Public consultation: Review of the Criminal history registration standard and other work to improve public safety in health regulation

Initial questions

To help us better understand your situation and the context of your feedback please provide us with some details about you. These details will not be published in any summary of the collated feedback from this consultation.

Question A

Are you completing this submission on behalf of an organisation or as an individual?

Your answer:

☒ Organisation

Name of organisation: Royal Australasian College of Medical Administrators (RACMA)

Contact email: [redacted]

☐ Myself

Name: Click or tap here to enter text.

Contact email: Click or tap here to enter text.

Question B

If you are completing this submission as an individual, are you:

☐ A registered health practitioner?

Profession: Click or tap here to enter text.

☐ A member of the public?

☐ Other: Click or tap here to enter text.

Question C

Would you like your submission to be published?

☒ Yes, publish my submission **with** my name/organisation name

☐ Yes, publish my submission **without** my name/ organisation name

☐ No – **do not** publish my submission

Focus area one – The Criminal history registration standard

Question 1

The *Criminal history registration standard* (**Attachment A**) outlines the things decision-makers need to balance when deciding whether someone with a criminal history should be or stay registered such as the relevance of the offence to practice, the time elapsed and any positive actions taken by the individual since the offence or alleged offence. All decisions are aimed at ensuring only registered health practitioners who are safe and suitable people are registered to practise in the health profession.

Do you think the criminal history standard gets this balance right?

If you think the *Criminal history registration standard* does not get this balance right, what do you think should change to fix this?

Your answer:

Yes. However, RACMA believes the above statement does not specify the impact of one's actions on others in terms of the severity of crime. Hence the College suggests a small addition to address this – see below words in red.

The Criminal history registration standard (Attachment A) outlines the things decision-makers need to balance when deciding whether someone with a criminal history should be or stay registered such as the relevance of the offence to practice, the time elapsed, the impact of the offence on others, and positive actions taken by the individual since the offence or alleged offence. All decisions are aimed at ensuring only registered health practitioners who are safe and suitable people are registered to practise in the health profession.

Question 2

Do you think the information in the current *Criminal history registration standard* is appropriate when deciding if an applicant or registered health practitioner's criminal history is relevant to their practice? If not, what would you change?

Your answer:

Yes. However, the impact on others (or self) is silent and therefore discounts a degree of severity in the crime. With reference to self – the impact one has already faced may be a good mitigating factor to consider (for example drink driving and lost own leg versus drink driving and killed young family?).

RACMA believes the difference between the 'one-off' and recidivism should be stated somewhere. Also, sometimes the impact on others is indirect – regarding safety and protection being disturbed. In other words, affecting trust in doctors, affecting local practices/hospitals in regional areas, causing community grief/distrust/fear and preventing or limiting access to healthcare especially in vulnerable or minority subgroups.

Question 3

Do you think the information in the current *Criminal history registration standard* is clear about how decisions on whether an applicant or registered health practitioner's criminal history is relevant to their practice are made? If you think it is not clear, what aspects need further explanation?

Your answer:

Yes. However, clarification regarding non-conviction charges could be better articulated by using some examples at the end. For example, this means that penalties like 'good behaviour bonds' and 'diversion orders' will appear on criminal history records obtained under the National Law.

RACMA also believes if someone is not a fit and proper person outside medicine then it is questionable whether they are a fit and proper person to practice medicine. We refer to Refer to Victorian Civil and Administrative Tribunal Case Farshchi v Medical Board of Australia [2018] VCAT 1619, which tests this. It goes to the Public Interest Test (s156(1)(e) of the Health Practitioner Regulation National Law (National Law) to ensure the public can have confidence in a practitioner.

RACMA suggests including a line which more explicitly states that criminal offences both inside and outside the profession can be relevant to how a medical practitioner is deemed safe and suitable to practice medicine.

Question 4

Is there anything you think should be removed from the current *Criminal history registration standard?* If so, what do you think should be removed?

Your answer:

No.

Question 5

Is there anything you think is missing from the 10 factors outlined in the current *Criminal history registration standard?* If so, what do you think should be added?

Your answer:

No.

Question 6

Is there anything else you would like to tell us about the *Criminal history registration standard*?

Your answer:

No.

Focus area two – More information about decision-making about serious misconduct and/or an applicant or registered health practitioner's criminal history

Question 7

Do you support Ahpra and National Boards publishing information to explain more about the factors in the *Criminal history registration standard* and how decision-makers might consider them when making decisions? Please refer to the example in **Attachment B.** If not, please explain why?

Your answer:

Yes. **Refer to the answer for question 3 as an example.**

Question 8

Is the information in **Attachment B** enough information about how decisions are made about practitioners or applicants with a criminal history? If not, what is missing?

Your answer:

Yes. RACMA strongly supports Paragraph 28 in Attachment B about public safety being a fundamental consideration.

Question 9

Is there anything else you would like to tell us about the information set out in **Attachment B**?

Your answer:

Yes. Paragraph 9 refers to the passage of time and a 10-year period of reoffending – is this evidence based and/or does this reflect a specific time period of consideration by the Board as a cut off?

Question 10

Thinking about the examples of categories of offences in **Attachment C**, do you think this is a good way to approach decision-making about applicants and registered health practitioners with criminal history? If you think this is a good approach, please explain why. If you do not agree with this approach, please explain why not.

Your answer:

Category A & B offences are clearly defined with examples. Category C are deemed minor offences but need more clarity. RACMA believes it is unclear how Category C differs from Category B. The inclusion of minor drug offences is difficult to interpret given in Category B there is a condition for drug cultivation/use/possession. What would therefore be included in Category C that is not already in Category B – does this refer to specific classes of drugs? The College believes all drug offences fall into Category B.

RACMA would like to see more clarity around traffic offences (depending on profession). Noting references elsewhere in the document to paramedics who drive ambulances, but what about community health workers or GPs who conduct home visits – albeit without patients in their vehicles, but perhaps with colleagues and under the remit of their professional roles? Is the risk to the public different depending on the profession?

RACMA believes it is also important to consider criminal offences where the person has used their power, privilege or knowledge to gain for self (for example fraud, conflict of interest, commissioning services etc). To highlight this, we refer to VCAT case Medical Board of Australia v Hung Phan (Review and Regulation) [2018] VCAT 1324. The biggest issue with this is related to the invasion of privacy of patient information.

Question 11

Do you think there are some offences that should stop anyone practising as a registered health practitioner, regardless of the circumstances of the offence, the time since the offence, and any remorse, rehabilitation, or other actions the individual has taken since the time of the offence? Please provide a brief explanation of your answer. If you answered yes, please explain what you think the offences are.

Your answer:

If we consider the underlying principles of the document and the 10 factors already in place, decisions should be made after a thorough assessment and application of those factors on a case-by-case assessment.

Question 12

Is there anything else you would like to tell us about the possible approach to categorising offences set out in **Attachment C**?

Your answer:

Please refer to the answer for Question 10.

Focus area three – Publishing more information about decisions that are made about serious misconduct by registered health practitioners

Question 13

Were you aware that disciplinary decisions by tribunals about registered practitioners were published to Ahpra and National Board websites and are linked to an individual practitioner's listing on the public register?

Your answer:

Yes.

Question 14

Do you think decisions made to return a practitioner to practice after their registration has been cancelled or suspended (reinstatement decisions) for serious misconduct should be published where the law allows? Please explain your answer.

Your answer:

Yes. This is important for transparency of decision making and builds trust and confidence in the decision-making process of the Board. It also provides a rationale of decision making that can be scrutinised over time.

Question 15

Is there anything else you would like to tell us about the approach to publishing information about registered health practitioners with a history of serious misconduct?

Your answer:

RACMA believes there is a need to promote a safety culture within reporting and self-disclosure/seeking of help. The document should not be read with a mindset purely of fear. Consideration should be made to include links to assistance for the "accused" or those worried about being accused.

Focus area four – Support for people who experience professional misconduct by a registered health practitioner

Question 16

What do you think Ahpra and National Boards can do to support individuals involved in the regulatory process who are affected by sexual misconduct by a registered health practitioner? (For examples, see paragraph 47 of the consultation paper.)

Your answer:

RACMA believes providing an opportunity for a victim impact statement is appropriate. Referral to appropriate counselling and other supports are also appropriate, but these may need to extend beyond short term interventions so a framework for such supports is necessary. A way to address these short-term interventions could be through the introduction of a "navigator" or case manager to assist individuals.

Question 17

Is there anything else you would like to tell us about how we can support individuals affected by a registered health practitioner's professional misconduct?

Your answer:

RACMA believes Ahpra could provide the option for tribunals to accept previous testimony from judicial or quasi-judicial settings (in other words court, Commission of Inquiry) to enable affected individuals to not have to testify again.

Focus area five – Related work under the blueprint for reform, including research about professional misconduct

Question 18

Are the areas of research outlined appropriate?

Your answer:

Yes.

Question 19

Are there any other areas of research that could help inform the review? If so, what areas would you suggest?

Your answer

RACMA believes research into the following would be most helpful to inform the review:

- whether certain types of crime in the past predisposes a practitioner to reoffend in future;
- types of crime and prevalence in different specialties and areas of practice;
- crime types with respect to understanding where 'power/privilege' has been a part of the crime (i.e. sexual assault of person/patient with disability or Medicare fraud vs drink driving);
- the fitness for purpose of the current conviction check system- is it sufficiently rigorous without being an impediment to recruitment and appointment? and
- given the minor offence Category C, does the application of this Category have any impact on public confidence versus practitioner management – and potentially their wellbeing (especially if not considered beneficial from a public confidence or clinician management perspective).

Additional question

This question is most relevant to jurisdictional stakeholders:

Question 20

Are there opportunities to improve how Ahpra and relevant bodies in each jurisdiction share data about criminal conduct to help strengthen public safety

Your answer:

Ahpra should continue to work closely with the state departments of health and police agencies so that there are open channels of communication. The College believes a data-sharing memorandum of understanding (MoU) between Ahpra and each jurisdiction should be a standard process.