considering a re-instatement order largely duplicate those considered by a National Board considering re-instatement. It is not clear what the purpose of the double handling of essentially the same considerations serves. A Board would consider each one of the factors considered by a Tribunal in considering a re-instatement order.

The major practical issue is the difficulty faced in Tribunal's listing matters and the unreasonable delays and costs being experienced. These delays impact the livelihood of practitioners, frequently after months and years of delay on the part of Ahpra itself at earlier stages of the process.

2. Do you agree that the National Law should be amended to adopt the New South Wales model for reinstatement orders?

   Yes / No / Unsure. Please explain why.

No.

See above.

Adopting the NSW model would unnecessarily use up Tribunal resources hearing reinstatement applications.

3. Are there any other initiatives or actions which could improve public protection and support national consistency for practitioners seeking re-registration after being disqualified or cancelled?

With the exception of NSW, there is already consistency.
If a practitioner is re-registered following a period of disqualification, the Public Register will also publish a hyperlink to the Tribunal decision that led to the period of disqualification. This makes enough information available on the Public Register.

4. Do you have any further comments or suggestions?

No.

Part 3 – Strengthening protections for notifiers and prospective notifiers

1. Do you support the proposed reforms to strengthen protections for notifiers and prospective notifiers?

   Yes / No / Unsure. Please explain why.

Yes: in principle.

The proposal will increase confidence in the system for notifiers, including health practitioners making notifications about other health practitioners.

It will have the practical effect of focusing the practitioner, the subject of a notification, on responding to the concerns raised in the notification. However, there are significant dangers of unintended consequences if the scope and definitions giving effect to the proposal are not sufficiently tailored to the specific interests of persons making notifications **under the Act** and **in good faith**.
This is illustrated by Non-Disclosure Agreements (NDAs) of general scope, rather than an NDA that expressly identifies an Ahpra notification.

Further, the proposal involves numerous elements directed to the same policy objective, namely:

a) Unspecified measures to "prevent" detriment or reprisals against notifiers; and

b) The creation of an **offence** to cause detriment or take reprisals; and

c) Provide that an NDA does not prevent notifications; and

d) Render an NDA void to the extent it purports to prevent a notification; and

e) Make it an **offence** to include an NDA without "advising' the subject they can still notify; and

f) Create an **offence** for "any NDA or **[any] agreement**" not to contain written advice informing the parties that they are entitled to make a complaint, regardless of signing an NDA.

The adoption of all six these elements involves duplication of outcome, is unnecessary and overly prescriptive. The creation of the three proposed offences is disproportionate and the last [para f) above] is unworkable, unwarranted, and oppressive.

The policy objective can be satisfactorily achieved by legislating that a term of an agreement to which a health practitioner is party in relation to their engagement in that capacity is void and of no effect to the extent that it has the effect of preventing or limiting the making of a notification in good faith under the National Law.

2. Do you support changes to make it an offence to seek to include an NDA in an agreement without advising the affected person that they can still make a notification to Ahpra, National Boards or another relevant regulatory body?

   Yes / No / Unsure. Please explain why.

No.

With respect to employee nurses and midwives, NDAs are sometimes offered by employers to entice the employee to resign rather than contest allegations.

In other words, the employer offers to make a NDA with the employee in return for their resignation, so that the employee does not pursue an unfair dismissal application in the Fair Work Commission. As noted above a provision that rendered void any restriction on notifications would serve the purpose of not restricting notifications in such circumstances.

If an NDA was void to the extent it restricted notifications, employees would be less likely to be coerced into resigning their position on the promise of no report.

The biggest issue is the lack of clarity or information available. A simple fact sheet around NDAs published by Ahpra (beyond what is contained in the Cosmetic Surgery Hub) to highlight the protection already given under s237(2) of the National Law would be more helpful than the creation of offences which people are unlikely to be aware of and are unlikely to be enforced. Ahpra should also have a firmer stance than 'We think that NDAs do not prevent patients from making a notification' given the clarity of the National Law.

In the alternative, a simple amendment to the National Law that provides that a person cannot be contractually bound to not make a notification would suffice.

3. Do you support changes which would mean that an NDA is void to the extent that it prevents a person making a notification to Ahpra, National Boards or other regulatory body?

   Yes / No / Unsure. Please explain why.

Yes.

Given that an NDA is probably void to the extent that it prevents a person making a notification to Ahpra, it is desirable to remove any doubt.

4. Are there any other initiatives or actions which could improve protections for notifiers and prospective notifiers?
• Embedding information about good faith protections in the notifications process. • Educating notifiers on what is 'good faith', and to think about what 'reasonable belief' looks like. • To make sure a notifier has been referred to the relevant part of the guidelines for mandatory notifications before making one.
5. Do you have any further comments or suggestions?
This – like the first proposal – is an overreaching reaction to failures of the regulators highlighted through the media. Any reforms must be aimed at achieving genuinely effective change whilst preserving the rights of health practitioners wherever possible.

REFERENCES

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[3] Ahpra and National Boards, 'Guidelines: Sexual boundaries in the doctor-patient relationship' https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Sexual-boundaries-guidelines.aspx#.