

Compelling Safety: Reforming Australian Treating Doctors' Mandatory Reporting Obligations

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Abstract

Depending on the Australian jurisdiction in which they are practising medicine, doctors have different mandatory obligations to report to regulatory authorities those doctors whom they are treating if their doctor-patients have engaged in 'notifiable conduct'. Some of those obligations are not new and have been introduced due to perceptions that doctors are reluctant to notify regulators about other doctors who endanger patients. Nevertheless, the ways in which the obligations are framed within the National Registration and Accreditation Scheme — the current regulatory scheme for registered Australian health practitioners — have been controversial, with good reason. Inconsistencies between doctors' obligations in different states and territories have caused confusion, concern has been expressed that some obligations may deter doctors from obtaining health care, and exemptions from the obligations for doctors in two state jurisdictions potentially inhibit regulators' capacity to protect the public and assist doctors. To address these problems, this article proposes changes to treating doctors' mandatory reporting obligations, which redefine the conduct that treating doctors are required to report, permit treating doctors to fulfil their mandatory reporting obligations by reporting certain notifiable conduct either to regulators *or* to national doctors' health services, and apply mandatory reporting obligations to doctors uniformly across Australia.

I Introduction

Let us imagine that Dr A, a general surgeon practising in Australia, consults a psychiatrist, Dr B, and discloses that he often drinks alcohol excessively. Dr A maintains, however, that he has periods of sobriety and never drinks before work. Dr B feels torn. She is concerned that Dr A suffers from alcoholism and observes that his hands tremor, a sign of this addiction that could compromise his operating skill. Nevertheless, Dr B does not wish to breach Dr A's confidentiality and believes that, with treatment, Dr A could overcome this dependence. What must Dr B do? What should Dr B be required to do?

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At present, Dr B has professional and ethical duties to notify the Medical Board of Australia ('MBA') if she suspects that her doctor-patient might be endangering patients because his ability to practise medicine may be impaired.¹ The MBA commenced operation in 2010 under the National Registration and Accreditation Scheme ('NRAS').² The Council of Australian Governments ('COAG') agreed to create the NRAS to unite into one regulatory scheme various Australian health professions, most of which had been regulated, but separately from one another and at a state and territory level by representatives of the professions.³ Under the NRAS, National Health Practitioner Boards ('National Boards'), including the MBA, register practitioners in 14 health professions across Australia,⁴ but matters relating to those practitioners' health, performance and conduct are not regulated in the same way in all jurisdictions. Despite COAG's intentions, an 'applied laws' model, whereby legislation enacted in one jurisdiction is applied by other jurisdictions, was not followed completely to implement the NRAS.⁵ Queensland passed the Health Practitioner Regulation National Law ('*National Law*') as the schedule to the *Health Practitioner National Law Act 2009* (Qld), but only some jurisdictions adopted it without variation.⁶ New South Wales ('NSW') and Queensland are co-regulatory jurisdictions: the National Boards and other entities regulate their practitioners, pursuant to the *National Law* and additional legislation.⁷

A major inconsistency in the regulation of health practitioners in Australia is their mandatory reporting obligations ('MROs'). Depending on the jurisdiction in which she is practising medicine, Dr B may have a statutory mandatory obligation to report Dr A to regulatory authorities, in addition to her professional and ethical reporting duties. In every state and territory other than Western Australia ('WA')

¹ Medical Board of Australia ('MBA'), *Good Medical Practice: A Code of Conduct for Doctors in Australia* (MBA, 2014) 22 <<http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx>>.

² Australian Health Practitioner Regulation Agency ('AHPRA'), '2010–11 Annual Report' (Annual Report, AHPRA and the National Boards, 30 September 2011) 1.

³ *Ibid* 7, 12; *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions*, signed 26 March 2008, cls 2.3, 2.5, 5.1, attachment A ('*Intergovernmental Agreement*'); Explanatory Notes, Health Practitioner Regulation National Law Bill 2009 (Qld) 3.

⁴ The Council of Australian Governments has recently agreed to incorporate a fifteenth health profession (paramedics) into the National Registration and Accreditation Scheme: Council of Australian Governments Health Council incorporating the Australian Health Workforce Ministerial Council, 'Communique' (Communique, 7 October 2016) 4.

⁵ *Intergovernmental Agreement* cl 6; Parliamentary Counsel's Committee, *Protocol on Drafting National Uniform Legislation* (4th ed, 2014) 1; Gabrielle Wolf, 'Sticking Up for Victoria?: Victoria's Legislative Council Inquires into the Performance of the Australian Health Practitioner Regulation Agency' (2014) 40(3) *Monash University Law Review* 890, 898–9, 905.

⁶ See *Health Practitioner Regulation National Law (ACT) Act 2010* (ACT); *Health Practitioner Regulation National Law (NSW) 2009* (NSW); *Health Practitioner Regulation (National Uniform Legislation) Act 2010* (NT); *Health Ombudsman Act 2013* (Qld); *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA); *Health Practitioner Regulation National Law (Tasmania) Act 2010* (Tas); *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic); *Health Practitioner Regulation National Law (WA) Act 2010* (WA).

⁷ See *Health Practitioner Regulation (Adoption of National Law) Act 2009* (NSW); *Health Practitioner Regulation National Law (NSW) 2009* (NSW); *Health Care Complaints Act 1993* (NSW); *Health Practitioner Regulation National Law Act 2009* (Qld) ('*National Law*'); *Health Ombudsman Act 2013* (Qld).

and Queensland, Dr B would need to notify regulators if she reasonably believes that Dr A has placed the public at risk of substantial harm in his medical practice because he has an impairment.⁸ As Dr A's treating practitioner, in WA Dr B is exempt from this MRO,⁹ and in Queensland Dr B is similarly exempt by virtue of this role, but only if she believes that Dr A's impairment will not place the public at substantial risk of harm.¹⁰

Whether treating health practitioners, such as Dr B, should be compelled to report other registered health practitioners who consult them, such as Dr A, is a highly controversial issue. The imposition of MROs on doctors in particular is not new to several Australian jurisdictions, but it has often polarised opinion. Changes to those duties made soon before, at the time and since the NRAS came into operation, ignited particularly intense debate. The Independent Review of the NRAS ('Independent Review'), which COAG scheduled for the third anniversary of the NRAS,¹¹ was directed to 'examine the impact of mandatory notification provisions'.¹² Its report was, therefore, eagerly awaited by the health professions and the Australian Health Workforce Ministerial Council, which comprises government health ministers, provides policy direction to the NRAS,¹³ and appointed Kim Snowball to undertake the Independent Review.¹⁴

The *Snowball Review* found that variations in health practitioners' MROs in different jurisdictions have caused confusion, and some inaccurately believed that treating practitioners in all jurisdictions were exempt from reporting other practitioners.¹⁵ Such misunderstandings are clearly undesirable. To make those obligations uniform, and also minimise the risk that they may deter practitioners from obtaining health care for fear of being reported to regulators, the *Snowball Review* recommended that all treating health practitioners have an exemption from MROs that mirrors WA practitioners' exemption from MROs ('the WA exemption').¹⁶ MROs have been introduced, however, to address concerns that health practitioners, and especially doctors, are disinclined to abide by their professional and ethical duties to bring to regulators' attention their patients who are registered health practitioners and pose a risk to the community.¹⁷ If this is the case, the WA exemption can potentially inhibit regulators' capacity to protect the public, which is, appropriately, a principal objective of the NRAS.¹⁸

⁸ *National Law* sch ss 140–1.

⁹ *Health Practitioner Regulation National Law (WA) Act 2010* (WA) s 4(7), inserting sch s 141(4)(da).

¹⁰ *Health Practitioner Regulation National Law Act 2009* (Qld) s 25(3), inserting *Health Practitioner Regulation National Law Act 2009* (Qld) sch s 141(5).

¹¹ *Intergovernmental Agreement* cl 14.1.

¹² Kim Snowball, 'Independent Review of the National Registration and Accreditation Scheme For Health Professions: Final Report' (Review, December 2014) 1, 79 ('*Snowball Review*').

¹³ *Intergovernmental Agreement* cl 7.

¹⁴ *Snowball Review*, above n 12, 1.

¹⁵ *Ibid* 36.

¹⁶ *Ibid* 36–7. For details regarding the WA exemption, see below n 57.

¹⁷ Kathleen Jackson and Malcolm Parker, 'Full Steam Ahead on the SS "External Regulator"? Mandatory Reporting, Professional Independence, Self-Regulation and Patient Harm' (2009) 17(1) *Journal of Law and Medicine* 29, 33, 35.

¹⁸ *National Law* sch s 3(2)(a).

The Australian Health Workforce Ministerial Council did not accept the Snowball Review's recommendation at this time, but has promised to 'consider a national approach to mandatory notifications'.¹⁹ Anticipating the opportunity for reform, this article proposes changes to MROs that could encourage doctors to obtain health care and treating doctors to report their unsafe doctor-patients. MROs apply to all registered health practitioners, but to explore relevant issues, it is convenient to focus on doctors' obligations because the medical profession constitutes the second largest registered health profession,²⁰ alleged failures in its self-regulation were a key reason for imposing MROs on practitioners in the NRAS,²¹ and the medical profession has been a forthright critic of MROs.²²

This article first describes doctors' professional, ethical and mandatory obligations to report their doctor-patients and the background to their introduction. It then evaluates those obligations. The article argues that it is necessary to retain treating doctors' MROs in the face of many disincentives for them not to report doctor-patients whom they believe could endanger the public and the potential harm such practitioners could cause. It then explains flaws of both the WA and Queensland exemptions from MROs. Finally, the article proposes, and outlines the likely benefits of, modifications to treating doctors' MROs that redefine the conduct that they are required to report and permit them to fulfil their MROs by reporting certain notifiable conduct either to regulators or to national doctors' health services ('NDHS'). The article recommends imposing those duties on doctors throughout Australia without any exemptions. This would reduce confusion about MROs and, if MROs are framed to maximise their potential to enhance public safety, there is no justification for not applying them to all practitioners.

II Treating Doctors' Current Reporting Obligations

Australian doctors' professional and ethical obligations to protect patients by reporting other doctors who pose a risk to their safety are not new, but the content of those duties is, at present, articulated unevenly and imprecisely. The *Code of Ethics* of the Australian Medical Association ('AMA'), Australian doctors' peak representative body, directs doctors to 'report suspected unethical or unprofessional conduct by a colleague to the appropriate authority', without indicating kinds of behaviour that might need to be reported.²³ While an AMA position statement refers

¹⁹ Council of Australian Governments Health Council, 'Communiqué' (Communique, 7 August 2015) 5. The Council was meeting as the Australian Health Workforce Ministerial Council.

²⁰ AHPRA, '2015–16 Annual Report' (Annual Report, AHPRA and the National Boards, 2 November 2016) 38.

²¹ M M Bismark, J M Morris and C Clarke, 'Mandatory Reporting of Impaired Medical Practitioners: Protecting Patients, Supporting Practitioners' (2014) 44(12a) *Internal Medicine Journal* 1165; Malcolm Parker, 'Embracing the New Professionalism: Self-Regulation, Mandatory Reporting and Their Discontents' (2011) 18(3) *Journal of Law and Medicine* 456, 457, 459.

²² Sherrill Nixon, 'Doctors Fight Expansion of Dob-In-Colleague Law', *The Sydney Morning Herald* (online), 5 September 2008 <<http://www.smh.com.au/news/national/doctors-fight-expansion-of-dobincolleague-law/2008/09/04/1220121430192.html>>.

²³ Australian Medical Association ('AMA'), *AMA Code of Ethics* (AMA, 2016) cl 3.1.10 <<https://ama.com.au/system/tdf/documents/AMA%20Code%20of%20Ethics%202004.%20Editorially%20Revised%202006.%20Revised%202016.pdf?file=1&type=node&id=46014>>.

to doctors' duties concerning impaired colleagues, it does not explicitly encourage reporting them; it states, 'when a doctor has concerns about a colleague's health, there is a legal and ethical responsibility to take action to minimise the risk to patients and the doctor's health'.²⁴

Developed to 'complement' the *Code of Ethics* and '[bring] together into a single Australian code, standards that have long been at the core of medical practice', the MBA's *Good Medical Practice: A Code of Conduct for Doctors in Australia* ('*Good Medical Practice*') does refer to doctors' reporting duties regarding impaired colleagues.²⁵ *Good Medical Practice* states that doctors have a 'professional ... responsibility' to notify the MBA if they are 'treating a doctor whose ability to practise may be impaired and may thereby be placing patients at risk'.²⁶ Nevertheless, *Good Medical Practice* does not specify the level of risk that gives rise to this duty.²⁷

In addition to professional and ethical reporting duties, doctors in certain jurisdictions have had statutory mandatory obligations to notify regulators about other practitioners for some time. For instance, from 1981, if treating doctors in Victoria considered that their doctor-patients suffered from 'a mental illness or abnormality' that may have prevented them from fulfilling a doctor's responsibilities and was sufficiently severe to require admission to hospital, doctors treating those doctor-patients in hospital were required to notify the Medical Board of Victoria of the doctors-patients' admission and their mental condition.²⁸ Similarly, from 1983, doctors in South Australia were required to submit reports to the Medical Board of South Australia about doctors whom they were treating for illnesses that they considered resulted or were likely to result in 'mental or physical incapacity' that did or could seriously impair their ability to practise medicine.²⁹

Contention surrounding MROs is also not a recent phenomenon. Some Victorian Members of Parliament ('MPs') opined in 1981 that mandatory reporting could 'violate a patient-doctor trust',³⁰ and place treating doctors 'in a difficult personal position'.³¹ Another MP highlighted, however, that giving regulators 'access to the advice of the treating doctor' was crucial for the 'protection for the community', because 'this is not merely a doctor-patient relationship, but potentially a relationship between the patient as a doctor and other patients'.³²

²⁴ AMA, 'Health and Wellbeing of Doctors and Medical Students' (Position Statement, 2011) 3 <<https://ama.com.au/position-statement/health-and-wellbeing-doctors-and-medical-students-2011>>. See also AMA, above n 23, cl 3.2.2, which states, 'recognise colleagues who are unwell or under stress. Know how and when to respond if you are concerned about a colleague's health and take action to minimise the risk to patients and the doctor's health'.

²⁵ MBA, above n 1, 4, 16.

²⁶ *Ibid* 22.

²⁷ *Ibid*.

²⁸ *Medical Practitioners Act 1970* (Vic) s 18(4), amended by *Medical Practitioners (Amendment) Act 1981* (Vic) s 9(5). This statute has been repealed.

²⁹ *Medical Practitioners Act 1983* (SA) s 52. This statute has been repealed.

³⁰ Victoria, *Parliamentary Debates*, Legislative Assembly, 9 December 1981, 4644 (Milton Whiting).

³¹ *Ibid* 4645 (Peter Ross-Edwards).

³² *Ibid* 4644 (Thomas Roper).

Doctors' representative bodies, insurers and regulators entered the debate especially when MROs were imposed on doctors in NSW and Queensland in 2008 and 2009 respectively.³³ Those duties applied to doctors in circumstances in which they believed that other practitioners were impaired, but also where they suspected that they had practised medicine in a manner that departed ('flagrantly', in the case of the NSW legislation) from the medical profession's accepted standards and risked harming others, and/or had engaged in sexual misconduct in connection with medical practice.³⁴ The AMA and the Medical Indemnity Industry Association of Australia predicted that this legislation would encourage doctors to ignore colleagues' misconduct to avoid being compelled, as they perceived it, to betray other practitioners by reporting them.³⁵ Encapsulating this concern, Dr Bruce Flegg, Queensland MP, pronounced, 'no-one wants to do in a mate in the workplace'.³⁶ The Medical Indemnity Industry Association of Australia also forecast that doctors would be intimidated into concealing errors, while the Medical Board of Queensland worried that impaired doctors might not consult other health practitioners for treatment because they did not want to risk being reported.³⁷ When similar MROs were introduced with the NRAS, the AMA expressed the same apprehension.³⁸

The AMA argued that doctors' professional and ethical obligations to report their colleagues were sufficient,³⁹ yet the NSW and Queensland legislation was passed owing to perceptions that doctors were reluctant to notify regulators when other doctors posed a threat to patients and, consequently, hampered those authorities' ability to protect the community.⁴⁰ Government-commissioned reports found that health practitioners had sometimes not reported promptly to regulators grave allegations about colleagues, including Dr Graeme Reeves in NSW, and Dr Jayant Patel and Dr Abdalla Khalafalla in Queensland,⁴¹ and, in the cases of Patel and Khalafalla, whistleblowers outside the medical profession ultimately brought the complaints to public notice.⁴² Those reports focused mainly, however, on hospitals' and regulators' failure to mitigate the doctors' risks to public safety

³³ See *Medical Practice Act 1992* (NSW) s 71A, inserted by *Medical Practice Amendment Act 2008* (NSW) sch 1, cl 18; *Medical Practitioners Registration Act 2001* (Qld) s 166, inserted by *Health and Other Legislation Amendment Act 2009* (Qld) s 61.

³⁴ *Medical Practice Act 1992* (NSW) s 71A, inserted by *Medical Practice Amendment Act 2008* (NSW) sch 1, cl 18; *Medical Practitioners Registration Act 2001* (Qld) s 166, inserted by *Health and Other Legislation Amendment Act 2009* (Qld) s 61.

³⁵ Nixon, above n 22.

³⁶ Queensland, *Parliamentary Debates*, Legislative Assembly, 28 October 2009, 2940 (Bruce Flegg).

³⁷ *Ibid* 2952 (Lionel Powell).

³⁸ Victoria, *Parliamentary Debates*, Legislative Assembly, 11 November 2009, 3894 (Helen Shardey).

³⁹ Nixon, above n 22.

⁴⁰ Parker, above n 21, 458; Ian Freckelton, 'Regulation of Health Practitioners: National Reform in Australia' (2010) 18(2) *Journal of Law and Medicine* 207, 219; Queensland, *Parliamentary Debates*, Legislative Assembly, 28 October 2009, 2954 (Margaret Keech).

⁴¹ Health Quality Complaints Commission (Qld), 'An Investigation Into Concerns Raised by Mrs De-Anne Kelly MP About the Quality of Health Services at Mackay Base Hospital' (Report, August 2008) 18–20; Deirdre O'Connor, 'Review of the Appointment, Management and Termination of Dr Graeme Reeves as a Visiting Medical Officer in the NSW Public Health System' (Report, New South Wales Health, 2 May 2008) 4–5, 9; Queensland, Queensland Public Hospitals Commission of Inquiry, *Report* (2005) 4–5, 140–3, 160, 190, 445 ('*Queensland Public Hospitals Commission of Inquiry Report*'); Jackson and Parker, above n 17, 33–4, 38.

⁴² Health Quality Complaints Commission (Qld), above n 41, 20; Queensland, *Queensland Public Hospitals Commission of Inquiry Report*, above n 41, 1, 160–1; Jackson and Parker, above n 17, 38.

(including by not responding swiftly and/or appropriately to allegations they did receive), and the reports did not recommend imposing MROs on doctors.⁴³

Nevertheless, public and political pressure in response to these scandals was one of the impetuses for creating the NRAS and imposing MROs on health practitioners regulated in the scheme.⁴⁴ MPs considered those duties essential to regulators' performance of their functions.⁴⁵ The Explanatory Notes to the Health Practitioner Regulation National Law Bill 2009 (Qld), which formed the basis of the *National Law*, state that it includes mandatory reporting provisions 'to protect the public from harm' due to 'a concern that in the past a failure to report notifiable conduct of registered health practitioners ... may have prevented State and Territory Boards from taking appropriate action to protect the public'.⁴⁶

Under the *National Law*, a treating doctor can make a 'voluntary notification' about another registered doctor to the Australian Health Practitioner Regulation Agency ('AHPRA'), which provides administrative support for the National Boards.⁴⁷ Grounds for voluntary notifications include: the doctor's professional conduct, knowledge, skill or judgement is substandard; the practitioner may be unsuitable to hold registration; or the doctor has an 'impairment', which this statute defines as 'a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect' the doctor's 'capacity to practise' medicine.⁴⁸

The *National Law* also imposes MROs on registered doctors. In Queensland, they must notify the Health Ombudsman;⁴⁹ and in all other jurisdictions, AHPRA,⁵⁰ if, 'in the course of practising' medicine, they form a 'reasonable belief' that another doctor has 'behaved in a way that constitutes notifiable conduct' because he/she has:

- (a) practised [medicine] while intoxicated by alcohol or drugs;
- (b) engaged in sexual misconduct in connection with the practice of [medicine];
- (c) placed the public at risk of substantial harm in the [doctor's] practice of [medicine] because the [doctor] has an impairment; or
- (d) placed the public at risk of harm because the [doctor] has practised [medicine] in a way that constitutes a significant departure from accepted professional standards.⁵¹

⁴³ Health Quality Complaints Commission (Qld), above n 41, 18–20; O'Connor, above n 41, 6, 10; Queensland, *Queensland Public Hospitals Commission of Inquiry Report*, above n 41, 2–3, 6, 33–4, 139–40, 374–7; Nick Goiran et al, 'Mandatory Reporting of Health Professionals: The Case for a Western Australian Style Exemption For All Australian Practitioners' (2014) 22(1) *Journal of Law and Medicine* 209, 211–12.

⁴⁴ Wolf, above n 5, 892–7; Parker, above n 21, 458–9; Bismark, Morris and Clarke, above n 21, 1166.

⁴⁵ See, eg, Queensland, *Parliamentary Debates*, Legislative Assembly, 28 October 2009, 2954 (Margaret Keech).

⁴⁶ Explanatory Notes, Health Practitioner Regulation National Law Bill 2009 (Qld) 5, 84.

⁴⁷ *National Law* sch ss 25(a), 145.

⁴⁸ *Ibid* sch ss 5 (definition of 'impairment'), 144.

⁴⁹ *Ibid* s 25(1), amending sch s 141(2); *Health Ombudsman Act 2013* (Qld) s 13(2).

⁵⁰ *National Law* sch s 141(2).

⁵¹ *Ibid* sch ss 140–1.

Although the *National Law* does not prescribe penalties for doctors who contravene these obligations, the National Boards have indicated that such practitioners ‘may be subject to health, conduct or performance [regulatory] action’,⁵² which could involve regulators cautioning them or imposing conditions on their registration, or the practitioners providing undertakings to them.⁵³

Doctors practising in all jurisdictions share exemptions from these obligations in certain circumstances, such as if, when they formed the reasonable belief that another doctor engaged in notifiable conduct, they were providing advice concerning the conduct for the purposes of legal proceedings or preparing legal advice.⁵⁴ Doctors practising in WA and Queensland, however, have additional exemptions. Those variations to the *National Law* reflect the influence especially of the AMA’s view that treating doctors who are supporting medical practitioners with health problems should not be required to notify regulators about their doctor-patients.⁵⁵ WA and Queensland MPs considered that such exemptions would ensure that the obligations did not discourage doctors from seeking medical treatment for the reason that they were afraid of becoming the subjects of notifications.⁵⁶

Since October 2010, WA doctors have been exempt from MROs if they ‘[form] the reasonable belief [that another doctor has behaved in a way that constitutes notifiable conduct] in the course of providing health services’ to that doctor.⁵⁷ From 2013, doctors in Queensland who ‘[form] the reasonable belief [that another doctor has behaved in a way that constitutes notifiable conduct] as a result of providing a health service’ to the doctor have been exempt from reporting the doctor if they:

- (b) reasonably [believe] that the notifiable conduct—
 - (i) relates to an impairment which will not place the public at substantial risk of harm; and
 - (ii) is not professional misconduct.⁵⁸

⁵² National Health Practitioner Boards, *Guidelines for Mandatory Notifications* (AHPRA, 2014) 13 <<http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Guidelines-for-mandatory-notifications.aspx>>. See also *National Law* sch s 141(3).

⁵³ *National Law* sch s 178.

⁵⁴ *Ibid* sch s 141(4).

⁵⁵ AMA, Submission, *Joint Submission on the Exposure Draft of the Health Practitioner Regulation National Law*, 21 July 2009, 4 <<https://ama.com.au/submission/joint-submission-exposure-draft-health-practitioner-regulation-national-law>>; Goiran et al, above n 43, 215; Western Australia, *Parliamentary Debates*, Legislative Council, 12 August 2010, 5443 (Simon O’Brien).

⁵⁶ Western Australia, *Parliamentary Debates*, Legislative Council, 12 August 2010, 5443 (Simon O’Brien); Explanatory Notes, Health Ombudsman Bill 2013 (Qld) 42.

⁵⁷ *Health Practitioner Regulation National Law (WA) Act 2010* (WA) s 4(7), inserting sch s 141(4)(da).

⁵⁸ *Health Practitioner Regulation National Law Act 2009* (Qld) s 25(3), inserting *Health Practitioner Regulation National Law Act 2009* (Qld) sch s 141(5) (‘the Queensland exemption’).

III Evaluating Treating Doctors' Mandatory Reporting Obligations

A *The Need to Retain Mandatory Reporting Obligations*

There are compelling reasons to retain treating doctors' MROs. According to the National Boards, 'the aim of the mandatory notification requirements is to prevent the public from being placed at risk of harm'.⁵⁹ Doctors can valuably assist regulators to protect the community by reporting their doctor-patients whom they believe may endanger patients. Some international research suggests that doctors can be disinclined to report other doctors to regulators,⁶⁰ and it is understandable why this would be the case in Australia and also why a statutory compulsion to report unsafe doctor-patients could help overcome causes of that reluctance. In the absence of empirical evidence of the extent to which those propositions apply to Australian doctors, it would be premature and, if MROs are effective in motivating treating doctors to make notifications, against the public interest to remove those duties.

It is undeniable that regulators better serve the interests of the public and the medical profession if they prevent impaired doctors from harming patients, rather than merely respond to serious incidents that have occurred. Doctors' ill health can lead them to contravene professional and ethical standards and diminish their competence in practising medicine. Research has confirmed the prevalence of mental health issues, including substance dependence, in particular within the medical profession,⁶¹ and doctors' tendencies to continue working when unwell, refrain from obtaining independent health care or regularly consulting a general practitioner, and self-medicate.⁶² Yet, it can be difficult to detect doctors whose ill health might compromise their care of patients, because problematic behaviour can be attributed to other causes,⁶³ and doctors may hide their symptoms.

To a substantial degree, regulators, which are removed from day-to-day medical practice, rely on the medical profession to bring impaired doctors to their attention.⁶⁴ Treating doctors occupy a unique and optimal position to identify such

⁵⁹ National Health Practitioner Boards, above n 52, 4.

⁶⁰ Helen Cull, 'Review of Processes Concerning Adverse Medical Events' (Report, March 2001) 15, 75–6; Sumit Raniga et al, 'Attitudes of Hospital Medical Practitioners to the Mandatory Reporting of Professional Misconduct' (2005) 118(1227) *New Zealand Medical Journal* 91, 95, 98, 100; Eric G Campbell et al, 'Professionalism in Medicine: Results of a National Survey of Physicians' (2007) 147(11) *Annals of Internal Medicine* 795, 798; Catherine M DesRoches et al, 'Physicians' Perceptions, Preparedness for Reporting, and Experiences Related to Impaired and Incompetent Colleagues' (2010) 304(2) *Journal of American Medical Association* 187, 191–2.

⁶¹ Danielle Clode, *Emotional Health: The Conspiracy of Silence Among Medical Practitioners: A Review of the Literature For the Royal Australian College of General Practitioners* (Royal Australian College of General Practitioners, 2004) 4–5, 12–18; Beyondblue, 'National Mental Health Survey of Doctors and Medical Students' (Research Report, Beyondblue, October 2013) 4, 6 <http://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report--nmhdms-full-report_web?>; Andrew Wilson et al, 'Psychiatrically Impaired Medical Practitioners: An Overview with Special Reference to Impaired Psychiatrists' (2009) 17(1) *Australasian Psychiatry* 6, 7–8; AMA, above n 24, 1.

⁶² Clode, above n 61, 5, 19–23; Beyondblue, above n 61, 7, 48, 53, 59; AMA, above n 24, 3.

⁶³ Wilson et al, above n 61, 8–9.

⁶⁴ DesRoches et al, above n 60, 187, 192.

practitioners.⁶⁵ As demonstrated in our hypothetical example of doctors A and B, their doctor-patients share details about their health with them and may disclose difficulties they have experienced in medical practice and/or risks to which they have exposed patients. Treating doctors can assess their doctor-patients' health issues and their likely impact on their ability to practise medicine. If treating doctors report this information, regulators can: encourage practitioners to obtain the help they require; constrain their practice if necessary; discipline doctors who have engaged in serious wrongdoing; and reassure the public that they are fulfilling their responsibilities to maintain professional standards and safe medical practice, and not prioritising the interests of the medical profession above those of patients.⁶⁶

No comprehensive study has yet been undertaken into Australian doctors' willingness to notify regulators if they believe that their doctor-patients may endanger the public.⁶⁷ Nevertheless, research in New Zealand ('NZ') and the United States ('US') found that a significant proportion of doctors who were aware that colleagues had not met professional standards, due to poor health, conduct or professional performance, were reluctant to report them to regulators, including where they believed that they should do so.⁶⁸

In 2001, Helen Cull QC recommended that NZ doctors have mandatory obligations to report colleagues who were 'practising below an acceptable standard', after doctors whom she interviewed for her review of that country's regulation of health professionals revealed that they tended not to do so.⁶⁹ From 2003, NZ legislation required doctors to report to regulators other doctors who were 'unable to perform the functions required for the practice' of medicine 'because of some mental or physical condition'.⁷⁰ Most of the hospital-based doctors who were the subjects of a subsequent NZ survey indicated that they considered themselves responsible for their colleagues' actions, and would act if they were not meeting professional standards due to poor health or conduct, or incompetence.⁷¹ Yet, only a small percentage of those doctors were willing to notify regulators; most preferred to report their concerns to more senior members of their teams and hospital management.⁷²

Results of two surveys of practising physicians in the US, published in 2007 and 2010 respectively, were similarly revealing. Ninety-six per cent of participants in the first survey believed that 'physicians should report all instances of significantly impaired or incompetent colleagues to hospital, clinic, or other relevant authorities',⁷³ while 64% of participants in the second survey agreed with this

⁶⁵ Marie M Bismark et al, 'Mandatory Reports of Concerns about the Health, Performance and Conduct of Health Practitioners' (2014) 201(7) *Medical Journal of Australia* 399, 399.

⁶⁶ *Ibid*; Jackson and Parker, above n 17, 34; DesRoches, above n 60, 193.

⁶⁷ Jackson and Parker, above n 17, 44.

⁶⁸ Cull, above n 60, 15, 75–6; Raniga et al, above n 60, 95, 98, 100; Campbell et al, above n 60, 798; DesRoches et al, above n 60, 191–2.

⁶⁹ Cull, above n 60, 15, 75–6.

⁷⁰ *Health Practitioners Competence Assurance Act 2003* (NZ) s 45.

⁷¹ Raniga et al, above n 60, 91, 94, 102.

⁷² *Ibid* 95, 98, 100.

⁷³ Campbell et al, above n 60, 795, 797.

statement.⁷⁴ Nevertheless, in the three years preceding the surveys, where participants had 'direct personal knowledge' of an impaired or incompetent physician, 45% of participants in the first survey had not always reported that individual,⁷⁵ and 67% of participants in the latter study reported the physician.⁷⁶ Therefore, one-third of participants in the second survey knew about and did not report impaired or incompetent colleagues, but only 19% of that cohort thought 'someone else was taking care of the problem'.⁷⁷

We cannot rely on these studies as precise determinants of Australian doctors' attitudes towards notifying regulators of their doctor-patients whom they believe pose a risk to the public. The results were varied, the research did not focus on treating doctors' inclinations to report their doctor-patients, and all participants in the NZ study worked in hospitals, so it may not reflect the views of doctors in other clinical settings. Yet, the fact that a substantial number of the surveyed doctors were reluctant to report other doctors who were a threat to patients, especially to regulators, even if they considered they should do so, may be instructive about Australian treating doctors' tendencies.⁷⁸ There are sufficient similarities between the medical professions in these countries, and there are several possible, persuasive and plausible motives for doctors' disinclination to report their doctor-patients, regardless of where they practise medicine.

As Victorian MPs suggested decades ago, doctors may be concerned that, by reporting their doctor-patients, they would breach their professional and ethical duties, originally derived from the Hippocratic Oath, to protect information that their patients have given to them in confidence in the course of the therapeutic relationship.⁷⁹ Doctors might understand rationally that, in Komesaroff's words, 'confidentiality has never been absolute in clinical practice but has always been subject to considerations relating to large-scale public welfare'.⁸⁰ Indeed, *Good Medical Practice* advises doctors to preserve their patients' confidentiality 'unless release of information is required by law or public interest considerations'.⁸¹ In practice, however, doctors may struggle to weigh these competing concerns, especially because, as the AMA, the Medical Indemnity Industry Association of Australia and some MPs have highlighted, they feel loyal to professional colleagues and regard reporting them as an unforgivable act of betrayal.⁸² This may explain, at

⁷⁴ DesRoches et al, above n 60, 190.

⁷⁵ Campbell et al, above n 60, 798.

⁷⁶ DesRoches et al, above n 60, 191.

⁷⁷ Ibid 191–2. The first survey did not ask participants whether they knew if the impaired or incompetent physicians had already been reported: Campbell et al, above n 60, 801.

⁷⁸ Parker, above n 21, 462.

⁷⁹ Marie M Bismark et al, 'Reporting of Health Practitioners by Their Treating Practitioner under Australia's National Mandatory Reporting Law' (2016) 204(1) *Medical Journal of Australia* 24.e1, 24.e4–5; Danuta Mendelson, 'Travels of a Medical Record and the Myth of Privacy' (2003) 11(2) *Journal of Law and Medicine* 136, 139; Danuta Mendelson and Ann Rees, 'Medical Confidentiality and Patient Privacy' in Ben White, Fiona McDonald and Lindy Willmott (eds), *Health Law in Australia* (Thomson Reuters, 2nd ed, 2014) 362, 363–6.

⁸⁰ P Komesaroff, 'Mandatory Reporting of Impaired Doctors: Protecting the Community or Increasing the Risk?' (2014) 44(12a) *Internal Medicine Journal* 1154, 1154.

⁸¹ MBA, above n 1, 8.

⁸² See also Raniga et al, above n 60, 2.

least partly, an apparent ‘culture of silence’ within the medical profession regarding doctors’ health issues.⁸³

The second American survey found that some doctors failed to report impaired or incompetent colleagues because they ‘believed nothing would happen as a result of the report’, while others assumed that doctors whom they reported ‘would be excessively punished’.⁸⁴ That study and other research confirms that doctors also fear retribution and harm to their professional relationships and careers from reporting colleagues.⁸⁵ It is conceivable that treating doctors experience such anxieties and that those concerns convince them — especially if they have any doubt about their doctor-patients’ risk to the public — that making a notification would be a disproportionate, futile and/or self-destructive response.⁸⁶

With these issues at the front of treating doctors’ minds, it could be greatly tempting for them to ignore the option of making a voluntary notification and neglect their professional and ethical reporting obligations. There is no means of ascertaining how many Australian doctors who should be reported are not,⁸⁷ and no data has been collected to verify whether MROs overcome impediments to Australian doctors reporting their unsafe doctor-patients, and motivate more of them to do so.⁸⁸ Yet, there are cogent explanations for the potential of a statutory compulsion to report unsafe doctor-patients — as well as the threat of disciplinary action for contravening it — to nullify factors that might otherwise dissuade treating doctors from making notifications.

Some participants in the second American survey indicated that they did not report impaired or incompetent colleagues because they ‘believed it was not [their] responsibility’.⁸⁹ Whereas the content of Australian doctors’ professional and ethical reporting duties is somewhat vague, the clear confirmation in legislation of treating doctors’ obligations conveys an unambiguous message that they are bound to report doctor-patients in specified circumstances. These statutory obligations enable treating doctors to justify soundly to their patients, colleagues and themselves a decision to report a doctor-patient as motivated not by choice, disloyalty to colleagues or disregard for their patients’ confidentiality, but by statutory requirement. Further, the medical profession should be reassured that regulators will respond appropriately to notifications, given that Australian legislatures have mandated doctors to report unsafe doctor-patients, empowered regulators to take

⁸³ Ian Freckelton and Patricia Molloy, ‘The Health of Health Practitioners: Remedial Programs, Regulation and the Spectre of the Law’ (2007) 15(3) *Journal of Law and Medicine* 366, 377–8; Jean E Wallace, Jane B Lemaire, William A Ghali, ‘Physician Wellness: A Missing Quality Indicator’ (2009) 374(9702) *Lancet* 1714, 1716.

⁸⁴ DesRoches et al, above n 60, 192.

⁸⁵ Ibid; Raniga et al, above n 60, 92; Marie R Baldisseri, ‘Impaired Healthcare Professional’ (2007) 35(2) *Critical Care Medicine* S106, S111; Jayne Hewitt, ‘Is Whistleblowing Now Mandatory? The Impact of Mandatory Reporting Law on Trust Relationships in Health Care’ (2013) 21(1) *Journal of Law and Medicine* 82, 98; Bismark, Morris and Clarke, above n 21, 1168.

⁸⁶ Baldisseri, above n 85, S111.

⁸⁷ Parker, above n 21, 462.

⁸⁸ Jackson and Parker, above n 17, 40, citing D Brand, ‘Working Towards an Outcome for Your Profession’, *Doctor Q* (Brisbane), December 2008, 7.

⁸⁹ DesRoches et al, above n 60, 192.

action against doctors who do not do so, and articulated functions of the MBA that focus on protecting the public and not punishing practitioners.⁹⁰

In addition, doctors may recognise that it is not disadvantageous for them and may even be in their interests to comply with MROs. They will want to avoid becoming the subjects of regulatory action for neglecting their compulsory duties. Treating doctors could consider it less likely that their careers would suffer from reporting a doctor-patient if the notification is made pursuant to a legal obligation, rather than solely professional or ethical duties, which other doctors can perceive as discretionary. Importantly, the *National Law* protects doctors who make notifications in good faith: they will not be liable civilly, criminally or under an administrative process for doing so.⁹¹

B *Shortcomings of Arguments for Removing Mandatory Reporting Obligations*

Various arguments have been made against MROs, and it is possible to envisage further objections to them. Although some of those claims need to be taken into account in reforming MROs, none of them represent sufficient reasons to abolish MROs.

Some may seek to rely on a recent Australian study to argue in favour of removing MROs. After analysing treating health practitioners' mandatory notifications to AHPRA between 1 November 2011 and 31 January 2013, Bismark and her co-researchers concluded that 'treating practitioner reports are rare' and 'very few are made in the context of an established treatment relationship'.⁹² During that period, 57 treating doctors made mandatory notifications about health practitioners, 15 of whom were doctors, and the treating doctors had not all been regularly caring for those medical practitioners.⁹³ This study is valuable, but its results cannot be used to confirm that MROs are ineffective in encouraging treating doctors to report doctor-patients who pose a risk to the public. The research did not expose the number of treating doctors who believed that their doctor-patients had engaged in 'notifiable conduct', but did not report them. It also did not compare the rates of notifications made by treating doctors to regulators before and after the commencement of the NRAS in jurisdictions where treating doctors did not previously have MROs.⁹⁴ The study did not examine mandatory notifications made in NSW,⁹⁵ though this is the jurisdiction with the highest number of registered doctors in Australia.⁹⁶ In addition, the study did not review notifications made in the last three years, during which more doctors probably consolidated their understanding of and accepted their reporting obligations under the NRAS.

⁹⁰ See *National Law* sch s 35.

⁹¹ *Ibid* sch s 237.

⁹² Bismark et al, above n 79, 24.e5.

⁹³ *Ibid* 24.e1–3.

⁹⁴ *Ibid* 24.e5.

⁹⁵ *Ibid* 24.e1: the authors explain that they did not examine treating practitioners' reports in NSW because they only analysed mandatory notifications received by AHPRA and, 'although health practitioners in NSW are subject to the same reporting requirements as those in other states, AHPRA has a more limited role in relation to notifications made in NSW'.

⁹⁶ AHPRA, above n 20, 38.

Some opponents of MROs under the NRAS feared that they would encourage doctors to make notifications excessively, especially about professional rivals.⁹⁷ Bismark's research confirms that this has not occurred.⁹⁸ It is nonetheless unclear why MROs would increase the volume of doctors' unnecessary or vexatious reporting, given that they could make such notifications voluntarily.⁹⁹ The *National Law* includes mechanisms to discourage this reporting anyway. The MBA is empowered to 'take no further action' if it 'reasonably believes the notification is frivolous, vexatious, misconceived or lacking in substance',¹⁰⁰ and it advises that doctors who make such notifications 'may be subject to conduct action' (the MBA may find that their notifications constitute unprofessional conduct or professional misconduct, in response to which it can take regulatory action).¹⁰¹

Other objections to MROs similarly do not justify their removal. Komesaroff warns that MROs could undermine treating doctors' competence to make ethical determinations and 'negotiate the nuances of decisions ... in relation to the peculiarities and specificity of local context and conditions'.¹⁰² Yet, doctors with MROs must still consider their doctor-patient's circumstances to determine whether they are required to make notifications about them. MROs have also been controversial because they encroach on the medical profession's autonomy to self-regulate.¹⁰³ It was, however, partly due to perceptions that the profession was not self-regulating properly that such duties were introduced.¹⁰⁴ An argument raised against mandatory obligations particularly to report substandard medical practice is that they can 'create a punitive atmosphere in the workplace that fosters a culture of fear' and encourages doctors to conceal errors, rather than promoting a trusting, learning environment.¹⁰⁵ Nevertheless, doctors' professional and ethical reporting obligations could also have this impact. Further, the likely harm inflicted on patients as a consequence of such a culture is probably outweighed by the benefits to them if MROs increase doctors' reporting of unsafe medical practitioners and thereby enhance regulators' capacity to protect the public.

The most consistent and vociferously-expressed objection to MROs before and after the introduction of the NRAS has been that they could result in a deterioration in doctors' health. Of the arguments against MROs, this demands the greatest consideration, but it is as yet unsubstantiated by empirical evidence and, therefore, is an insufficient reason for jettisoning MROs. A central concern is that unwell doctors will mask their symptoms and not seek and disclose information

⁹⁷ See, eg, AMA, above n 55, 4; Avant Mutual Group, 'Avant Position Paper: Mandatory Reporting' (Position Paper, Avant Mutual Group, June 2015) 5 <<http://www.avant.org.au/mandatory-reporting>>.

⁹⁸ Bismark, above n 79, 24.e4.

⁹⁹ Bismark, Morris and Clarke, above n 21, 1167.

¹⁰⁰ *National Law* sch s 151(1)(a).

¹⁰¹ National Health Practitioner Boards, above n 52, 5.

¹⁰² Komesaroff, above n 80, 1155.

¹⁰³ *Ibid* 1154; Jackson and Parker, above n 17, 29.

¹⁰⁴ Jackson and Parker, above n 17, 43; Bismark, Morris and Clarke, above n 21, 1166–7.

¹⁰⁵ Jonathan Coates, 'Removal of the Mandatory Reporting Provisions — Only a Pyrrhic Victory?' (2002) 115(1162) *New Zealand Medical Journal* 1, 2. The Medical Indemnity Industry Association of Australia has also made this argument: Queensland, *Parliamentary Debates*, Legislative Assembly, 28 October 2009, 2952 (Lionel Powell).

necessary to obtain effective medical care because they are anxious about being reported to regulators.¹⁰⁶ In light of research confirming that doctors already often face formidable obstacles to accessing independent health care,¹⁰⁷ the possibility that MROs further deter them from doing so is perceived as unduly exacerbating risks to patient safety.¹⁰⁸

It appears that misunderstandings about MROs account to some extent for this apprehension.¹⁰⁹ A 2010 media release by AMA Queensland stated, 'it's understandable that doctors ... are reluctant to seek treatment ... because they know their GP must report any impairment'.¹¹⁰ The MBA has since reinforced that 'the threshold to be met to trigger a mandatory notification in relation to a practitioner is high':¹¹¹ treating doctors are only required to report doctor-patients if they reasonably believe (not merely suspect and, generally, have direct knowledge of or have observed)¹¹² both that their ill health meets the statutory definition of 'impairment' as it detrimentally affects or is likely to detrimentally affect their capacity to practise medicine,¹¹³ and that they have 'placed the public at risk of substantial harm' (meaning 'considerable harm') in their medical practice.¹¹⁴

Those who argue that MROs discourage doctors from seeking health care point to anecdotal evidence that, soon after their introduction in Queensland and the Australian Capital Territory, the number of doctors who contacted doctors' health programs in those jurisdictions dropped.¹¹⁵ Yet, this circumstance may also be explained by confusion about MROs. Indeed, in Victoria, where the medical profession has had MROs for many years and is, therefore, more likely to understand them, there was 'no significant change to the number or nature of contacts both by phone and in person' to the Victorian Doctors Health Program ('VDHP') almost a year after the NRAS commenced.¹¹⁶

¹⁰⁶ Avant Mutual Group, above n 97, 7; AMA, above n 24, 2; Royal Australian College of General Practitioners, 'Response to the Australian Health Workforce Ministerial Council's Communiqué of 8 May 2009 Regarding Proposed National Registration Arrangements and Proposed Accreditation Arrangements' (15 May 2009), cited in Parker, above n 21, 464; The Royal Australian College of General Practitioners, Submission 46 to Senate Finance and Public Administration References Committee (Cth), *Inquiry into the Administration of Health Practitioner Registration by the Australian Health Practitioner Regulation Agency*, 18 April 2011, 5, quoted in Senate Finance and Public Administration References Committee, Parliament of Australia, *The Administration of Health Practitioner Registration by the Australian Health Practitioner Regulation Agency* (2011) 100.

¹⁰⁷ Beyondblue, above n 61, 4–7, 63, 66; Clode, above n 61, 5, 19–20.

¹⁰⁸ Goiran et al, above n 43, 216; Kerry J Breen, 'Doctors' Health: Can We Do Better under National Registration?' (2011) 194(4) *Medical Journal of Australia* 191, 191.

¹⁰⁹ Malcolm H Parker, 'Mandatory Reporting, Doctors' Health and Ethical Obligations' (2011) 194(4) *Medical Journal of Australia* 205, 205.

¹¹⁰ AMA Queensland, 'A Step in the Right Direction on Mandatory Reporting' (Media Release, 12 November 2010) 1.

¹¹¹ National Health Practitioner Boards, above n 52, 4.

¹¹² *Ibid* 6.

¹¹³ MBA, *Information on the Management of Impaired Practitioners and Students* (20 January 2012) 1 <<http://www.medicalboard.gov.au/Search.aspx?q=information+on+the+management+of+impaired>>; *National Law* sch s 5 (definition of 'impairment').

¹¹⁴ *National Law* sch s 140(c); National Health Practitioner Boards, above n 52, 8. See also: at 9.

¹¹⁵ Goiran et al, above n 43, 217; AMA Queensland, above n 110, 1; Senate Finance and Public Administration References Committee, above n 106, 100.

¹¹⁶ Kay Dunkley and Kym Jenkins, 'Will I Be Reported For Seeking Help?', *Vidoc* (Melbourne), March 2011, 31.

No studies have yet confirmed that Australian treating doctors' MROs do, in fact, deter medical practitioners from seeking health care.¹¹⁷ Moreover, it is unclear why MROs would dissuade doctors from accessing treatment any more than professional and ethical reporting obligations might have that impact, given that they, too, require treating doctors to report doctor-patients who endanger the public and the consequences of reporting doctors pursuant to those duties are identical.¹¹⁸ Parker aptly commented, 'if impaired doctors and their treating doctors feel deterred by mandatory reporting laws, we are entitled to conclude that there was, and continues to be, significant non-compliance in relation to the ethical obligations'.¹¹⁹

It is unlikely that treating doctors' MROs would be the sole cause of doctors avoiding or delaying seeking independent medical treatment and self-treating and, indeed, MROs do not account for many of the reasons why, doctors have informed researchers, they do so. There is no apparent connection between MROs and doctors refraining from obtaining health care because:

- doctors believe that medical practitioners with mental health issues are stigmatised and assume colleagues will regard their ill health as a manifestation of weakness and/or incompetence, so disclosure of it will hinder their professional development;¹²⁰
- doctors are embarrassed to adopt the role of a patient and especially to discuss mental health problems;¹²¹
- doctors fear they will receive substandard treatment;¹²²
- the medical profession accepts self-care as usual and appropriate practice for doctors;¹²³
- doctors trivialise their illnesses;¹²⁴
- the medical profession expects doctors to continue working while unwell;¹²⁵
- doctors lack access to health care if they are time-poor and/or geographically isolated;¹²⁶ and
- it is more convenient for doctors to have informal 'corridor consultation[s]' with colleagues.¹²⁷

¹¹⁷ National Health Practitioner Boards and AHPRA, Submission, *Independent Review of the National Registration and Accreditation Scheme*, October 2014, 32.

¹¹⁸ Parker, above n 21, 461; Parker, above n 109, 205.

¹¹⁹ Parker, above n 21, 461. See also Parker, above n 109, 205.

¹²⁰ Beyondblue, above n 61, 7, 63, 66; Clode, above n 61, 21; Wallace, Lemaire and Ghali, above n 83, 1716; AMA, above n 24, 2; Wilson et al, above n 61, 7.

¹²¹ Beyondblue, above n 61, 5, 66; Wallace, Lemaire and Ghali, above n 83, 1716; AMA, above n 24, 2; Margaret Kay et al, 'Developing a Framework for Understanding Doctors' Health Access: A Qualitative Study of Australian GPs' (2012) 18(2) *Australian Journal of Primary Health* 158, 161; Wilson et al, above n 61, 7.

¹²² Clode, above n 61, 21; Kay et al, above n 121, 160–1; Beyondblue, above n 61, 66.

¹²³ Kay et al, above n 121, 162.

¹²⁴ *Ibid* 160.

¹²⁵ AMA, above n 24, 2.

¹²⁶ Beyondblue, above n 61, 66; AMA, above n 24, 2; Kay et al, above n 121, 160.

¹²⁷ Kay et al, above n 121, 161–2.

The imposition of MROs on treating practitioners may, nonetheless, augment some significant, proven barriers to doctors seeking help. Doctors can be anxious that obtaining medical care will result in disclosure of information that they have provided in confidence, imposition of constraints on or cancellation of their registration to practise medicine, disciplinary action, and/or increases to the cost and difficulty of obtaining medical insurance.¹²⁸ These obstacles to doctors seeking treatment may be heightened if they believe that MROs increase the likelihood that their treating practitioners will report them to regulators. This risk cannot be ignored, but as research has not yet been undertaken to confirm that MROs definitely have this impact or that the risk is high, it does not justify removing MROs.

Other harms to doctors' health from MROs have also been forecast. The act of reporting a doctor may adversely affect a notifier's emotional health,¹²⁹ and/or worsen the condition of the subject of the notification.¹³⁰ One doctor's insurer informed a Senate Committee of its suspicion that a doctor who had been under psychiatric care and suicided did so in response to his/her treating doctor making a notification.¹³¹ Ironically, however, some MPs endorsed MROs because they believed that they might improve doctors' health; Khalil Eideh considered, 'mandatory reporting ... better assists doctors' health by encouraging practitioners to seek help early, before there is any "risk of substantial harm"'.¹³²

C *Problems with Treating Doctors' Exemptions from Mandatory Reporting Obligations*

The WA and Queensland legislatures created exemptions from MROs for treating health practitioners because they believed they would ensure that those duties did not deter practitioners from obtaining health care for fear of being reported to regulators.¹³³ For the same reason, 74% of written submissions to the Independent Review recommended applying the WA exemption to practitioners in all jurisdictions,¹³⁴ and commentators and doctors' representative groups and insurers have supported the exemptions.¹³⁵ Nevertheless, not only do we lack empirical evidence that MROs strengthen impediments to doctors seeking medical treatment, but the WA exemption, in particular, does not eradicate such obstacles, and the WA

¹²⁸ Beyondblue, above n 61, 7, 66; Wallace, Lemaire and Ghali, above n 83, 1716; Kay et al, above n 121, 161–2.

¹²⁹ Ian Freckelton, 'Disciplinary Investigations and Hearings: A Therapeutic Jurisprudence Perspective' in G Reinhardt and A Cannon (eds), *Transforming Legal Processes in Court and Beyond* (Australasian Institute of Judicial Administration, 2007) 139, 140–3.

¹³⁰ Helen Kiel, 'Regulating Impaired Doctors: A Snapshot from New South Wales' (2013) 21(2) *Journal of Law and Medicine* 429, 440.

¹³¹ Senate Finance and Public Administration References Committee, above n 106, 101.

¹³² Victoria, *Parliamentary Debates*, Legislative Council, 27 November 2009, 5837 (Khalil Eideh). See also Gavin Jennings at 5840.

¹³³ Western Australia, *Parliamentary Debates*, Legislative Council, 12 August 2010, 5443 (Simon O'Brien); Explanatory Notes, Health Ombudsman Bill 2013 (Qld) 42.

¹³⁴ *Snowball Review*, above n 12, 36.

¹³⁵ Goiran et al, above n 43, 216–17, 219; Avant Mutual Group, above n 97, 7; Roger Sexton and Brian Morton, *Mandatory Notification* (21 March 2011) Australian Medicine <<https://ama.com.au/ausmed/mandatory-notification>>; Breen, above n 108, 191; K Phelps, 'Mandatory Reporting Erodes Doctors' Rights', *Medical Observer* (online), 8 November 2010, cited in Parker, above n 21, 459.

and Queensland exemptions can potentially result in harm to the public and medical practitioners.

1 *The Western Australian Exemption*

If treating doctors rely on the WA exemption and do not adhere to their professional and ethical duties to report doctor-patients who pose a risk to the public, they hamper regulators' capacity to safeguard the community and support those practitioners. Commenting on a case involving a drug-addicted pharmacist, the NSW Civil and Administrative Tribunal highlighted the impact of withholding information about unwell practitioners from regulators:

[A] failure to notify [AHPRA] actually inhibited this impaired practitioner from being provided the supervision, monitoring and treatment that could have helped him, and may even have prevented the events that ultimately led to these disciplinary proceedings.

We suggest that the 'code of silence' prevailed in this instance, to the detriment of both the public's safety and the practitioner's health and professional standing.¹³⁶

The WA exemption may lead to more doctors failing to report unsafe doctor-patients and there is no research that demonstrates that it does not have this effect. The *Snowball Review* recommendation was justified on the basis that there was 'no evidence that the exemptions [for WA treating doctors] have significantly altered mandatory notification rates'.¹³⁷ Other proponents of the WA exemption similarly claim that it 'has not inhibited reporting'.¹³⁸ Nevertheless, these statements are not substantiated by any comparison of the rates at which treating doctors reported doctor-patients before and after MROs and exemptions to those duties were introduced (WA doctors had no MROs prior to the NRAS).¹³⁹ A comparison of the percentage of doctors about whom notifications were made in each state and territory also tells us little because we do not know whether more doctors in certain jurisdictions than others engaged in notifiable conduct. Further, it is impossible to discern how many treating doctors in WA did not report their doctor-patients in circumstances where they would have done so if they did not have an exemption from MROs. In addition, these obligations were introduced together with other changes to doctors' regulation under the NRAS that might also have influenced the number of notifications made.¹⁴⁰

Other detrimental consequences may flow from the WA exemption if it encourages the medical profession to believe that treating doctors have an option not to report doctor-patients who represent a hazard to the community. While this perception is inaccurate given doctors' professional and ethical duties to promote

¹³⁶ *Health Care Complaints Commission v Orr* [2015] NSWCATOD 124 (30 October 2015) [149]–[150] (Senior Member Millbank, Members Frost, Samimi, French).

¹³⁷ *Snowball Review*, above n 12, 37.

¹³⁸ Goiran et al, above n 43, 219.

¹³⁹ See *Medical Practitioners Act 2008* (WA), which was repealed by the *Health Practitioner Regulation National Law (WA) Act 2010* (WA).

¹⁴⁰ Bismark et al, above n 79, 24.e5.

public safety,¹⁴¹ without a statutory compulsion to report unsafe doctor-patients, and in light of the weighty disincentives for doctors to do so, WA treating doctors may feel especially conflicted about whether to make a notification. Knowing that a possible consequence of reporting them is that their doctor-patients' medical practice will be formally curtailed, with the stigma and humiliation that can accompany such constraints, treating doctors might convince themselves inappropriately that they are able to manage their patients' risk. Monitoring doctor-patients' compliance with recommended treatment and practice restrictions can be an onerous burden for treating doctors. In addition, their doctor-patients could attempt to convince them not to make a notification, whereas they may not subject doctors without an exemption from MROs to similar manipulation, considering that they had no choice but to report them.

For these reasons, the Snowball Review's further rationale for extending the WA exemption to treating doctors in all jurisdictions — that it will 'not impinge on the treating practitioner-patient relationship'¹⁴² — is unconvincing. Indeed, the relationship between treating doctors and their doctor-patients could be adversely affected more by the WA exemption than by MROs. The *Snowball Review* implies that MROs inhibit doctors from discussing their health problems freely with treating practitioners because they worry about being reported. WA doctors are, however, still aware that their treating practitioners must assess their risk to the public and any need to make a voluntary notification, even if they believe, albeit inaccurately, that they are not necessarily required to report them.

2 *The Queensland Exemption*

While the Queensland exemption could encourage unwell doctors to obtain health care and treating doctors to assess their doctor-patients' risk to the public, it may also, like the WA exemption, preclude regulators' timely management of doctors whose conduct and/or professional performance is substandard.

Some favour the WA exemption because they argue that the Queensland exemption merely restates treating doctors' MROs without providing a meaningful exemption from them.¹⁴³ Certainly, no doctors in any Australian jurisdiction (not only in Queensland) are required to report doctor-patients who have 'an impairment which will not place the public at substantial risk of harm'.¹⁴⁴ Queensland doctors are, however, exempt from the obligation imposed on doctors practising elsewhere in Australia (except WA) to report other practitioners whom they reasonably believe have 'placed the public at risk of substantial harm in [their] practice of [medicine] because [they have] an impairment', but do not continue to pose a risk to the

¹⁴¹ The National Health Practitioner Boards have emphasised that 'practitioners in Western Australia continue to have a professional and ethical obligation to protect and promote public health and safety. They may therefore make a voluntary notification or may encourage the practitioner ... they are treating to self-report': above n 52, 11.

¹⁴² *Snowball Review*, above n 12, 37.

¹⁴³ Goiran et al, above n 43, 220.

¹⁴⁴ *Health Practitioner Regulation National Law Act 2009* (Qld) s 25(3), inserting *Health Practitioner Regulation National Law Act 2009* (Qld) sch s 141(5). See also *National Law* sch ss 140-1; *Health Practitioner Regulation National Law (WA) Act 2010* (WA) s 4(7), inserting sch s 141(4)(da).

community.¹⁴⁵ This aspect of the Queensland exemption addresses the criticism of MROs by Dr Kerry Breen, former President of the Australian Medical Council and the Medical Practitioners Board of Victoria, for being ‘worded in the past tense so that no exception can be made for an impaired doctor who seeks help and voluntarily ceases to practise while receiving care’.¹⁴⁶ Doctors’ insurers have expressed similar concerns that the *National Law* ‘implies an obligation to report’ an impaired doctor’s ‘past actions’, ‘even if the practitioner is under active and successful treatment’ and ‘is no longer placing the public at risk’.¹⁴⁷

The Queensland exemption could both persuade unwell doctors to seek treatment — by reassuring them that their treating doctors will probably not need to report them if they comply with their recommendations — and remind treating doctors of their duty to assess whether their doctor-patients represent a threat to patients. The *Snowball Review* criticised the Queensland exemption for its application when ‘the treating practitioner believes there is not a future risk to the public’, because it requires practitioners to ‘make a judgement about the risk posed by the individual they are treating’.¹⁴⁸ Nevertheless, all treating doctors have at least professional and ethical obligations to evaluate their doctor-patients’ possible future threat to the public and determine if they need to report them, and it is critical to community safety that they do so. The *Snowball Review*’s statement indicates both that MROs are essential because they alert doctors to this responsibility, and that the WA exemption is flawed as it appears to contradict this message.

The Queensland exemption for treating doctors from reporting impaired doctor-patients who may have, but do not still represent a risk to the public, is sensible. However, a potential problem with this exemption is that it can result in regulators not learning promptly of doctors’ unprofessional conduct and poor professional performance. By stating that treating doctors are not required to report doctor-patients whose notifiable conduct they reasonably believe is ‘not professional misconduct’, the Queensland legislation implies that they need not comply with their mandatory obligations to report a doctor-patient who has ‘placed the public at risk of harm because the practitioner has practised [medicine] in a way that constitutes a significant departure from accepted professional standards’.¹⁴⁹ Such behaviour may involve a doctor’s unprofessional conduct or unsatisfactory professional performance. The National Boards have explained that ‘professional standards cover not only clinical skills but also other standards of professional behaviour’.¹⁵⁰ Even if a doctor’s behaviour does not meet the statutory definition of ‘professional misconduct’,¹⁵¹ and was precipitated by his/her ill health, it might warrant being

¹⁴⁵ *National Law* sch ss 140(c), 141.

¹⁴⁶ Breen, above n 108, 191.

¹⁴⁷ *Avant Mutual Group*, above n 97, 6.

¹⁴⁸ *Snowball Review*, above n 12, 37.

¹⁴⁹ *National Law* sch s 140(d).

¹⁵⁰ National Health Practitioner Boards, above n 52, 10.

¹⁵¹ See *National Law* sch s 5 (definition of ‘professional misconduct’). The *National Law* defines ‘professional misconduct’ as ‘unprofessional conduct ... that amounts to conduct that is substantially below the standard reasonably expected of a registered [doctor] of an equivalent level of training or experience’; ‘more than one instance of unprofessional conduct that, when considered together’ amounts to that; and conduct ‘that is inconsistent with the practitioner being a fit and proper person to hold registration’.

brought to regulators' attention. 'Unsatisfactory professional performance' involves doctors' failure to demonstrate the 'knowledge, skill or judgment' of, or exercise care to the same standard as, doctors of an 'equivalent level of training or experience'.¹⁵² 'Unprofessional conduct' could entail doctors' breaches of conditions on their registration or undertakings they have given to the MBA, or their provision of excessive or unnecessary health services.¹⁵³ If regulators are unaware of this behaviour, they cannot minimise the risk of its repetition (including through restricting the doctors' practice and ensuring they develop their competencies) and maintain professional standards.

IV Proposed Modifications to Treating Doctors' Mandatory Reporting Obligations

While accepting that it is unsafe to abandon treating doctors' MROs at this time, it is prudent to modify those duties to mitigate risks to public safety that they might engender. This article proposes two significant changes to MROs that are designed to encourage unwell doctors to obtain health care and disclose their mistakes, and motivate treating doctors to report unsafe doctor-patients. First, it recommends rewording three of the four categories of 'notifiable conduct' that currently give rise to treating doctors' MROs if they reasonably believe that their doctor-patients have engaged in one or more of them. Second, the article suggests giving treating doctors an option to fulfil their MROs by reporting either to regulators or to NDHS their doctor-patients whom they reasonably believe have engaged in one or more of two of the three reworded categories of notifiable conduct. The article proposes that these MROs apply to all Australian treating doctors without any exemptions.

A Changes to 'Notifiable Conduct'

As noted above, at present, doctors have MROs where, during their practice of medicine, they form a 'reasonable belief' that another doctor has engaged in one or more of four categories of 'notifiable conduct', namely, if the practitioner has:

1. engaged in sexual misconduct in connection with medical practice;
2. placed the public at risk of substantial harm because the doctor has an impairment;
3. practised medicine while intoxicated; and/or
4. placed the public at risk of harm because the doctor has departed significantly from accepted professional standards.

Amending the wording of three of those categories could minimise the risk that MROs will deter doctors from seeking health care. The category of notifiable conduct that the article does not recommend rewording is that involving sexual misconduct in connection with the practice of medicine, which has been the least controversial aspect of MROs under the NRAS. Such misconduct is particularly egregious, as the National Boards have explained, 'because of the power imbalance

¹⁵² Ibid sch s 5 (definition of 'unsatisfactory professional performance').

¹⁵³ Ibid sch s 5 (definition of 'unprofessional conduct').

between practitioners and their patients'.¹⁵⁴ It merits being brought to regulators' attention — regardless of who discovers it, including if it is the doctors' treating practitioners, and even if the doctor's ill health was a catalyst for the behaviour — so that appropriate action can be taken.

By contrast, whether doctors should be obliged to report another doctor whom they reasonably believe has 'placed the public at risk of substantial harm in the [doctor's] practice of [medicine] because the [doctor] has an impairment'¹⁵⁵ has been a contentious issue. This article recommends modifying this category of notifiable conduct to require doctors only to report other doctors whom they reasonably believe *may place* the public at risk of substantial harm because they have an impairment.

The National Boards and AHPRA have indicated that they support rewording practitioners' MROs 'to focus on future rather than past risk'.¹⁵⁶ If regulators learn that doctors placed the public at risk in the past due to their impairment, they can convey to the profession that practising medicine while impaired is dangerous. Yet this message is self-evident and any possible advantage to be gained from reporting a doctor who jeopardised patient safety, but no longer represents a danger to the public, is most probably outweighed by the risk, even if unproven and however slight, that an obligation to report a doctor in these circumstances may deter practitioners from obtaining medical treatment. Doctors could, however, be encouraged to seek health care if they are assured that, providing they comply with recommendations for treatment and, where required, restrictions on their practice, their treating practitioners will probably not need to report them because they will not constitute a present or future threat to the community. If this MRO applied to our hypothetical example, Dr B would not be obliged to report Dr A if he followed her advice to obtain treatment for alcoholism and refrain from practising medicine while doing so.

This article also recommends qualifying the category of notifiable conduct that obliges a doctor to report another doctor whom he/she reasonably believes has 'practised [medicine] while intoxicated by alcohol or drugs',¹⁵⁷ so that it applies only where that doctor *may have caused substantial harm*.

Reporting doctors who have practised medicine while intoxicated, but are not thought to have caused substantial harm, can enable regulators to censure them for their breach of professional standards. Nevertheless, this gain would not offset the potential, even if slender, for an obligation to report them to discourage doctors from seeking treatment for substance dependence, and generate the 'punitive atmosphere' and 'culture of fear' that some have forecast MROs could create.¹⁵⁸ If, however, treating doctors believe that their doctor-patients may have caused substantial harm by practising medicine when they were intoxicated, it is critical that they report them to regulators so that they can ensure that the doctors' patients are advised of this fact.

¹⁵⁴ National Health Practitioner Boards, above n 52, 8.

¹⁵⁵ *National Law* sch s 140(c).

¹⁵⁶ National Health Practitioner Boards and AHPRA, above n 117, 32.

¹⁵⁷ *National Law* sch s 140(a).

¹⁵⁸ Coates, above n 105, 2.

The need for this MRO is illustrated by the case of Dr James Peters, a substance-dependent anaesthetist who transmitted Hepatitis C to patients when he injected himself with fentanyl and administered the remainder of the drug, using the same needle, to patients whom he anaesthetised.¹⁵⁹ The Medical Practitioners Board of Victoria had required Peters to be supervised, but the monitoring process was deficient.¹⁶⁰ Yet, had Peters' conduct been reported to regulators promptly, they could have exercised their power to alert public health authorities, which would have been able to locate Peters' patients sooner, rather than later, to inform them of their possible infection.¹⁶¹

This article proposes rewording the final category of notifiable conduct, which concerns doctors who have 'placed the public at risk of harm' because they have 'practised [medicine] in a way that constitutes a significant departure from accepted professional standards'.¹⁶² The modified MRO would apply only where doctors reasonably believe that other doctors have placed the public at risk of *substantial* harm because they engaged in *unprofessional conduct or unsatisfactory professional performance*.

Dr Mukesh Haikerwal, former federal AMA president, observed that the 'threshold' at which the current MRO applies is too 'low'.¹⁶³ The National Boards explain that 'a significant departure is one which is serious and would be obvious to any reasonable practitioner', such as 'a clear breach of the health profession's code of conduct'.¹⁶⁴ Nevertheless, because the MRO applies where doctors have placed the public at risk of harm, not only at risk of substantial harm, and the *National Law* does not define 'professional standards', doctors may consider that practitioners are required to report mistakes that, while not trivial, do not have grave consequences. The duty may therefore dissuade unwell doctors from discussing their errors with treating practitioners and obtaining treatment for health problems that precipitated such mistakes.

Although doctors' departure from professional standards is undesirable, if it does not critically threaten the public, the benefits of treating doctors bringing it to regulators' attention would not outweigh problems that can arise if their obligation to do so discourages doctor-patients from confiding in them. Indeed, there is no justification for the inconsistency between this duty and the obligation to report doctors who, due to their impairment, have placed the public at risk of substantial harm (not merely risk of harm). If treating doctors are only required to report doctors

¹⁵⁹ Moira Sim and Eric Khong, 'How Was a Drug-Addicted Doctor With Hep C Able to Infect His Patients', *The Conversation* (online), 26 February 2013 <<https://theconversation.com/how-was-a-drug-addicted-doctor-with-hep-c-able-to-infect-his-patients-12166>>.

¹⁶⁰ Ibid; Pia Akerman, 'Anaesthetist James Latham Peters Jailed for Injecting 55 Women With Hepatitis C', *The Australian* (Sydney), 7 March 2013.

¹⁶¹ Margaret Simons, 'Duty of Care', *The Monthly* (online), August 2010 <<https://www.themonthly.com.au/monthly-essays-margaret-simons-duty-care--2639>>. See *National Law* sch s 220: if a National Board reasonably believes that a registered health practitioner poses or may pose a risk to public health, or patients' health and safety may be at risk due to their practice, the Board may give written notice of the risk and relevant information about the practitioner to a government entity that may be required to take action in relation to it.

¹⁶² *National Law* sch s 140(d).

¹⁶³ Senate Finance and Public Administration References Committee, above n 106, 100.

¹⁶⁴ National Health Practitioner Boards, above n 52, 10.

whom they reasonably believe may have placed the public at risk of substantial harm and for the reason that they engaged in ‘unprofessional conduct’ or ‘unsatisfactory professional performance’, phrases that are defined clearly in the *National Law*, ill doctors will feel more secure about disclosing and seeking assistance with their difficulties. Treating doctors would nonetheless still make regulators aware of behaviour that necessitates their swift intervention.

B *Treating Doctors’ Option to Report Doctor-Patients to National Doctors’ Health Services*

In 2014, the MBA committed to establishing a national doctors’ health program,¹⁶⁵ and subsequently partnered with the AMA to deliver a new network of nationally-consistent doctors’ health services in all Australian jurisdictions.¹⁶⁶ NDHS are a vital initiative that can improve doctors’ health. This article proposes giving treating doctors an option to fulfil their MROs by reporting, either to NDHS or to regulators, their doctor-patients whom they reasonably believe have engaged in one or both of two of the reworded categories of notifiable conduct, namely: if they may place the public at risk of substantial harm because they have an impairment; and/or if they have practised medicine while intoxicated by alcohol or drugs and may have caused substantial harm.

While treating doctors would have discretion to report such doctor-patients to regulators or NDHS, regulators could guide them about how to exercise it. For instance, they could recommend that doctors report patients to them, rather than to NDHS, where it is clear that those practitioners would be unlikely to follow NDHS’s advice. When treating doctors report their doctor-patients to NDHS, health practitioners involved with NDHS would assume their MROs in relation to the doctors. Nevertheless, the NDHS practitioners will not need to report the doctors to regulators if they have not engaged in notifiable conduct and enter agreements with NDHS to undergo treatment, monitoring and/or supervision, and/or refrain from practising medicine. They will, however, need to advise the doctors’ employers of their agreements if NDHS permit them to continue practising medicine.

Enabling treating doctors to report doctor-patients who engage in some notifiable conduct to NDHS, rather than to regulators, could mitigate risks that MROs might heighten, while also avoiding problems that the WA and Queensland exemptions can cause and even lead to improvements in doctors’ health.

¹⁶⁵ AMA and MBA, ‘Medical Board of Australia and AMA Join Forces on Doctors’ Health’ (Media Release, 5 May 2015) <<https://ama.com.au/act/medical-board-australia-and-ama-join-forces-doctors%E2%80%99-health>>.

¹⁶⁶ AMA and MBA, ‘New Doctors’ Health Service Arrangements’ (Media Release, 28 April 2016) <<http://www.medicalboard.gov.au/News/2016-04-28-doctors-health.aspx>>.

1 *Essential Features of National Doctors' Health Services*

This article envisages a model for NDHS, which draws on aspects of the highly successful VDHP, North American Physician Health Programs that were exemplars for the VDHP,¹⁶⁷ and DLA Piper's advice to AHPRA regarding governance of external doctors' health programs.¹⁶⁸

If doctors are reported to NDHS, experienced medical practitioners, employed by NDHS as 'case managers', would assess their health and circumstances. Depending on their needs, the case managers would refer doctors who are willing to participate in NDHS ('participants') to 'service practitioners', drawn from a panel of health practitioners appointed by NDHS. The service practitioners would remain external to NDHS, but receive training from them in treating doctors who may have engaged in notifiable conduct. Based on the service practitioners' recommendations, NDHS would enter written agreements with participants to undertake certain treatment, restrict their medical practice, and/or undergo monitoring and/or supervision of their health, conduct and/or performance.¹⁶⁹ The service practitioners would treat, monitor and supervise participants, report regularly to the case managers on participants' progress and compliance with their agreements and, if necessary, advise NDHS to vary the agreements in response to fluctuations or relapses in participants' conditions. NDHS could also offer participants rehabilitation programs, return-to-work assistance, and mentoring from doctors who have experienced ill health.¹⁷⁰

Pursuant to their MROs, the service practitioners and case managers will need to report participants to regulators if they reasonably believe that they have engaged in one or more of three of the reworded categories of notifiable conduct, namely, if they have: engaged in sexual misconduct in connection with the practice of medicine; practised medicine while intoxicated and may have caused substantial harm; and/or placed the public at risk of substantial harm because they have engaged in unprofessional conduct or unsatisfactory professional performance.

Nevertheless, where the case managers and service practitioners are concerned that participants have engaged in the remaining category of notifiable conduct (that is, if they have an impairment that may place the public at risk of substantial harm), they will not need to report them to regulators if participants enter and comply with agreements with NDHS and therefore do not pose a threat to the community. They will also not need to report participants if they have practised medicine while intoxicated without causing substantial harm. It may comfort

¹⁶⁷ Naham Warhaft, 'The Victorian Doctors Health Program: The First 3 Years' (2004) 181(7) *Medical Journal of Australia* 376, 376.

¹⁶⁸ AHPRA, on behalf of the MBA, commissioned DLA Piper to advise it about external doctors' health programs' structure, funding, governance arrangements and agreements with the MBA: DLA Piper, 'Governance of External Doctors' Health Programs' (Report, DLA Piper, April 2014) 9–10 <<http://www.ahpra.gov.au/Search.aspx?q=dla+piper>>.

¹⁶⁹ Warhaft, above n 167, 377–8: this is a feature of the Victorian Doctors Health Program ('VDHP').

¹⁷⁰ DLA Piper, above n 168, 25; Alan Rosen et al, 'Psychiatrically Impaired Medical Practitioners: Better Care to Reduce Harm and Life Impact, With Special Reference to Impaired Psychiatrists' (2009) 17(1) *Australasian Psychiatry* 11, 14–15. These are also features of the VDHP and the mentoring system is based on the Louisiana Physicians' Health Program.

participants if NDHS have an explicit exemption from reporting them to regulators in these circumstances,¹⁷¹ and NDHS could enter contracts with regulators specifying the required communication between them.¹⁷²

If, however, impaired doctors refuse to enter agreements with NDHS that NDHS propose, or depart from or do not accept variations to their agreements, and may, therefore, place the public at risk of substantial harm, NDHS will need to report them to regulators.¹⁷³ In these circumstances, NDHS could arrange peer personal support for the doctors (though not advocacy or advice, as that could confuse NDHS's roles and expose NDHS to liability).¹⁷⁴

Where impaired doctors enter and comply with agreements with NDHS that permit them to continue practising medicine, NDHS can largely maintain the doctors' confidentiality, but will need to advise the doctors' employers that they are undergoing treatment, monitoring and/or supervision. This recommendation is modelled on a NSW legislative provision that requires Councils for the health professions (which fulfil National Boards' responsibilities in NSW) to inform health practitioners' employers if they impose conditions on their registration.¹⁷⁵ It was introduced in 2014 in response to the case of Dr Suresh Nair, a cocaine-addicted neurosurgeon who harmed patients while he was participating in a regulator's health program, but his employers were not fully informed of his substance dependence.¹⁷⁶ To reassure doctors that their agreements with NDHS will not be widely disseminated, this article proposes that it should be an offence (as it is in NSW) for employers to disclose or use such information about the doctors other than to supervise them and ensure patients' safety.¹⁷⁷

It will be important for NDHS and the MBA to develop protocols for compliance with MROs in specific situations,¹⁷⁸ and for NDHS to audit their adherence to these rules.¹⁷⁹ Such initiatives could: assist the case managers and service practitioners to decide whether they need to report participants; assure the

¹⁷¹ See National Health Practitioner Boards and AHPRA, above n 117, 32; AMA, above n 55, 4; VDHP, Submission to MBA and AHPRA, *Draft Guidelines for Mandatory Notifications*, April 2010, 2 <<http://www.vdhp.org.au/website/articles.html>>; R G Beran, 'Mandatory Notification of Impaired Doctors' (2014) 44(12) *Internal Medicine Journal* 1161, 1164; the National Health Practitioner Boards, AHPRA, the AMA, the VDHP, and commentators have expressed support for an exemption for health services from mandatory reporting obligations.

¹⁷² DLA Piper, above n 168, 69, 71.

¹⁷³ The US Federation of State Medical Boards recommends that Physician Health Programs follow this protocol for reporting doctors to licensing boards: Federation of State Medical Boards, 'Policy on Physician Impairment' (Policy, Federation of State Medical Boards, April 2011) 15–16, 26 <<http://www.fsmb.org/policy/advocacy-policy/policy-documents>>.

¹⁷⁴ DLA Piper, above n 168, 31–3; Freckelton and Molloy, above n 83, 379.

¹⁷⁵ *Health Practitioner Regulation National Law (NSW) 2009* (NSW) ss 176BA(1)–(4); New South Wales, *Parliamentary Debates*, Legislative Assembly, 14 October 2014 (Jillian Skinner, Minister for Health and Minister for Medical Research) 1021–2.

¹⁷⁶ Australian Broadcasting Corporation, 'The Hand That Holds the Scalpel', *Four Corners*, 26 August 2014 (Tracy Bowden) <<http://www.abc.net.au/4corners/stories/2014/08/25/4071837.htm#transcript>>; Antonio Bradley, 'Employers to be Told of Doctors' Impairments', *Australian Doctor* (online), 26 August 2014 <<http://www.australiandoctor.com.au/news/latest-news/doctors-employers-to-be-told-of-impairments>>.

¹⁷⁷ *Health Practitioner Regulation National Law (NSW) 2009* (NSW) s 176BA(5).

¹⁷⁸ DLA Piper, above n 168, 65–6.

¹⁷⁹ Federation of State Medical Boards, above n 173, 4.

public and the MBA that NDHS are not maintaining participants' confidentiality at the expense of community safety;¹⁸⁰ and minimise the risk of claims being made against the case managers and service practitioners in tort and/or contract for failing to report participants whom they were aware, or should have been aware, represented a 'foreseeable risk to patients' and harmed them.¹⁸¹

Also imperative is that NDHS remain independent from regulators.¹⁸² Promisingly, the MBA and the AMA have confirmed that NDHS are intended to operate at arm's length from the MBA and AHPRA, and the AMA has created a subsidiary company to administer service providers' delivery of the programs.¹⁸³ The MBA and the AMA appreciated that 'separation between regulators and health programs was essential for them to work' because it ensures that doctors will 'trust these services, and use them at an early stage in their illness'.¹⁸⁴ The distance between them can also encourage participants to comply with their agreements with NDHS,¹⁸⁵ and demonstrate to the public that regulators are not shirking their responsibilities by permitting NDHS to monitor doctors whom they should be managing.¹⁸⁶

The success of this proposal depends, too, on adequate resourcing of NDHS.¹⁸⁷ Pursuant to its statutory discretion 'to provide financial or other support for health programs for registered health practitioners',¹⁸⁸ the MBA has committed to fund NDHS through doctors' registration fees.¹⁸⁹ Given that NDHS will promote public safety, COAG might agree for the governments to supplement those payments, and doctors' insurers and employers may also be willing to contribute to NDHS's costs.¹⁹⁰

NDHS that are currently being established could accommodate this article's proposals. The MBA and the AMA have already indicated that service providers will offer 'health-related triage, advice and referral services', 'follow up services ... including support and advocacy in returning to work', 'training to support doctors to treat other doctors', and 'facilitation of support groups for medical practitioners ... with significant health problems'.¹⁹¹ Moreover, the VDHP and North American Physician Health Programs, which provide doctors' health services independently

¹⁸⁰ DLA Piper, above n 168, 28.

¹⁸¹ Freckelton and Molloy, above n 83, 377–9, 382.

¹⁸² DLA Piper, above n 168, 10, 23.

¹⁸³ AMA and MBA, above n 166; AMA and MBA, above n 165.

¹⁸⁴ AMA and MBA, above n 166. See also AMA and MBA, above n 165.

¹⁸⁵ Freckelton and Molloy, above n 83, 379.

¹⁸⁶ DLA Piper, above n 168, 14.

¹⁸⁷ *Ibid* 21.

¹⁸⁸ *National Law* sch s 35(1)(n). The proposed NDHS clearly falls within the statutory definition of 'health program', namely, 'a program providing education, prevention, early intervention, treatment or rehabilitation services relating to physical or mental impairments, disabilities, conditions or disorders, including substance abuse or dependence': at sch s 5 (definition of 'health program').

¹⁸⁹ AMA and MBA, above n 166; AMA and MBA, above n 165.

¹⁹⁰ VDHP, 'The Future of the Victorian Doctors Health Program (Discussion Paper, Victorian Branch of the AMA, Medical Practitioners Board of Victoria and Board of the VDHP, February 2009) 8, 13 <<http://www.vdhp.org.au/website/articles.html>>.

¹⁹¹ AMA and MBA, above n 166. See also AMA and MBA, above n 165.

of regulators, have proven the viability and advantages of this recommended model of NDHS to a significant extent.

The VDHP offers the most comprehensive services of the six existing external doctors' health services in Australia.¹⁹² Its Senior Clinicians evaluate the health of doctors self-referred and referred by other practitioners to it, develop treatment plans, and refer doctors for treatment by external health practitioners for whom the VDHP runs training courses.¹⁹³ Doctors who require ongoing support participate in the VDHP's Case Management, Aftercare and Monitoring Program, entering written agreements to comply with therapeutic treatment, undergo monitoring and participate in support groups.¹⁹⁴ In 2002, a year after the VDHP commenced operation, its intervention had halved the number of unwell doctors referred to the Medical Practitioners Board of Victoria for monitoring.¹⁹⁵ By 2004, all impaired doctors whom the VDHP had asked to cease practice had complied with its requests or already had their registration suspended.¹⁹⁶ The VDHP was able to permit most doctors on Case Management, Aftercare and Monitoring Program agreements for 12 months or more between 2001 and 2008 to return to medical practice.¹⁹⁷ The VDHP had a memorandum of understanding with the Medical Practitioners Board of Victoria that required the VDHP to report participants who substantively failed to comply with recommendations for treatment and restriction of practice and/or relapsed.¹⁹⁸ In its first seven years, the VDHP only needed to report two participants while they were being case managed, and was able to maintain the confidentiality of the 37% of participants who had no prior involvement with the Medical Practitioners Board of Victoria.¹⁹⁹

North American Physician Health Programs, first developed in the 1970s and 1980s, have reported similar successes.²⁰⁰ Most evaluate doctors who are referred to them, coordinate treatment provided to the doctors by specialist practitioners external to their services, monitor them once their health is stable, and assist with their rehabilitation and re-entry into the workforce.²⁰¹ The Physician Health Programs maintain the confidentiality of participants who comply with their programs and treating practitioners' recommendations, but report them to regulators

¹⁹² DLA Piper, above n 168, attachment 3. Tasmania and the Northern Territory have not had external doctors' health services: at 3, 18–19.

¹⁹³ VDHP, above n 190, 3; Warhaft, above n 167, 376–7; Victorian Doctors Health Program, *How We Help* (2016) VDHP <<http://www.vdhp.org.au/website/services.html>>; DLA Piper, above n 168, attachments 3 and 4.

¹⁹⁴ VDHP, above n 190, 3–4; Warhaft, above n 167, 377; Cheryl Wile, Matthew Frei and Kym Jenkins, 'Doctors and Medical Students Case Managed by an Australian Doctors Health Program: Characteristics and Outcomes' (2011) 19(3) *Australasian Psychiatry* 202, 202; DLA Piper, above n 168, 25.

¹⁹⁵ VDHP, above n 171, 1.

¹⁹⁶ Warhaft, above n 167, 378.

¹⁹⁷ Wile, Frei and Jenkins, above n 194, 204.

¹⁹⁸ Breen, above n 108, 192; Warhaft, above n 167, 378.

¹⁹⁹ Wile, Frei and Jenkins, above n 194, 203–5.

²⁰⁰ Thomas McLellan et al, 'Five Year Outcomes in a Cohort Study of Physicians Treated for Substance Use Disorders in the United States' (2008) *BMJ* 1, 1 <<http://www.bmj.com/content/337/bmj.a2038.short>>; VDHP, above n 190, 5.

²⁰¹ Federation of State Medical Boards, above n 173, 4, 8; McLellan et al, above n 200, 1; Roger L Brown and Barbara S Schneidman, 'Physicians' Health Programs — What's Happening in the USA?' (2004) 181(7) *Medical Journal of Australia* 390, 390; VDHP, above n 190, 5–6.

if they are unable or unwilling to cease practice while impaired, dismiss treatment advice, or do not complete recommended treatment.²⁰² A five-year study of US Physician Health Programs found that three-quarters of substance-dependent participants had favourable outcomes with most being rehabilitated and retaining their licences to practise medicine.²⁰³

2 *Benefits of Treating Doctors' Option to Report Doctor-Patients to National Doctors' Health Services*

It is likely that treating doctors' discretion to fulfil their MROs by reporting doctor-patients to NDHS would appeal to doctors, regulators, consumers of NDHS and doctors' insurers, as it potentially offers advantages for all these stakeholders.

This option promises to lead to improvements in doctors' health, which is in everyone's interests. The principal purpose of NDHS is to facilitate doctors' early access to high-quality health care.²⁰⁴ According to the proposed model, doctors referred to them would receive appropriate treatment, preferably before their illness develops into impairment, and, where possible, be rehabilitated. Tightly-structured, supervised health programs have proven success, particularly for doctors who suffer from substance-dependence and psychiatric illness.²⁰⁵

Moreover, the risk of treating doctors' MROs resulting in harm to doctors could be minimised by giving treating doctors the option to report doctor-patients to NDHS. If doctors are discouraged from seeking health care, or do not fully inform treating practitioners of their symptoms for fear that they will be reported to regulators and have their medical practice officially curtailed, they may self-treat,²⁰⁶ and their conditions could deteriorate and impair their ability to practise medicine.²⁰⁷ Doctors would, however, probably be more willing to access the help they need if their treating practitioners could report them to non-disciplinary, non-judgemental, therapeutic NDHS, instead of to regulators.

Once reported to NDHS, doctors would be inclined to discuss their problems candidly with case managers and service practitioners and follow their treatment recommendations, knowing that they would not need to report them to regulators if they have not engaged in notifiable conduct, enter and comply with agreements with NDHS, and do not pose a risk to the public. Further, while some consider that treating doctors' notifications to regulators about their doctor-patients could worsen the patients' conditions and adversely affect the notifiers, it is unlikely that the same report to NDHS would have these effects, owing to their differences from regulators.

Treating doctors' option to report their doctor-patients to NDHS would appeal to unwell doctors. They could receive treatment, depending on their

²⁰² Federation of State Physician Health Programs, *Physician Health Program Guidelines* (Federation of State Physician Health Programs, 2005) 4, 15 <www.fsphp.org/sites/default/files/pdfs/2005_fsphp_guidelines-master.pdf>; Baldisseri, above n 85, S114.

²⁰³ McLellan et al, above n 200, 4–5.

²⁰⁴ AMA and MBA, above n 166; AMA and MBA, above n 165.

²⁰⁵ Rosen et al, above n 170, 12.

²⁰⁶ AMA, above n 24, 3.

²⁰⁷ Bismark, Morris and Clarke, above n 21, 1166; Sexton and Morton, above n 135.

condition, be rehabilitated, and potentially remain in or return to medical practice and evade the unpalatable consequences of being reported to regulators. Indeed, the MBA appreciates that doctors ‘who have been notified to the Board as a result of a possible impairment can find their dealings with the Board and AHPRA to be very stressful’, particularly if they are ‘concerned that their registration and therefore their livelihood may be at risk’ and ‘fear that their private health information will be made public’.²⁰⁸ Regulators may be able to maintain doctors’ confidentiality — for instance, the MBA can decide not to record in its register conditions imposed on impaired doctors’ registration or details of those practitioners’ undertakings to it²⁰⁹ — and the intention behind regulating impaired doctors can be purely therapeutic and non-disciplinary.²¹⁰ Nevertheless, the options that regulators can pursue if they determine that a doctor is impaired could lead to their formal curtailment and surveillance of doctors’ medical practice, which practitioners may experience as disempowering, invasive, punitive and distressing.

In jurisdictions other than NSW and Queensland (which have their own processes for dealing with impaired doctors), if, after undertaking a preliminary assessment of a notification, the MBA ‘decides that a [doctor] is or may be impaired and further action is necessary’, it can require the doctor to undergo a ‘health assessment’ to determine whether the doctor has an impairment, which may include a ‘medical, physical, psychiatric or psychological examination or test’.²¹¹ While NDHS may require similar evaluations, the MBA has clarified that the ‘purpose’ of the health assessment is ‘for the Board to obtain independent expert advice about the [doctor’s] ... health and its potential impact on the practitioner’s practice’ to ‘inform what further action needs to be taken’.²¹² The MBA’s ‘further action’ could involve ‘immediate action’ or ‘relevant action’.²¹³ If the MBA ‘reasonably believes’ that, because of the doctor’s health, he/she ‘poses a serious risk to persons’ and ‘it is necessary to take immediate action to protect public health or safety’, the MBA can propose to suspend or impose a condition on the doctor’s registration, or accept an undertaking from the doctor or the surrender of his/her registration.²¹⁴ If the MBA takes relevant action, it can caution the doctor, accept an undertaking from the doctor, impose conditions on the doctor’s registration, and/or refer the matter to another entity, such as a health complaints entity, for investigation or other action.²¹⁵ The MBA may also refer the matter to a health panel that it establishes,²¹⁶ which, if it determines that the doctor has an impairment, can impose conditions on or suspend his/her registration.²¹⁷

Regulators would probably also prefer that NDHS arranged for the performance of the often complex, resource and time-intensive task of managing

²⁰⁸ MBA, above n 113, 4–5.

²⁰⁹ *National Law* sch s 226(1).

²¹⁰ Kiel, above n 130, 432.

²¹¹ MBA, above n 113, 3; *National Law* sch ss 5 (definition of ‘health assessment’), 169.

²¹² MBA, above n 113, 3. See also *National Law* sch s 177.

²¹³ MBA, above n 113, 3; *National Law* sch ss 155–6, 178.

²¹⁴ *National Law* sch ss 155–6.

²¹⁵ *Ibid* sch s 178.

²¹⁶ MBA, above n 113, 3; *National Law* sch s 181.

²¹⁷ *National Law* sch s 191.

impaired doctors.²¹⁸ It is burdensome for AHPRA, on the MBA's behalf, to: identify appropriate practitioners who are willing to monitor impaired doctors' compliance with restrictions on their practice; ensure they participate honestly in drug-testing procedures and other health tests; supervise doctors' practice through observing and educating them; formulate suitable management plans, especially for doctors with relapsing conditions; and treat them.²¹⁹

It is likely that regulators will also appreciate that giving treating doctors an option to report their doctor-patients to NDHS can enhance public health and safety. As a consequence of being reported to NDHS, doctors, whom the community has invested in training, may be rehabilitated sufficiently to return to meeting demand for safe medical care.²²⁰ Daniel Andrews, then Victorian Minister for Health, recognised that the VDHP has demonstrated that health programs 'are essential to the ongoing good health and working ability of the health workforce'.²²¹ In addition, doctors who care for their own health influence their patients to follow their example.²²² Importantly, this option promises to reduce doctors' risk to patients because: it can encourage doctors to seek health care early and access appropriate treatment through NDHS; NDHS could compile data about doctors' health,²²³ which can be used to improve management of impaired doctors; it is likely that doctors who pose a substantial risk to patient safety will be brought to regulators' attention; and either NDHS or regulators will ensure that doctors refrain from practising medicine while it is unsafe for them to do so.

Treating doctors would probably feel unperturbed about reporting doctor-patients to NDHS and not discouraged from doing so by the same reasons that may make them reluctant to comply with their obligations to notify regulators. By reporting their doctor-patients to NDHS that are independent from the regulatory process and its attendant reputation, even if inaccurate, as disciplinary and punitive,²²⁴ they might not consider that they were breaching their patients' confidentiality and betraying their colleagues, or expect any retaliation for taking this action. NDHS could provide feedback to treating doctors, confirming that their doctor-patients were receiving appropriate treatment and supervision.

²¹⁸ Kiel, above n 130, 437.

²¹⁹ Ibid. See also Robert S Walzer and Stephen Miltimore, 'Mandated Supervision, Monitoring and Therapy of Disciplined Health Care Professionals: Implementation and Model Regulations' (1993) 14(4) *Journal of Legal Medicine* 565, 565–7, 570–1, 590–1. In addition to Dr James Peters' case, recent revelations of doctors' non-compliance with conditions on their registration that require them to consult patients only in the presence of chaperones, highlight difficulties regulators can face in performing these functions: see, eg, Tessa Hoffman, 'Call to Abolish "Failing" Medical Chaperone System', *Australian Doctor* (online), 2 August 2016 <<https://www.australiandoctor.com.au/news/latest-news/calls-to-abolish-failing-medical-chaperone-model>>.

²²⁰ Walzer and Miltimore, above n 219, 573–4; Rosen et al, above n 170, 16; Federation of State Medical Boards, above n 173, 29; AMA Victoria, Submission to AHPRA, *Funding for External Doctors Health Programs*, 4 April 2012, 1.

²²¹ Victoria, *Parliamentary Debates*, Legislative Assembly, 15 October 2009, 3697 (Daniel Andrews, Minister for Health).

²²² EB Oberg and E Frank, 'Physicians Health Practices Strongly Influence Patient Health Practices' (2009) 39(4) *Journal of the Royal College of Physicians of Edinburgh* 290.

²²³ Freckelton and Molloy, above n 83, 379.

²²⁴ Ibid.

If the option to report their doctor-patients to NDHS encourages treating doctors to do so, the mandatory obligations to report those doctors to regulators will be borne by health practitioners who are likely to comply with MROs appropriately. This proposal places considerable responsibility on the case managers and service practitioners to assess doctors' risk to the public and determine when to breach their confidentiality. Nevertheless, it is imperative that some health practitioners who know of the doctors' potential danger carry this onus, as regulators and the community depend on unsafe doctors being brought to regulators' attention. Moreover, it is preferable that practitioners who have volunteered to shoulder this burden through becoming involved in NDHS, have been trained for this task and follow clear guidelines about their duties, do so. Those practitioners probably will not share treating doctors' disinclination to make notifications to regulators if this is required, and are unlikely to underestimate participants' threat to the public, as they will be taught to assess this risk objectively, regard participants as patients rather than colleagues,²²⁵ and resist attempts by doctors to manipulate them not to make notifications.

Doctors' insurers could also benefit from treating doctors reporting their insured to NDHS, rather than to regulators in the first instance. They could avoid paying for doctors' representation in disciplinary proceedings that regulators may be compelled to initiate. Indeed, when MROs were imposed on NSW doctors in 2008, the Chairman of the Medical Indemnity Industry Association of Australia suggested that it might be more appropriate to refer impaired doctors to health programs, rather than to 'escalate' such matters by reporting them to regulators.²²⁶

V Conclusion

It is crucial to recognise and bolster health professions' capacity to protect the public. Nevertheless, concern has grown that their self-regulation has been inadequate. Consciousness of the risks to which such failures can expose the public has led to the imposition of MROs on registered health practitioners. MROs of health practitioners who are treating other registered health practitioners have been particularly controversial. At the heart of this debate is a perennial challenge: how can we minimise the threat that impaired health practitioners may pose to public safety?

In exploring this issue, this article has focused on doctors' MROs, though its observations apply to all registered health practitioners. While diverse opinions have been expressed on this subject, none is substantiated by comprehensive Australian empirical research. In the absence of this evidence, it is sensible to consider probabilities and objectively weigh apparent risks, to determine the most effective means of encouraging unwell practitioners to access the help they need and ensuring that those who remain a threat to their patients come to regulators' notice before it is too late.

²²⁵ DLA Piper, above n 168, 23.

²²⁶ Nixon, above n 22.

Australian treating doctors' current reporting obligations are unsatisfactory. Their professional and ethical reporting duties are imprecise, practitioners are confused about treating doctors' MROs because they vary between jurisdictions, and there is a concern that MROs deter doctors from obtaining health care. Nevertheless, exemptions for treating doctors from MROs in WA and Queensland could lead to detrimental consequences for doctors and the public, especially by hindering regulators' capacity to protect the community.

The Australian Health Workforce Ministerial Council has, however, opened the door to the possibility of reforming MROs. This article therefore proposes changes to treating doctors' MROs. While recognising the importance of retaining such duties and deficiencies in arguments for removing them, it recommends rewording three of the four categories of doctors' conduct that practitioners are required to report, and giving treating doctors an option to fulfil their MROs by reporting certain conduct either to regulators or to NDHS. The article suggests applying these MROs to Australian doctors uniformly and jettisoning the WA and Queensland exemptions.

These proposals take into account various considerations that are illustrated by our hypothetical scenario. There are weighty disincentives for treating doctors, such as Dr B, to report their doctor-patients, such as Dr A, to regulators. Yet, if Dr B refrains from making a notification about Dr A, she would deprive regulators of critical information on which they depend to protect the public. MROs could overcome impediments to Dr B's unwillingness to report Dr A and motivate her to do so. There is, however, a risk, if marginal, that MROs will result in a deterioration in Dr A's health, particularly if they discourage him from obtaining further treatment.

Before any changes are made to treating doctors' MROs, this article recommends that research be conducted into the likely effectiveness of the proposals. A comprehensive survey of Australian doctors could be undertaken to determine their attitudes to the recommendations and the extent to which they might encourage treating doctors to report unsafe doctor-patients without deterring unwell doctors from obtaining health care.

