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Dear Ahpra

RE: Draft Ahpra Data Strategy

The Royal Australasian College of Surgeons (RACS) welcomes the opportunity to provide comment concerning Ahpra's draft data strategy. RACS is the leading institution for the training of surgical practice for more than 7,000 surgeons and 1,300 surgical trainees and Specialist International Medical Graduates in Australia and Aotearoa New Zealand.

1. **Does the draft data strategy cover the right issues?**

   The main objective of any medical registration scheme should be to protect patients and the draft strategy broadly encompasses the key themes to support this objective. RACS would appreciate more dialogue about how Ahpra makes assessments with respect to balancing the public interest with the interest of an individual practitioner/s.

   As presented, the strategy does not provide sufficient information to provide a considered response as it relates to our membership and the implementation of the strategy. RACS would particularly like more detail as to how the provision of the extra information on the public register assists in protecting patients, and we would also want to know how best the privacy of our membership is adequately protected. Any details providing personal details of any practitioner must be vigorously protected, including marital status, home address, contact telephone numbers – with the information provided being restricted to main office contact, email, fax, and telephone number only.

2. **Do you think that anything should be added to or removed from the draft data strategy?**

   With respect to the information that has been made available for the purposes of this consultation, we do not have anything to add or remove. We would welcome the opportunity to review further once more detail is available.

FOCUS AREA 1 – THE PUBLIC REGISTER

3. Do you agree with adding more information to the public register?

RACS is supportive of including additional information on the public registrar to improve informed decision making and health literacy. The information must be factually accurate, be kept up to date and be easy to interpret by all users. The data provided must not breach practitioner privacy as raised earlier. How this 'data' is translated into information that is digestible across diverse communities in Australia will be particularly important to addressing health inequity.

- **If yes, what additional information do you think should be included?**

  Patient safety and the quality of care delivered is enhanced when the diversity of the medical profession reflects that of the communities in which they serve. A greater understanding of the evolving diversity of the surgical profession would help to inform selection policies, workforce planning, allow for greater choice and will provide more opportunity to measure progress and the impact of interventions over time.

  RACS encourages Ahpra to collect and publish diversity data across medical specialities. This could include gender, geography (Modified Monash Model), Aboriginal and Torres Strait Islander identity, cultural and linguistic diversity, LGBTIQ and disability. This data could be made available in a form that maintains the privacy of the individual.

  Ahpra is also best placed to provide accurate data that informs Priority 1 and 2 (data and workforce planning, distribution) of the National Medical Workforce Strategy'[1]. This would represent a unique opportunity for Ahpra to collect data that would add significant value to patient care through participation in the workforce strategy.

  Publication of diversity data on the public register could also be a valuable tool to support patient choice. We would be supportive of this inclusion only where a medical practitioner has the choice of determining what information they wish to make publicly available.

  RACS is also broadly supportive of including memberships and associations on the public register. We would expect that this be limited to an approved listing and that it includes qualifying information on what is required to obtain this affiliation. For example, where an affiliation requires completion of training and assessment against those that only require on-going payment of membership fees (Please see Q.7 for comments on qualifications).

- **If no, please share your reasons**

  RACS would not support the expansion of the public register to include:

[1] Department of Health and Ageing, Australian Government (2021). *National Medical Workforce Data Strategy*: Accessed on 30 January 2023 at https://www.health.gov.au/resources/publications/national-medical-workforce-strategy-2021-2031?language=en

Outcomes Data: RACS does not support the release of outcomes-based data on an individual surgeon's performance or league tables.[2] RACS would strongly oppose an expansion that included non-risk adjusted data or data on an individual surgeon.

Consumer Ratings: We would caution against any changes to the public register that provided a platform for consumer ratings, particularly that rate one clinician above another clinician. While there are an increasing number of websites and social media platforms that publicise consumer feedback, testimonials, and ratings, this is not the function of a regulator.

4. Do you agree with adding health practitioners' disciplinary history to the public register?

RACS broadly supports disciplinary history being available on the public record subject to the following exclusions:

- Where a matter is under investigation (i.e., notifications should not be made public)
- Where a matter is under appeal
- Where a matter is subject to a court order
- Where disciplinary action was taken, with a sunset period based on the nature of the offending action (see question 5).

- **If yes, how much detail should be included?**

RACS supports the publication of information that is factual. Disciplinary matters should be reported in a manner that balances the interest of the public with the welfare of the practitioner. Where a disciplinary matter relates to a practitioner's health condition or impairment, these details should never be published.

5. How long should a health practitioner's disciplinary history be published on the public register?

Publication of disciplinary history and how long this information is available to the public must consider that not all actions resulting in a disciplinary sanction are the same. As outlined in the Registration Standard: Criminal History[3], the nature and gravity of the behaviour, whether a conviction was recorded, the age of the victim and the likelihood of future threat to patients are all relevant factors that can influence the publication of disciplinary history. Emphasis of such publication must be on protection of the public rather than punishment of the practitioner.

Subject to the above being taken into consideration, a period of 5 years would be appropriate and is consistent with other professional bodies (i.e., lawyers). Given that a small number of practitioners are responsible for most notifications, this period should not substantially impede those who are subject to a single disciplinary sanction.

[2] Royal Australasian College of Surgeons (2015). *Public Reports on Surgical Outcomes and Performance*. Accessed on 28 January 2023 at https://www.surgeons.org/about-racs/position-papers/public-reports-on-surgical-outcomes-and-performance-2015

[3] Australian Health Practitioner Regulation Agency (2015). *Registration Standard: Criminal History*. Accessed on 30 January 2023 at https://www.medicalboard.gov.au/Registration-Standards.aspx

6. Who should be able to add additional information to the public register?

Who should add data to the public register is dependent on who holds the authority to report this information. Data such as qualifications, accredited affiliations or disciplinary matters should be reported by an organisation that holds appropriate authority or accreditation. Personal information relating to diversity or practice details would more appropriately be self-reported.

An expansion of data on the register would require consideration of how this was monitored and include a mechanism to report factually erroneous information. There may also be value in providing a distinction on the register between data that has been verified versus data which has been self-reported.

7. Are there other ways to enhance the effectiveness and value of the public register for the public and/or practitioners?

There is inconsistency with how qualifications are recorded on the register which we anticipate will be addressed in this strategy. The award of a degree by a tertiary institution should not be treated in the same manner as the award of a Fellowship with a specialist medical college. While a tertiary qualification is awarded permanently without requiring an on-going relationship between the recipient and the institution, a Fellowship requires on-going maintenance of standards and oversight to retain.

We remain concerned that the report of loss of the FRACS to Ahpra is not necessarily reflected on the register. RACS feels that this is misleading to the public as it implies that the practitioner is complying with the standards of that specialist medical college. More information about the distinction between qualifications, Fellowships, memberships etc. would support improved patient decision-making.

FOCUS AREA 2 – DATA SHARING

8. Our National Law enables us to share data with some other organisations in certain situations. Do you have suggestions about Ahpra could share data with and/or receive data from other organisations to benefit the public, practitioners and/or our regulatory work?

The way RACS receives data from Ahpra about changes to registration - via the PIE service – does not enable us to take any meaningful action. We receive periodic communication about restrictions on practitioners' records, however this does not appear to have consistent application across jurisdictions. The direction towards notifications being sent to a generic inbox does not engender proactive collaboration or expedient action. We would welcome discussion with Ahpra on how to improve two-way communication.

FOCUS AREA 3 – ADVANCED ANALYTICS

9. Do you have any suggestions about how Ahpra should approach using advanced analytics and machine learning technologies?

RACS does not hold sufficient expertise to provide considered comment. We do note that the implementation of advanced analytics and machine learning technology requires support from

a range of stakeholders and systematic structural change. For Ahpra to get the most value out of this transition, early engagement with organisations that hold source data will be essential.

OTHER

10. **Please describe anything else Ahpra should consider in developing the data strategy.**

    RACS would also be interested in any initiatives under this strategy that help to support improved workforce planning.

Thank you for the opportunity to provide this submission.

Yours sincerely

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Chair, Professional Standards Committee

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