Q1.

Consultation on a draft Data strategy

Thank you for taking time to respond to the consultation.

Introduction

The Australian Health Practitioner Regulation Agency (Ahpra) is inviting feedback on a draft Data strategy. The Data strategy will guide how we use the data that we collect and hold.

We are inviting responses to specific questions about the future use of this data and general comments on the draft Data strategy.

In addition to the Data strategy, we are consulting on the future directions for three key focus areas:

- the public register of health practitioners
- data sharing, and
- advanced analytics.

Please read the public consultation paper (including the draft Data strategy) before responding.

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Publication of responses

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Please select the box below if you do not want your responses to be published.

- [ ] Please do **not** publish my responses

Q3.

Questions

If you have any questions, please contact Ahpra's Strategy and Policy Directorate by emailing AhpraConsultation@ahpra.gov.au.

Q39.

Acknowledgement of Country

Ahpra acknowledges the Traditional Owners of Country throughout Australia and their continuing connection to lands, waters and communities. We pay our respect to Aboriginal and Torres Strait Islander cultures and Elders past, present and emerging.

Q4.

Please click on the arrow below to start your submission.

Q5.

About your responses

Are you responding on behalf of an organisation?

- ○ Yes
- ◉ No

Q6.

Please provide the name of the organisation.

This question was not displayed to the respondent.

Q7.

Which of the following best describes your organisation?

This question was not displayed to the respondent.

Q8.

Which of the following best describes you?

- ◉ I am a health practitioner
- ○ I am a member of the community
- ○ I am an employer (of health practitioners)
- ○ Other - please describe below

Q9.

Which of the following health profession/s are you registered in, in Australia?
You may select more than one answer.

- [ ] Aboriginal and Torres Strait Islander Health Practice
- [ ] Chinese Medicine
- [ ] Chiropractic
- [ ] Dental
- [x] Medical
- [ ] Medical Radiation Practice
- [ ] Midwifery
- [ ] Nursing
- [ ] Occupational Therapy
- [ ] Optometry
- [ ] Osteopathy
- [ ] Paramedicine
- [ ] Pharmacy
- [ ] Physiotherapy
- [ ] Podiatry
- [ ] Psychology
- [ ] Other - please describe below

Q10.

Your contact details

Name:

[redacted]

Q11. Email address:

[redacted]

Q12.

Draft Data strategy

The draft Data strategy can be found on page 7 of the consultation paper.

Does the draft Data strategy cover the right issues?

Yes

Q13.
Do you think that anything should be added or removed from the draft Data strategy?

Yes

Q14.
Focus area 1: The public register

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

- ○ Yes
- ◉ No

Q15.
Focus area 1: The public register

What additional information do you think should be included on the public register?

This question was not displayed to the respondent.

Q16.
Please share your reasons

The register is an important instrument in the provision of safe health care in Australia; it is not an advertisement for a practitioner's ability , for example, to speak five languages! In addition, and more importantly, historical restrictions are exactly that- historical.if conditions have been applied, the practitioner has been remediated then this is the end of the story. Further publication of register issues beyond this is unprofessional

Q17.
Focus area 1: The public register

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

- ○ Yes
- ◉ No

Q18.
Focus area 1: The public register

How much detail (about a health practitioner's disciplinary history) should be included on the public register?

This question was not displayed to the respondent.

Q19.
Please share your reasons

I strongly disagree this is unprofessional.everyone deserves a second chance don't they? Sports people are regularly afforded this in the public domain!

Q20.
Focus area 1: The public register

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

- ○ 0 to 1 year
- ○ 1 to 4 years
- ○ 5 to 10 years
- ○ 10 to 20 years
- ○ As long as the practitioner is registered as a health practitioner
- ◉ Disciplinary history should not be published on the public register. Only current conditions or limits on practise should be published on the public register.
- ○ Other, please describe

Q22.
Focus area 1: The public register

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

Only aphra

Q23.
Focus area 1: The public register

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

N/a

Q24.
Focus area 2: Data sharing

The Health Practitioner Regulation National Law enables us to share data with some other organisations in certain situations.

Do you have suggestions about how Ahpra could share data with and/or receive data from other organisations to benefit the public, practitioners and/or our regulatory work?

Don't share it with [redacted] and get hacked!

Q25.

Focus area 3: Advanced analytics

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

This is not aphra's prime focus

Q26.

Other

Please describe anything else Ahpra should consider in developing the Data strategy.

Keep register simple and no historical data

Q1.

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- [ ] Please do **not** publish my responses

Q3.

Questions

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Q4.

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Q5.

About your responses

Are you responding on behalf of an organisation?

- ○ Yes
- ◉ No

Q6.

Please provide the name of the organisation.

This question was not displayed to the respondent.

Q7.

Which of the following best describes your organisation?

This question was not displayed to the respondent.

Q8.

Which of the following best describes you?

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- ○ I am an employer (of health practitioners)
- ○ Other - please describe below

Q9.

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Q10.

Your contact details

Name:

[redacted]

Q11. Email address:

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Q12.

Draft Data strategy

The draft Data strategy can be found on page 7 of the consultation paper.

Does the draft Data strategy cover the right issues?

No

Q13.
Do you think that anything should be added or removed from the draft Data strategy?

There needs to be a process to systematically destroy data that is no longer needed for a current purpose, re [redacted] breach, [redacted] breach. Only the minimum necessary data should be collected and stored. Excess data collection and storage is a potential risk for any person who's data is stored. All stored data on a person should be regularly provided to that person to ensure it is accurate. Data should not be shared without the specific consent of the person who's data it is and the option to opt out of sharing must be provided.

Q14.
Focus area 1: The public register

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

- ○ Yes
- ◉ No

Q15.
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What additional information do you think should be included on the public register?

This question was not displayed to the respondent.

Q16.
Please share your reasons

Individual privacy. Misuse of data. Data breaches. Identity theft.

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How much detail (about a health practitioner's disciplinary history) should be included on the public register?

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Please share your reasons

Fitness to practice should be yes or no. If there is nothing currently preventing a practitioner then there should be nothing more to add.

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- ○ Other, please describe

Q22.

Focus area 1: The public register

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

Nobody

Q23.

Focus area 1: The public register

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

The register should be a register only. No more, no less.

Q24.

Focus area 2: Data sharing

The Health Practitioner Regulation National Law enables us to share data with some other organisations in certain situations.

Do you have suggestions about how Ahpra could share data with and/or receive data from other organisations to benefit the public, practitioners and/or our regulatory work?

Data sharing should be minimised due to risk of privacy breaches and hacking. Data sharing should be encrypted and only shared as a single individual at a time.

Q25.

Focus area 3: Advanced analytics

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

They should not be used.

Q26.

Other

Please describe anything else Ahpra should consider in developing the Data strategy.

Avoid unnecessary data collection and risk of data loss. Re [redacted] Hack. [redacted] Hack.

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- ( ) No

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regulatory action history

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Limited to other health gov organisations

Q25.

Focus area 3: Advanced analytics

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

Q26.

Other

Please describe anything else Ahpra should consider in developing the Data strategy.

Submission to
Ahpra and National Boards

Public consultation on a Draft Data Strategy

[redacted]

January 2023

Executive Summary

1. The views expressed in this submission are based on feedback from the author's extensive network of community members and health practitioners who include nursing, paramedicine, allied health and medical personnel. They also draw on the author's experience as an expert policy advisor for regulatory, security, compliance and accreditation activities in Australia and overseas.
2. These inputs and activities have involved consideration of the information management safeguards needed to minimise the potential for fraud and corruption. Although written in the context of and with examples drawn from paramedicine, the recommendations are intended to have general application and focus on identifying issues of broad policy significance that affect the integrity of information management and underpin the regulatory process.
3. The submission notes the importance of appropriate information security regimes to protect sensitive personal and practitioner information and the importance of rigorous pre-qualification, accreditation or validation of the supporting infrastructure service providers and provider and employer networks. These concerns are of particular importance where outsourced (third-party) information systems and network-based systems are used.
4. Drawing comparisons with practices in the field of paramedicine, it highlights the risks and deficiencies associated with fragmented information systems. Better shared data arrangements are supported especially with workforce skills and employment data.
5. The submission supports the proposed Draft Data Strategy and makes observations on various proposals within the consultation document. Reference is made to a greater focus on community (patient) engagement and more transparent and accessible data related to (inter alia):
    a. Collection and reporting of diversity including Indigenous status
    b. Reporting of registrants with dual or multiple registrations
    c. Reporting of more granular (MMM) practitioner distribution
    d. An indication of whether the registrants are working as full-time, fractional time or (less commonly) volunteer practitioners, and
    e. An indication of whether the registrant is working as a private or public system practitioner and information on practitioner flow into and out of defined employment sectors or practice roles.

Table of Contents

Scope

This submission is made in response to the call for public consultation issued by the Australian Health Practitioner Regulation Agency (Ahpra) into a draft Data strategy and future directions for three focus areas:

- the public register of health practitioners
- data sharing, and
- advanced analytics.

Ahpra has published a consultation paper that includes the draft Data strategy and further information about the three focus areas, including case studies.

Author

The author of this submission is [redacted] and the submission is made in a personal capacity. An independent policy advisor and Executive Committee member of the [redacted], [redacted] is the recipient of an [redacted] awarded for contributions to [redacted].

The views expressed in this submission draw on feedback from the author's extensive network of community members and health practitioners who are predominantly paramedics but include other nursing, allied health and medical personnel.

They also draw on the author's experience as an expert policy advisor for regulatory, security, compliance and accreditation activities in Australia and overseas. These activities have involved consideration of the information management safeguards needed to minimise the potential for fraud and corruption.

The author agrees with the intent of the draft Data strategy to ensure that the data collected is used to achieve the objectives of the National Scheme, including:

- to protect the physical, psychological, and cultural safety of the public
- enable high-quality service delivery and a sustainable health workforce
- facilitate public choice and access to health care by registered health practitioners
- uphold the guiding principles of the National Scheme, specifically to ensure operation in a transparent, accountable, efficient, effective and fair way, and
- help to regulate health practitioners more efficiently and effectively.

The four strategic objectives – '*Regulatory efficiency and effectiveness', 'Trust and confidence', 'Insight generation' and 'Shared data value'* - appear appropriate. The objectives also reflect how data can enhance the National Scheme's contribution to public safety, workforce planning, and access to health services.

The author believes the underlying commitment to a stronger patient-oriented approach to health care with greatly enhanced community engagement is timely. He supports the view that the users (the public) should play a significant role in the regulatory processes and be suitably informed by appropriate and readily accessible information processes.

While acknowledging the work of Ahpra with partners such as the Digital Health CRC he draws attention to the broader components of information management that extend beyond the collection of data on individual practitioners and include the use of relevant information by supporting infrastructure providers and educational entities.

Attention is drawn to the need for suitable pre-qualification, accreditation or validation of the supporting infrastructure providers and the information security ramifications of registration networks, as well as provider and employer networks. These concerns are of particular importance where outsourced (third-party) information systems and network-based systems are used.

Regulatory and data integrity

The author's concern for the transparency and integrity of registration data and appropriate information systems stems from an evaluation of the discrepancies between the national datasets provided by the Department of Health and Aged Care (DOHAC), the reports of the Productivity Commission and the Australian Bureau of Statistics (ABS) dealing with paramedicine. The need for better sharing and harmonization of data is indicated.

The expertise of paramedics and their clinical interventions are the mainstays in providing out-of-hospital emergency health care in Australia. Working for ambulance services as government agencies or as contractors, paramedics deliver emergency and allied medical services that reach every level of Australian society.[1]

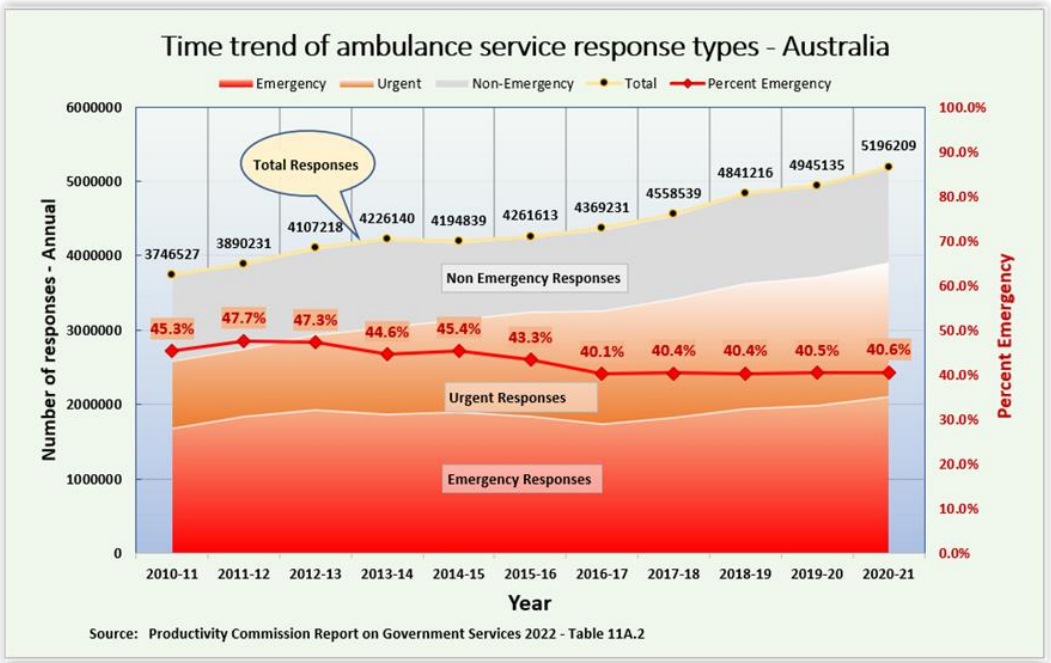

Figure 1. Time trend of ambulance service responses - Australia

While jurisdictional ambulance services employ the bulk of paramedics, they do not represent the full story. The annual Report on *Government Services (ROGS)* prepared by the Productivity Commission does not include the contributions made by the Royal Flying Doctor Service, the private sector, industrial paramedics in the field or the paramedics who work in the defence force, universities, and other peacekeeping and humanitarian roles, funded by Government and Aid agencies.

Many Government discussion papers pay little attention to the crucial work of ambulance (aka paramedic) services operating daily at the face of community contact and care, while paramedics are haphazardly omitted (or included) as part of the allied health workforce by jurisdictional health departments and the DOHAC.

1 Productivity Commission, Report on Government Services (ROGS) 2022, Australian Government, 1 February 2022. https://bit.ly/34ppuSc

Survey data collected by the Australian Health Practitioner Regulation Agency (Ahpra) is based on voluntary responses. Private service providers predominantly employing paramedics (apart from the WA and NT ambulance services) are poorly captured - with the result that data on paramedicine are scattered, unreliable and inadequate.

This is despite paramedicine having more than 23,000 registered practitioners in Australia and their current and growing engagement within the public and private healthcare systems.

The *Modified Monash Model (MMM) 2019* was developed to better target health workforce programs to attract health professionals to more remote and smaller communities. The MMM classifies metropolitan, regional, rural, and remote areas according to geographical remoteness, as defined by the ABS.

Internationally, the impact of regulatory activities on the professions has become part of the public policy agenda. In the context of paramedic practice both the ambulance services and professional paramedics are subject to greater than normal public interest and consumer protection considerations. The dissemination of relevant practitioner and provider information is thus a critical element in protecting public safety.

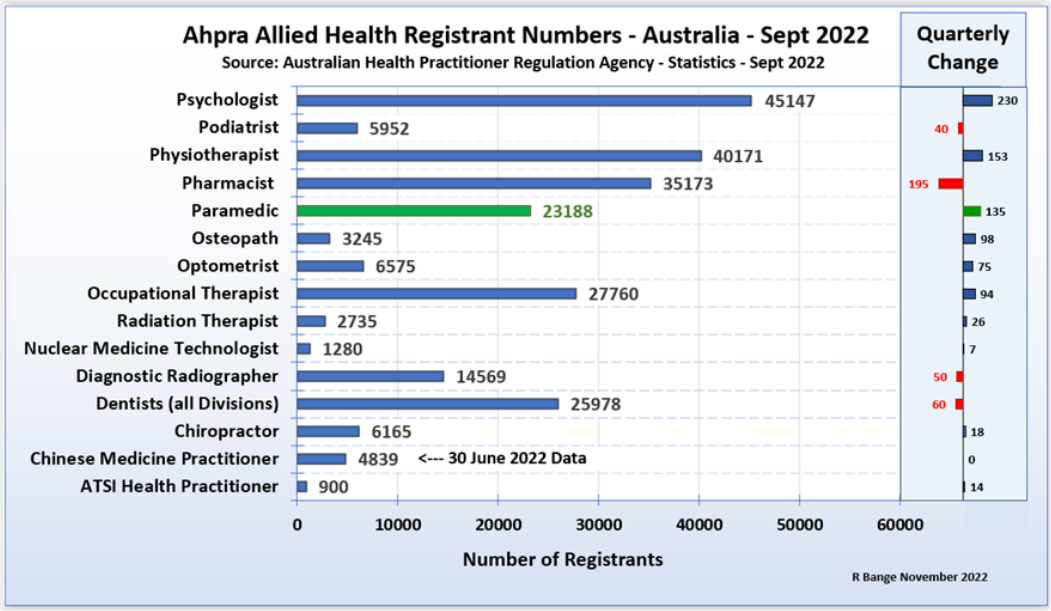

Figure 1. Ahpra Registered Allied Health Practitioners in Australia

Yet the publicly available Ahpra registration data does not provide an effective picture of practitioner geographical distribution without recourse to secondary data application and analysis. A more transparent public picture should be provided with a broad indication of relative public and private practitioner populations/distributions.

To ensure an informed community the available data should indicate whether the registrants are working as full-time, fractional time or (rare) volunteer practitioners. This information would complement the existing non-practising category.

This coverage should cater for private practitioners and registered members of the defence force as well as those employed within the various State agencies, hospitals, universities, and industrial settings. Attention should also be given to providing information on practitioner flow into and out of defined employment or practice roles.

The cultural dimensions of regulation

Workforce diversity is important for encouraging multicultural awareness, enhancing respect and communication and improving equality in the delivery of care. Diversity can have many dimensions and goes well beyond the matter of gender to embrace culture and the practice of equity, diversity, and inclusion.

Gender is often used as a measure of diversity, but this is a narrow viewpoint when it comes to diversity and disability. For example, while Australia is better placed than most jurisdictions with female paramedics now forming about 48% of registered paramedics, the published registration data on the health professions do not give a picture of the ethnic, cultural and disability diversity.

By creating an inclusive working environment, people living with a disability may have a greater decision-making role and contribution by sharing their experiences and perspectives. The objective is to ensure that health services are provided in a fair and inclusive manner, and are accessible to everyone regardless of race, gender, ability, religion, sexual orientation or age.

In addition to our Aborigine and Torres Strait Islander populations, nearly half of all Australians were either born overseas, or one or both parents were born overseas. The most common overseas countries of birth are the United Kingdom and New Zealand. But there is an increasing proportion of people who were born in Asia.

The author considers it is time for more extensive reporting of ethnic and disability diversity as well as gender, as part of the commitment to inclusiveness that acknowledges Culturally and Linguistically Diverse (CALD) people. This would be consistent with the principles of cultural safety and inclusion embedded in the Australian health professional regulatory framework.

In 2022, the UK Health and Care Professions Council (HCPC) released a Diversity Data Report 2021. The report presents the findings from a registrant survey that collected data relating to protected characteristics and socio-economic indicators, as well as workplace information. Ahpra should do likewise from time to time.[2, 3]

From informed observation, the adoption of a national information management scheme under common legislative provisions has the potential to improve the nature and flow of information, while at the same time introducing a more rigorous and harmonised approach that should enhance the integrity and protection of information.

Subject to the development of suitable information-gathering protocols and the adoption of appropriate security and confidentiality measures, the author supports the general principles for information collection, sharing and privacy as articulated in the consultation document. The additional information options outlined in paragraph 29 are supported in principle.

While more extensive and detailed workforce-related reporting is recommended, this should be on a de-identified basis such that a person's identity is no longer apparent or cannot be reasonably ascertained from the released information or data. For some situations of practitioner distribution that may require sensitive treatment.

2 Bange R, *Diversity in paramedicine revisited*, The Paramedic Observer, Facebook, 15 August 2022. https://bit.ly/3XN4mw6

3 Health and Care Professions Council, HCPC Diversity Data Report 2021, https://bit.ly/3C6jexK

Response to consultation details

In the following observations, comments are made on the consultation proposals only if deemed necessary to reinforce, select an option or offer a viewpoint or alternative.

Draft Data strategy

1. Does the draft Data strategy cover the right issues?

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

Responses:

The draft data strategy appears adequate. There might be a benefit in placing a great focus on the engagement of the public and how this is achieved by the strategies through the information held and displayed in regular reporting.

The public register

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

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

• If no, please share your reasons

Responses:

Yes.

The matters outlined in paragraph 29 of the consultation paper provide a good selection of data items. Certain matters are considered a priority, such as specific practice approvals such as the administration of vaccinations and the authority to prescribe. More details of a CALD nature may be beneficial subject to privacy and other protections.

The public register

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

• If yes, how much detail should be included?

• If no, please share your reasons

Responses:

Yes.

The nature of the breach/offence should determine the form of both reporting and the length of time that the disciplinary record remains available. Generally, this matter should be made the responsibility of the disciplinary tribunal or body.

For example, a decision to cancel registration is definitive and applies absolutely (by removing the person from the register). A minor breach in signage may be treated more leniently and only apply until the breach is rectified. A fitness-to-practice issue also should not apply indefinitely but have an end date - perhaps limited to one registration cycle beyond the period for breach correction.

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

Response:

See responses to Question 4 above. The factual reporting of disciplinary action on the Ahpra website and in other formal records should not be time-limited and remain indefinitely as a record of fact.

The public register

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

Responses:

Authorised Ahpra personnel only.

Individuals should not be allowed to remove their names from the list by voluntary withdrawal. In other words, there is no diminution of the rights of the individual to choose whether or not they wish to be registered (if qualified) but the ability to modify the list in any way is to be governed by the relevant formal due processes (and appeal procedures) of registration.

In determining whether there should be a statute of limitations for newly de-registered persons, the author recognises the public interest as the dominant factor in mandating and transparent reporting of registration.

The author suggests that care be taken in the use of the term "practitioner" as it connotes currency of registration and that alternative terminology be used when describing de-registered persons.

The public register

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

Responses:

See the narrative content of this submission. Additional data to be captured and accessible with aperiodic reporting should include:

a. **Collection and reporting of diversity including Indigenous status**
b. **Reporting of more granular (MMM) practitioner distribution**
c. **Reporting of registrants with dual or multiple registrations**
d. **Whether the registrant is working as a full-time, fractional time or (less commonly) volunteer practitioner, and**
e. **An indication of whether the registrant is working as a private or public system practitioner and information on practitioner flow into and out of defined employment sectors or practice roles.**

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?

Response:

Endorsed in principle especially with those government bodies having an interest or responsibility for planning, workforce development and education. Typical agencies might include the DOHAC, Productivity Commission, the ABS, major peak professional bodies, Education, Treasury/Finance etc.. and under t**he Trans-Tasman Mutual Recognition Act 1997 which provides for the sharing of information between New Zealand and Australian registration authorities.**

Power to withhold the release of information from the register may be appropriate in certain circumstances but the threshold test should be generous.

Information from the register should normally be available unless Ahpra determines that it is not in the public interest. The threshold test therefore would apply - based on allowing access unless contraindicated.

Similarly, there should be publication of tribunal decisions unless otherwise determined that it is not in the public interest. The process of determination of the public interest and the threshold to apply should be suitably demanding. However, the primacy of the public interest is relevant, and given the multiplier effect of potential harm from practitioner failings, the author accepts that the interests of the practitioner should be subservient to the public interest.

Focus area 3: Advanced analytics

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

Response:

The developments in data analytics are manifold and it is difficult to predict what may be possible through advanced algorithms, Artificial Intelligence and machine learning.

The author generally endorses the use of available technologies to support the objectives of sensitive and appropriate regulation.

Other

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

Response:

The importance of and maintenance of confidentiality and information security given the risks posed by external consultants, contractors, IT and health service providers and other persons and groups who are legitimate users and processors of information.

Definitions / Abbreviations

The following abbreviations and definitions are used in this submission.

DOHAC	Department of Health and Aged Care
ABS	Australian Bureau of Statistics
AHP	Allied Health Profession/Professional
Ahpra	Australian Health Practitioner Regulation Agency
CALD	Culturally and Linguistically Diverse
MMM	Modified Monash Model 2019
ROGS	Report on Government Services (Productivity Commission)
UK	United Kingdom

Registered Paramedic - A professional health care practitioner registered under the National Registration and Accreditation Scheme and whose education and competencies empower the individual to provide a wide range of patient-centred care and medical procedures in diverse settings including out-of-hospital scheduled and unscheduled care situations.

Q1.

Consultation on a draft Data strategy

Thank you for taking time to respond to the consultation.

Introduction

The Australian Health Practitioner Regulation Agency (Ahpra) is inviting feedback on a draft Data strategy. The Data strategy will guide how we use the data that we collect and hold.

We are inviting responses to specific questions about the future use of this data and general comments on the draft Data strategy.

In addition to the Data strategy, we are consulting on the future directions for three key focus areas:

- the public register of health practitioners
- data sharing, and
- advanced analytics.

Please read the public consultation paper (including the draft Data strategy) before responding.

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Q3.

Questions

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Q39.

Acknowledgement of Country

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Q4.

Please click on the arrow below to start your submission.

Q5.

About your responses

Are you responding on behalf of an organisation?

- ○ Yes
- ◉ No

Q6.

Please provide the name of the organisation.

This question was not displayed to the respondent.

Q7.

Which of the following best describes your organisation?

This question was not displayed to the respondent.

Q8.

Which of the following best describes you?

- ◉ I am a health practitioner
- ○ I am a member of the community
- ○ I am an employer (of health practitioners)
- ○ Other - please describe below

Q9.

Which of the following health profession/s are you registered in, in Australia?
You may select more than one answer.

- [ ] Aboriginal and Torres Strait Islander Health Practice
- [ ] Chinese Medicine
- [ ] Chiropractic
- [ ] Dental
- [x] Medical
- [ ] Medical Radiation Practice
- [ ] Midwifery
- [ ] Nursing
- [ ] Occupational Therapy
- [ ] Optometry
- [ ] Osteopathy
- [ ] Paramedicine
- [ ] Pharmacy
- [ ] Physiotherapy
- [ ] Podiatry
- [ ] Psychology
- [ ] Other - please describe below

Q10.

Your contact details

Name:

[redacted]

Q11. Email address:

[redacted]

Q12.

Draft Data strategy

The draft Data strategy can be found on page 7 of the consultation paper.

Does the draft Data strategy cover the right issues?

Yes

Q13.
Do you think that anything should be added or removed from the draft Data strategy?

Trust and confidence - it is imperative to include a focus on data providers (practitioners) and how they are assured that their data is being used responsibly

Q14.
Focus area 1: The public register

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

- (●) Yes
- ( ) No

Q15.
Focus area 1: The public register

What additional information do you think should be included on the public register?

It is very important that only objectively verifiable information is included in the register - that is to say, not matters of opinion. Information that could be included would be: qualifications, MBS item access, registration history, regulatory action history.

Q16.
Please share your reasons

This question was not displayed to the respondent.

Q17.
Focus area 1: The public register

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

- (●) Yes
- ( ) No

Q18.
Focus area 1: The public register

How much detail (about a health practitioner's disciplinary history) should be included on the public register?

The level of seriousness should determine if (and for how long) the disciplinary history is published on the register.

Q19.
Please share your reasons

This question was not displayed to the respondent.

Q20.
Focus area 1: The public register

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

- ○ 0 to 1 year
- ○ 1 to 4 years
- ◉ 5 to 10 years
- ○ 10 to 20 years
- ○ As long as the practitioner is registered as a health practitioner
- ○ Disciplinary history should not be published on the public register. Only current conditions or limits on practise should be published on the public register.
- ○ Other, please describe

Q22.
Focus area 1: The public register

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

Practitioners and the Regulator (AHPRA)

Q23.
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Are there other ways to enhance the effectiveness and value of the public register for the public and/or practitioners?

Q24.
Focus area 2: Data sharing

The Health Practitioner Regulation National Law enables us to share data with some other organisations in certain situations.

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Q25.

Focus area 3: Advanced analytics

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

Q26.

Other

Please describe anything else Ahpra should consider in developing the Data strategy.

AHPRA should evaluate if the current collection of "sex" and/or "gender" data is aligned with modern guidelines (e.g. Australian Bureau of Statistics, Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables, 2020)

Q1.

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Please share your reasons

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- ○ No

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Q25.

Focus area 3: Advanced analytics

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

Q26.

Other

Please describe anything else Ahpra should consider in developing the Data strategy.

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Q39.

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Q4.

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Q5.

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- ◉ No

Q6.

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Which of the following best describes your organisation?

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Which of the following health profession/s are you registered in, in Australia?
You may select more than one answer.

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Your contact details

Name:

[redacted]

Q11. Email address:

[redacted]

Q12.
Draft Data strategy

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Does the draft Data strategy cover the right issues?

No

Q13.
Do you think that anything should be added or removed from the draft Data strategy?

The affects of over policing of services and profits made by organisations by making licensing mandatory issue should be added.

Q14.
Focus area 1: The public register

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

- ○ Yes
- ◉ No

Q15.
Focus area 1: The public register

What additional information do you think should be included on the public register?

This question was not displayed to the respondent.

Q16.
Please share your reasons

No one is going to read it; people decide by their experience what practitioner they will go and see; the only people who benefit are those getting paid to licence and police what should be private agreements between clients and practitioners

Q17.
Focus area 1: The public register

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

- ○ Yes
- ◉ No

Q18.
Focus area 1: The public register

How much detail (about a health practitioner's disciplinary history) should be included on the public register?

This question was not displayed to the respondent.

Q19.
Please share your reasons

Its only fodder for click bait journalists and sensationalist news and there is enough of that already.

Q20.
Focus area 1: The public register

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

- ◉ 0 to 1 year
- ○ 1 to 4 years
- ○ 5 to 10 years
- ○ 10 to 20 years
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- ○ Disciplinary history should not be published on the public register. Only current conditions or limits on practise should be published on the public register.
- ○ Other, please describe

Q22.
Focus area 1: The public register

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

Still do not agree that the public register solves any problem at all other than inventing pointless work for government departments and their offshoots.

Q23.

Focus area 1: The public register

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

Effectiveness at what? It doesn't achieve anything except funding, work, wages, and busy-work for bureaucrats.

Q24.

Focus area 2: Data sharing

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.

Q25.

Focus area 3: Advanced analytics

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

Don't use advanced analytics and machine learning technologies

Q26.

Other

Please describe anything else Ahpra should consider in developing the Data strategy.

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Q5.

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- ○ Yes
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Name:

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Q12.

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Yes

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Do you think that anything should be added or removed from the draft Data strategy?

Yes

Q14.
Focus area 1: The public register

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

- ○ Yes
- ◉ No

Q15.
Focus area 1: The public register

What additional information do you think should be included on the public register?

This question was not displayed to the respondent.

Q16.
Please share your reasons

It will worsen the already poor mental health of practitioners. Practitioners who have made mistakes and have gained insight and improved their practice should not be publicly outed for their entire career.

Q17.
Focus area 1: The public register

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

- ○ Yes
- ◉ No

Q18.
Focus area 1: The public register

How much detail (about a health practitioner's disciplinary history) should be included on the public register?

This question was not displayed to the respondent.

Q19.

Please share your reasons

Practitioners who have made mistakes should be allowed to address their errors and gain insight without being humiliated. The aim is to improve patient outcomes by educating and supporting practitioners not humiliating them. This will add to the stress and poor mental health that accompanies such notifications.

Q20.

Focus area 1: The public register

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

- ○ 0 to 1 year
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Who should be able to add additional information to the public register?

AHPRA

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

No

Q24.

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Do you have suggestions about how Ahpra could share data with and/or receive data from other organisations to benefit the public, practitioners and/or our regulatory work?

Practitioners should be allowed to opt in confidential information sharing in much the same way as my health record allows individuals to opt in

Q25.

Focus area 3: Advanced analytics

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

It is dangerous to expect complex issues involving practitioner assessment to be handled by advanced analytics in much the same way as the robodebt automated machine analysis created incorrect and stressful outcomes. Individual situations are unique and cannot be learnt to be categorised by a machine

Q26.

Other

Please describe anything else Ahpra should consider in developing the Data strategy.

Q1.

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Q12.
Draft Data strategy

The draft Data strategy can be found on page 7 of the consultation paper.

Does the draft Data strategy cover the right issues?

Yes

Q13.
Do you think that anything should be added or removed from the draft Data strategy?

No

Q14.
Focus area 1: The public register

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

- (●) Yes
- ( ) No

Q15.
Focus area 1: The public register

What additional information do you think should be included on the public register?

Date of when condition was imposed upon registration

Q16.
Please share your reasons

This question was not displayed to the respondent.

Q17.
Focus area 1: The public register

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

- (●) Yes
- ( ) No

Q18.
Focus area 1: The public register

How much detail (about a health practitioner's disciplinary history) should be included on the public register?

Very detailed so that individuals can make informed decisions about their healthcare providers

Q19.
Please share your reasons

This question was not displayed to the respondent.

Q20.
Focus area 1: The public register

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

- ( ) 0 to 1 year
- ( ) 1 to 4 years
- (●) 5 to 10 years
- ( ) 10 to 20 years
- ( ) As long as the practitioner is registered as a health practitioner
- ( ) Disciplinary history should not be published on the public register. Only current conditions or limits on practise should be published on the public register.
- ( ) Other, please describe

Q22.
Focus area 1: The public register

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

Previous employers

Q23.

Focus area 1: The public register

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

Make it a known website so that the general public know about it

Q24.

Focus area 2: Data sharing

The Health Practitioner Regulation National Law enables us to share data with some other organisations in certain situations.

Do you have suggestions about how Ahpra could share data with and/or receive data from other organisations to benefit the public, practitioners and/or our regulatory work?

no

Q25.

Focus area 3: Advanced analytics

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

no

Q26.

Other

Please describe anything else Ahpra should consider in developing the Data strategy.

n/a

Q1.

Consultation on a draft Data strategy

Thank you for taking time to respond to the consultation.

Introduction

The Australian Health Practitioner Regulation Agency (Ahpra) is inviting feedback on a draft Data strategy. The Data strategy will guide how we use the data that we collect and hold.

We are inviting responses to specific questions about the future use of this data and general comments on the draft Data strategy.

In addition to the Data strategy, we are consulting on the future directions for three key focus areas:

- the public register of health practitioners
- data sharing, and
- advanced analytics.

Please read the public consultation paper (including the draft Data strategy) before responding.

Q1.

Publication of responses

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- [ ] Please do **not** publish my responses

Q3.

Questions

If you have any questions, please contact Ahpra's Strategy and Policy Directorate by emailing AhpraConsultation@ahpra.gov.au.

Q39.

Acknowledgement of Country

Ahpra acknowledges the Traditional Owners of Country throughout Australia and their continuing connection to lands, waters and communities. We pay our respect to Aboriginal and Torres Strait Islander cultures and Elders past, present and emerging.

Q4.

Please click on the arrow below to start your submission.

Q5.

About your responses

Are you responding on behalf of an organisation?

- ○ Yes
- ◉ No

Q6.

Please provide the name of the organisation.

This question was not displayed to the respondent.

Q7.

Which of the following best describes your organisation?

This question was not displayed to the respondent.

Q8.

Which of the following best describes you?

- ○ I am a health practitioner
- ◉ I am a member of the community
- ○ I am an employer (of health practitioners)
- ○ Other - please describe below

Q9.

Which of the following health profession/s are you registered in, in Australia?
You may select more than one answer.

This question was not displayed to the respondent.

Q10.
Your contact details

Name:

[redacted]

Q11. Email address:

[redacted]

Q12.
Draft Data strategy

The draft Data strategy can be found on page 7 of the consultation paper.

Does the draft Data strategy cover the right issues?

No

Q13.
Do you think that anything should be added or removed from the draft Data strategy?

Yes. Doctors must be able to give information re the experimental jab that is not dictated to by corrupt AHPRA. True informed consent, the good and the bad.

Q14.
Focus area 1: The public register

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

- (●) Yes
- ( ) No

Q15.
Focus area 1: The public register

What additional information do you think should be included on the public register?

The names of AHPRA members opposed to freedom of speech from doctors that do not go with the narrative. AHPRA knows the truth and misinformation health agencies are giving.

Q16.
Please share your reasons

This question was not displayed to the respondent.

Q17.
Focus area 1: The public register

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

- (●) Yes
- ( ) No

Q18.
Focus area 1: The public register

How much detail (about a health practitioner's disciplinary history) should be included on the public register?

All history related to misconduct.

Q19.
Please share your reasons

This question was not displayed to the respondent.

Q20.
Focus area 1: The public register

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

- ( ) 0 to 1 year
- (●) 1 to 4 years
- ( ) 5 to 10 years
- ( ) 10 to 20 years
- ( ) As long as the practitioner is registered as a health practitioner
- ( ) Disciplinary history should not be published on the public register. Only current conditions or limits on practise should be published on the public register.
- ( ) Other, please describe

Q22.
Focus area 1: The public register

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

The public

Q23.

Focus area 1: The public register

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

Do not know

Q24.

Focus area 2: Data sharing

The Health Practitioner Regulation National Law enables us to share data with some other organisations in certain situations.

Do you have suggestions about how Ahpra could share data with and/or receive data from other organisations to benefit the public, practitioners and/or our regulatory work?

No

Q25.

Focus area 3: Advanced analytics

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

Stop relying on tech and listen to doctors speaking out.

Q26.

Other

Please describe anything else Ahpra should consider in developing the Data strategy.

Truth

Q1.

Consultation on a draft Data strategy

Thank you for taking time to respond to the consultation.

Introduction

The Australian Health Practitioner Regulation Agency (Ahpra) is inviting feedback on a draft Data strategy. The Data strategy will guide how we use the data that we collect and hold.

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- advanced analytics.

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Q3.

Questions

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Q39.

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Q4.

Please click on the arrow below to start your submission.

Q5.

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Are you responding on behalf of an organisation?

- ○ Yes
- ◉ No

Q6.

Please provide the name of the organisation.

This question was not displayed to the respondent.

Q7.

Which of the following best describes your organisation?

This question was not displayed to the respondent.

Q8.

Which of the following best describes you?

- ○ I am a health practitioner
- ◉ I am a member of the community
- ○ I am an employer (of health practitioners)
- ○ Other - please describe below

Q9.

Which of the following health profession/s are you registered in, in Australia?
You may select more than one answer.

This question was not displayed to the respondent.

Q10.
Your contact details

Name:

[redacted]

Q11. Email address:

[redacted]

Q12.
Draft Data strategy

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Does the draft Data strategy cover the right issues?

Q13.
Do you think that anything should be added or removed from the draft Data strategy?

The sex (not gender identity) of practitioners should be recorded as some people are traumatised -primarily women are traumatised by suffering male violence. People should be able To select a practitioner the basis of sex if needed.

Q14.
Focus area 1: The public register

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

- (●) Yes
- ( ) No

Q15.
Focus area 1: The public register

What additional information do you think should be included on the public register?

Number of complaints made against practitioner in the last 5 years. The nature of any disciplinary measures imposed on the practitioner since their registration.

Q16.
Please share your reasons

This question was not displayed to the respondent.

Q17.
Focus area 1: The public register

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

- (●) Yes
- ( ) No

Q18.
Focus area 1: The public register

How much detail (about a health practitioner's disciplinary history) should be included on the public register?

Nature of the offence committed, number of instances, duration of offending and sanctions imposed

Q19.
Please share your reasons

This question was not displayed to the respondent.

Q20.
Focus area 1: The public register

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

- ( ) 0 to 1 year
- ( ) 1 to 4 years
- ( ) 5 to 10 years
- ( ) 10 to 20 years
- (●) As long as the practitioner is registered as a health practitioner
- ( ) Disciplinary history should not be published on the public register. Only current conditions or limits on practise should be published on the public register.
- ( ) Other, please describe

Q22.
Focus area 1: The public register

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

Q23.

Focus area 1: The public register

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

The public register is limited by the efficacy of AHPRA's investigations. The extent of investigation for complaints unless someone is actually killed is limited to asking the practitioner or institution for comment and dismissing the complaint. Why bother trying to report incompetence and malpractice BEFORE it kills someone as nothing is done, patient concerns aren't taken seriously.

Q24.

Focus area 2: Data sharing

The Health Practitioner Regulation National Law enables us to share data with some other organisations in certain situations.

Do you have suggestions about how Ahpra could share data with and/or receive data from other organisations to benefit the public, practitioners and/or our regulatory work?

No

Q25.

Focus area 3: Advanced analytics

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

With great caution.

Q26.

Other

Please describe anything else Ahpra should consider in developing the Data strategy.

Privacy, data protection from hacking, adequately de-identifying data-with certain rare diseases if data is linked to a post code it is easy to tell who the person is.

Q1.

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Q4.

Please click on the arrow below to start your submission.

Q5.

About your responses

Are you responding on behalf of an organisation?

- ○ Yes
- ◉ No

Q6.

Please provide the name of the organisation.

This question was not displayed to the respondent.

Q7.

Which of the following best describes your organisation?

This question was not displayed to the respondent.

Q8.

Which of the following best describes you?

- ○ I am a health practitioner
- ◉ I am a member of the community
- ○ I am an employer (of health practitioners)
- ○ Other - please describe below

Q9.

Which of the following health profession/s are you registered in, in Australia?
You may select more than one answer.

This question was not displayed to the respondent.

Q10.
Your contact details

Name:

[redacted]

Q11. Email address:

[redacted]

Q12.
Draft Data strategy

The draft Data strategy can be found on page 7 of the consultation paper.

Does the draft Data strategy cover the right issues?

NO

Q13.
Do you think that anything should be added or removed from the draft Data strategy?

The strategy does not outline the arguments why change is necessary from the current situation.

Q14.
Focus area 1: The public register

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

- ○ Yes
- ◉ No

Q15.
Focus area 1: The public register

What additional information do you think should be included on the public register?

This question was not displayed to the respondent.

Q16.
Please share your reasons

The current strategy is sufficient to protect the public. Further information would have to be at the discretion of AHPRA who have been shown they cannot be trusted to be impartial. Stricter rather than less stringent policy is needed to protect the public and practitioners from AHPRA. It is not the role of AHPRA or the register to advocate or seem to advocate for one health practitioner over another. The register is not a marketing or advertising tool. If the Board has deemed that a practitioner is no longer a risk to the public, there is no longer any need to warn the public of that risk.

Q17.
Focus area 1: The public register

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

- ○ Yes
- ◉ No

Q18.
Focus area 1: The public register

How much detail (about a health practitioner's disciplinary history) should be included on the public register?

This question was not displayed to the respondent.

Q19.
Please share your reasons

Once the Board has deemed that a practitioner is no longer a risk to the public there is no statutory reason for the information to be published on the register. To do so suggests the practitioner is in some way still a risk to the public or that the Board is not correct in its decision to remove restrictions. AHPRA have been shown to have tried to mislead the Boards in their decision making and so the decisions may not have been legitimately proven. Immediate action does not require the same degree of evidence as a finding and may be quite incorrect. To publish incorrect or misleading information is not fair to the public or the practitioner. It is not up to the Board or AHPRA to advocate for or against a practitioner. It is reasonable however to publish current restrictions that the Board has imposed if the practitioner has been found to be a significant risk to the public and the public needs to be protected from the practitioner by the current restrictions. That is currently the case and does not need to be changed.

Q20.
Focus area 1: The public register

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

- ○ 0 to 1 year
- ○ 1 to 4 years
- ○ 5 to 10 years
- ○ 10 to 20 years
- ○ As long as the practitioner is registered as a health practitioner
- ◉ Disciplinary history should not be published on the public register. Only current conditions or limits on practise should be published on the public register.

◯ Other, please describe

Q22.

Focus area 1: The public register

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

Only the Board should be allowed to decide what is to be published. It is the responsibility of the Board and not AHPRA to decide the requirements for registration, who is to be registered, whether restrictions are required to protect the public, and to oversee the investigation and management of health practitioners. AHPRA only has the power to act under the Board's guidance under the National Law.

Q23.

Focus area 1: The public register

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

The register is to provide the public with a list of practitioners that the Board has deemed are suitable for registration. The information has to be able to identify that practitioner from others and must be easily accessible. The presence of the practitioner on the register is to provide the public with the expectation that the Board has deemed that practitioner fit to practice and not of any significant risk to the public. Restrictions imposed by the Board to protect the public from significant risk ensures the public can be reassured that the practitioner is still registered but has to comply with the restrictions to be deemed by the Board to be safe to practice. These principles are itemised in the National Law and forms eh current policy. No change is needed to protect the public.

Q24.

Focus area 2: Data sharing

The Health Practitioner Regulation National Law enables us to share data with some other organisations in certain situations.

Do you have suggestions about how Ahpra could share data with and/or receive data from other organisations to benefit the public, practitioners and/or our regulatory work?

Sharing pooled, non-identifiable data is own the best interests of the practitioners and the public. The current policy of sharing of pooled data that does not identify individual practitioners does not need to be changed. Sharing a practitioner's individual details to enable third parties to identify that practitioner without his or her permission is not in keeping with Human Rights and Freedom of Information Laws. AHPRA , the Board and the register cannot be used to advocate for one practitioner over another. If the practitioner does not give consent to share the practitioner's personal information, applications can be made under the Freedom of Information Act if required. AHPRA have been shown to have taken measures to deliberately mislead the Boards and the Courts. Information held by AHPRA about an individual practitioner must be allowed to be accessed by that practitioner to ensure that the information kept by AHPRA is correct. Currently this can only be done through a Freedom of information application and those applications are in general deliberately obstructed by AHPRA. The current policy of sharing personal information about a practitioner with third parties such as Courts or other regulatory bodies is reasonable and does not need to change.

Q25.

Focus area 3: Advanced analytics

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

Analytics are only as good as the data collected. AHPRA have been shown to have manipulated information and distorted information to advance their own cause. AHPRA cannot be trusted to input all data that is accurate and verified. Pooled data must not be able to be used to identify individual practitioners nor used as anything but a generalisation. To ensure the public is not misled, the limits of the data collection, the analytics used, and the inferences drawn must be made public with every piece of data presented to the public. To ensure data is being used appropriately, any use of an individual practitioner's information must first be approved by the practitioner(s) involved and any use of pooled data should have been approved by all practitioners whose data has been used.

Q26.

Other

Please describe anything else Ahpra should consider in developing the Data strategy.

The primacy of protection of the public must be the determining factor in any deliberation to change policy. If the protection of the public is not enhanced no changes to policies should ensue. It is becoming more obvious to the public and practitioners alike that AHPRA is seeking to extend its power in ways that not necessarily result in an improvement of the protection of the public. Changes should only be made if there is a significant and proven (not hypothetical) benefit to the protection of the public.

Public consultation on Ahpra's Draft Data Strategy:

A community perspective

Context

As a member of the public who has spent over a decade supporting survivors of harm in healthcare, I make this submission to provide a community perspective on components of the public consultation into Ahpra's draft Data Strategy.

Focus area 1: the public register

The below response addresses question 4 and 5.

What should be on the register, and for how long?

Disciplinary history (other than components specifically relating only to practitioner health) should appear on the public register indefinitely. It should take the form of a description of the nature of the conduct or performance concerns, and the type of disciplinary action taken in response (of all types – including cautions and reprimands), including any history of non-compliance with conditions. It is appropriate that past disciplinary action and current disciplinary action be distinguished, but both should be given equal prominence.

This approach will allow users of the register to understand where the areas of potential concern in a practitioner's conduct and/or performance are, and determine for themselves the likelihood that the regulatory action taken has meaningfully rectified these issues to achieve an acceptable level of safety from that persons' perspective.

Publishing disciplinary history and the draft data strategy

The data strategy refers to the National Scheme's desire to trusted, and to have a good reputation among the public. The surest way to be trusted is to be trustworthy. Indeed, trust without trustworthiness is a dangerous thing. This very notion is at the centre of why non-publication of practitioners' disciplinary history is so problematic. Publishing a 'clean' record for a practitioner with a potentially extensive disciplinary history may lead patients to trust practitioners who are not, for them, trustworthy. And it asks patients to trust in a system of regulation that is not, to them, trustworthy, because it withholds crucial safety information. To be trustworthy, and thus trusted, the National Scheme must begin to truly prioritise public protection and publish practitioners' disciplinary histories.

Precedents and norms in wider society

A key justification for publishing disciplinary history on the public register is that past conduct/performance is a relevant consideration in determining the risk of future conduct/performance. This is true even after other the formal consequences of the past conduct/performance, such as conditions, have ceased. Boards know and accept this – they take past conduct/performance concerns into account in making risk assessments. The public deserve the right to do the same.

Within Australian society we already have well-established and broadly accepted institutional structures that are founded on the principle of past behaviour as a factor in future behaviour. Furthermore, we have well-embedded institutional practices which recognise it is proper that certain conduct be made publicly known, or accessible to relevant parties seeking to use the services of individuals, long after other formal consequences for that conduct have ceased.

Examples of accepted institutional practices that meet both of these criteria include:

- Public registers of professional regulation and membership schemes – regulatory systems for other professions that publish outcomes of disciplinary and regulatory proceedings indefinitely on public registers (see below for specific examples).
- The National Personal Insolvency Index – a public register listing individuals who have been declared bankrupt. Entries are permanent, and not removed once the period of bankruptcy ends.
- Banned and Disqualified Director Register – a public register listing individuals who have been banned/disqualified by ASIC from acting as company directors and/or officers. Entries are permanent, and not removed once the period of ban/disqualification ends.
- Working with Children Checks – whereby people wishing to work or volunteer with children must submit to a history check which includes both criminal and non-criminal conduct relevant to working with children, be this current or historical (including, notably, compliance with health practitioner legislation).
- Criminal history checks – whereby people wishing to undertake various roles (including working and volunteering) must submit to a criminal history check which captures recent and historical offences, including those for which other formal sanction have been completed.

As per these examples and others, the idea that some forms of conduct necessarily and rightfully have a 'long shadow' in society is well accepted, and has been deemed necessary to public safety and societal functioning more broadly.

Precedents and best practice in professional regulation

Among other registered and/or regulated professions, indefinite and/or long-term public publication of disciplinary histories (including findings, cautions, reprimands, conditions etc) – including after matters or closed or conditions are met – is a well-established practice. Examples of professions in which this occurs include (note this list is far from exhaustive):

- Teachers (e.g. Victorian Institute of Teaching)
- Lawyers (e.g. Victorian Legal Services Board and Commissioner)
- Finance professionals such as registered liquidators (e.g. Australian Securities and Investments Commission)
- Company directors (e.g. Australian Securities and Investments Commission)
- Architects (e.g. Architects Registration Board of Victoria)
- Building industry professionals (e.g. Victorian Building Authority)
- Financial planners (e.g. Financial Planning Association of Australia)
- Accountants (e.g. Chartered Accountants Australia and New Zealand)

The weight given to practitioner's 'privacy', 'reputation' and 'career prospects' over public transparency in the regulation of health practitioners is an anomaly among registered and regulated professions, and inconsistent with best industry practice and community expectations.

Like health practitioner, members of the above professions (and other with such provisions) are trained professionals whose reputation is important to them and valuable to their careers, and whose professions enjoy privilege, status and implied trust from the public. That trust, privilege and status comes with responsibilities, and responsibilities come with accountability and consequences for breaches. With that in mind, regulators for each of these professions (and many others) have determined indefinite publication of this disciplinary information is, on balance, necessary and justifiable in the public interest, and to protect public safety. The National Scheme must do the same, especially given that the potential stakes of practice in health professions (including death and serious disability) are, overall, equal to or higher than those of the other professions listed above.

Precedents in the National Scheme

The principle that past conduct/performance is a relevant and reasonable consideration in determining the risks of future conduct – even after other the formal sanctions of that conduct have ceased – is already established in

practice in the National Scheme. First, the fact that past notifications/regulatory action are considered in risk assessment of practitioners necessarily relies on this concept. Second, and of particular pertinence to the issues at hand, this concept is well embedded, and widely accepted, in the practice of conducting criminal history checks.

Boards regularly consider past criminal history, including that with completed sanctions, in judging whether a practitioner is fit to practise. This is despite criminal history checks including information about past crimes for which all formal sanctions have been served, and a court has therefore deemed the person to have 'paid their dues to society'. The same is true of employers, who routinely make judgements about whether to employ a person based on criminal history, even where that conduct is historical. This is accepted practice.

An argument often made against publication of disciplinary history is that practitioners who have 'served their time' and been deemed 'safe' by an authority should be able to obscure this history in future on those grounds. Yet, it is notable a similar argument is not made against the use of criminal history checks within the scheme. This reflects an understanding in society that certain conduct speaks to character, judgement and morality that may influence future behaviour, and that it is justifiable and even ethically necessary to consider this in decision-making about installing individuals in high responsibility, high risk societal roles.

Different contexts, different thresholds

The National Scheme and society already accept that boards have the right to make their own decisions about the suitability of a person to practice a profession, even when another authority has decided the person has experienced sufficient consequences and/or has been sufficiently rehabilitated for the purposes with which that authority is concerned. This is because we accept that the thresholds of comfort may differ for parties with different contexts in mind. For example, law enforcement may find that sexual conduct between an adult patient and practitioner was consensual and thus not a crime. However, a board may still find the same conduct constitutes an abuse of power, and amounts to professional misconduct. In this example, a person can be deemed 'safe to not be in prison' by one party, but also 'not safe to be a health practitioner' by another party. Both can be true.

Likewise, a board may deem, based on their generalised threshold, that a person is 'safe to be registered'. This does not mean that they meet a patient's threshold of 'safe to treat me for childhood abuse trauma' or an employer's threshold of 'safe to work at our centre for vulnerable children'. For example, a board may consider a person suitable to practice as a psychologist in general after undertaking mentoring for sexually inappropriate behaviour. However, a person seeking treatment specifically for trauma resulting from rape may deem that psychologist is not a psychologically safe and appropriate practitioner for them specifically, given their circumstances.

It is a practical reality that boards make determinations about practitioners' safety and suitability to practice based on general, over-arching considerations. When a board grants registration, removes conditions etc, they determine that practitioners are safe to practice 'on balance'. They cannot be certain that practitioners will be safe to treat all patients of all circumstances. Likewise, it is not practical for boards to impose permanent, highly specific conditions that attempt to prevent practitioners providing services to individuals with highly specific vulnerabilities of relevance to a practitioner's history, especially where those vulnerabilities are not apparent 'on the face' (such as individuals who are specific kinds of sexuality diverse, have experienced institutional racism, or are survivors of stalking). In can be true that a practitioner is 'generally safe to be a health practitioner for most people', and at the same time, for example, 'not safe to treat patients with a history of asexual conversion practice trauma' due to their past involvement in such practices. Therefore, it is necessary that the public has access to information that supports them to decide for themselves if a practitioner is likely to unsafe for them specifically. That is, information about serious and high risk matters which is held, and currently obscured, by the regulatory whom the public have no choice but to rely on and trust.

To deny patients access to information about disciplinary history on the grounds that 'the board has already determined the practitioner is safe' is akin to denying boards (or employers) access to criminal history records on the grounds that 'a court has determined that these matters have been resolved'. Indeed, the present situation regarding the public register is actually worse than even this hypothetical. Because the register does not tell users that they are being denied access to past disciplinary history information. Instead, it simply present a 'clean'

registration record for a practitioner with significant past regulatory history, misleading the reader into believing the practitioner has no such history. This is akin to a police force providing the board with a criminal history transcript stating 'no relevant records', simply because sanctions for a string of serious criminal offences have been completed. Boards would deem such a situation unacceptable, and an obstruction to informed decision-making. The public likewise deems the present approach a misleading, paternalistic, and unacceptable.

Lack of evidence-based mitigation or behaviour change assurance

There is substantial empirical evidence that the types of conduct boards often address – such as gendered or domestic violence, sexual misconduct, threatening and intimidating behaviour, fraud and dishonesty, financial abuse, and exploitation of vulnerable individuals, have high rates of recurrence and recidivism, and low amenability to change. Indeed, research by Bismark et al. using the National Scheme's own data (and similar research from other jurisdictions and professions) has found past notifications/complaints/disciplinary action are the strongest predictor of future notifications/complaints/disciplinary action. In other words, past behaviour is, objectively, the strongest predictor of future behaviour, and disciplinary action is not guaranteed to mitigate this. To ignore this evidence is to place the public in peril.

Some argue the strong association between past negative behaviour and future behaviour is mitigated by regulatory action taken by the boards. Those who espouse this position justify not publishing disciplinary history on the grounds that it is rendered irrelevant by such interventions. On the contrary, there is insufficient evidence to reach this conclusion, and a wealth of evidence suggesting the contrary is true.

Boards use a variety of remedial methods to address conduct and performance issues – such as cautions, counselling, assessments, mentoring, supervision, education/training and personal reflections – for which there is limited or no evidence of efficacy. Particularly in matters of conduct. Furthermore, many types of remedial methods are primarily a 'box tick' exercise – in which the success of the method is determined based on activity (e.g. turning up to a training course), not demonstrable outcome (i.e. demonstrating true behaviour or competence change). Furthermore, many common methods of attempting to measure outcomes are either easily 'faked through' (e.g. personal reflections – which can also now be automatically generated in seconds with technology such as ChatGPT), or are highly subjective (e.g. mentoring/supervision reports from individual practitioners with no specific training in assessing other practitioners).

Despite the lack of definitive evidence, these methods of remediation are used as they are seen to strike a balance between allowing unacceptable conduct or performance to go unchecked (which would be unacceptable for public safety), or using suspension or deregistration without any lower-level intervention options (which would be excessive in some instances). An examination of more evidence-based approaches to regulation is beyond the scope of this consultation and submission. However, in the absence of definitive empirical evidence or more evidence-based methods, we must accept that reasonable people can disagree about the efficacy of methods boards presently use in attempting to return practitioners to safe practice, and subsequently, in assessing their safety to practice.

While a board may judge a practitioner safe to practice following, for example, completion of conditions, a reasonable member of the public may disagree, with or without specific note to their personal circumstances or vulnerabilities. It is not unreasonable for a patient to doubt, for example, that a practitioner's lifetime of misogynistic attitudes has been remedied by sitting through a training course and submitting a 'reflection' written for them by ChatGPT. A long and often inglorious history of recurrent poor conduct and performance by practitioners who have completed previous regulatory conditions, alongside empirical evidence about the challenges of recurrence, recidivism and behaviour change, supports such assessments by members of the public as rational and proportionate. It is only right that members of the public have access to the necessary information about the conduct or performance matters that led to disciplinary action, and the type of remedial action taken, to determine for themselves whether a practitioner's conduct is likely to have been sufficiently remedied to assure their individual safety.

Choice, accountability and the inherent requirements of being a health practitioner

The National Scheme is required by law to treat public safety as its first and most important priority. In this way, public safety matters more than a practitioner's desire for an untarnished reputation or career following seriously deficient conduct or performance. Opponents of publishing disciplinary history often claim that this practice amounts somehow to 'discrimination'. However, when practitioner health matters are excluded, this is a blatant abuse of the concept of discrimination. In law and ethics, discrimination protections are in place to protect people from unjust negative treatment by others specifically and only based on characteristics over which they have no control (e.g. sex, age, race), and/or which are not justifiably relevant to the circumstances (e.g. a restaurant refusing to serve a same-sex couple because of their relationship). However, the concept of discrimination, and Australian laws against it, have always recognised that consideration of personal characteristics, and differential treatment based on these, is ethical and lawful when characteristics are inherently relevant to the circumstances. Especially where those characteristics represent conscious choices (e.g. people denied a customer service job due to racist face tattoos), or are demonstrably relevant to the circumstances and inherent requirements of a role (e.g. barring a person who is blind from being a commercial pilot).

When practitioner health matters are excluded from publication, remaining disciplinary history reflects wither choices made by practitioners (conduct) or their ability to meet the inherent requirements of their profession (performance). Therefore, their actions and their consequences do not qualify for anti-discrimination protection on the grounds of being unchosen characteristic, or irrelevant to the context. Therefore, publishing disciplinary action that flows from these actions is not 'discrimination', but a relevant and proportionate consequence necessary to public protection.

While practitioner make choices that create disciplinary scenarios, the public, in many instances, have little choice in finding themselves in need of the services of a health practitioner. In these scenarios, the burden of risk and consequences must fall on the party most responsible for the risk, and the priority for protection on the party most at risk. Therefore, on balance, we must support the needs of the not-at-fault and most-at-risk party (member of the public) over those of the party whose poor choices or substandard practice created that risk (a practitioner with disciplinary history).

As in the examples above, all members of society face the possibility of having records of certain actions or capacity shortcomings 'attached' to their identity for life. This is part of a functioning civil society. And health practitioners, who enjoy exceptional levels of status and public trust in their roles in exchange for the promise of integrity, morality and competence, are no exception. Breaching this social contract is a serious matter, which calls for a response conducive to its gravity.

Preventing real risks and harm to public

The harm done to the public, particularly patients, by not publishing disciplinary history on the register is real, serious and multi-faceted. On the contrary, publication of this information will have many benefits for public safety.

General deterrence

Long term or permanent publication of disciplinary action on the register will act as a general deterrent – a recognised principle in the Australian justice system and behaviour change practice. Practitioners are less likely to choose misconduct, or to persist in poor performance, if they know that resulting disciplinary action will remain on the register long term, or permanently.

Early intervention and prevention

It has been well demonstrated that due to various cultural, practical and administrative barriers, regulatory action often comes very late in the period of a practitioner's problematic conduct or performance. Often not occurring until a great deal of damage has been done to many people. Combining this with high rates of recidivism/recurrence, and publication of disciplinary history has an obvious public protection benefit. If employers, colleagues and patients are able to know that a practitioner has engaged in particular types of problematic conduct or practice in the past, they will be better able to watch out for early signs of recurrence (for example, signs of professional boundaries being blurred, or signs of unsafe practice). This will allow them to act quickly to protect themselves (if they are a patient), prevent or stop the problem, and report it if necessary.

The key pillar of the National Scheme monitoring the safety of practitioners, and the effectiveness of disciplinary action imposed upon them in the past, is effective 'eyes on the ground' around them (including employers, educators, colleagues and patients). Publishing disciplinary history improves this method of assurance by informing those around the practitioner about areas of potential concern. It also has a side benefit of supporting the scheme to gather evidence about which disciplinary actions are effective, and which are not, by improving detection of recurrence or problematic conduct and performance.

Specific deterrence

Following on from early intervention and prevention, long term or permanent publication of disciplinary action on the register will act as a specific deterrent to the individual practitioner to whom it relates. When a practitioner knows that employers, colleagues and the public are aware they have engaged in certain problematic conduct or performance in the past (for example fraud, or a specific unsafe clinical practice), they will know these parties are more likely to notice if these patterns recur, and more likely to report them. This will make the practitioner less likely to engage in this behaviour in future.

Protecting patients from direct clinical harm

Not publishing disciplinary history on the register places members of the public at increased risk of harm from recurrence of past conduct or performance problems. Not providing the public with the regulatory information they need to inform their decisions about managing and reducing such risks is unacceptable.

Consider, for example, a patient seeking treatment for prescription drug addiction from a GP, where that GP has a disciplinary history relating to inappropriate prescribing of that same medication. Without awareness of this disciplinary history, the patient is not given the necessary information to decide whether they feel safe being treated by somebody who has a history of enabling the very behaviour they are seeking to stop. Such a situation places both the practitioner and the patient at risk. In another example, consider a person with a connective tissue disorder seeking treatment from a physiotherapist. Due to their connective tissue disorder, they are extremely prone to spinal injury when their body is manipulated in ways that may be harmless to most people. The physiotherapist was subject to a one-day education course about spinal manipulation after causing spinal injury to another patient due to serious deficiencies in this skill. Without knowledge of that history, the patient cannot make an informed decision about whether to see this practitioner with their specific vulnerability, and is unknowingly placing themselves at increased risk of a life-changing injury.

Protecting patients from intolerable, unconsented vulnerability

The interpersonal vulnerability patients experience when placing their lives, bodies and minds into the hands of health practitioners is rarely matched elsewhere in the routines of society. This comes with an extreme vulnerability to all kinds of harm, should a practitioner choose to inflict it, or not have the insight to refrain from inflicting it. This harm spans the full spectrum of possibilities – physical, psychological, social, legal, financial, occupational, environmental etc. This harm can ruin patients' lives, and end patients' lives. When individuals either inflict this harm, or act in a way that creates an unacceptable risk of it occurring, it is a serious breach of the privileged social contract health practitioners enjoy, and the trust that entails. To breach this social contract is a grave matter indeed, which often speaks deeply to the character and/or capacity of the person who does so. The vulnerability of being a patient is taxing enough, without discovering that the person to whom you became so vulnerable posed an intolerable risk to you, which was known to others, who chose not to warn you.

Presently, members of the public can and do sometimes find out about practitioners' disciplinary histories through means other than the public register, often after having been treated by them. For example, they may find out via mainstream media, word of mouth (e.g. small community grapevine), unofficial online sources (e.g. social media), professional roles, or – in arguably the worst case scenario – when subsequence legal or regulatory action occurs due to recurrence of conduct or performance concerns.

For members of the public, to find out that a practitioner they have been treated by had a serious history of either morally objectionable conduct or unsafe practice can be, and often is, psychologically devastating. Even when that person does not themselves specifically experience the heights of the conduct or unsafe practice that led to the disciplinary history – but especially if they do. To know that an authority knew the crucial risk information and did not share it in the interests of public protection only compounds the harrowing experience of betrayal and often

despair that comes with being harmed in healthcare. To have intolerable, unconsented vulnerability knowingly thrust upon oneself by 'the authorities' is an unbearable event for those who experience it, and an appalling risk to every person in Australia – any of whom may experience it in future if regulatory practice remains unchanged.

A sexual abuse survivor who finds out after years of treatment that their psychologist has a long disciplinary history of sexual misconduct matters and conditions when the psychologist is arrested for sexual assault. An Aboriginal person who finds out via a yarning circle the GP treating their adolescent son was previously subject to a reprimand for racist online abusive tirades towards Aboriginal people. A gay man who finds out from a conversion therapy survivor organisation that the nurse at a sexual health clinic he visits had previous restrictive conditions for engaging in abusive attempted 'sexuality conversion' practices. For members of the public in these and innumerable other scenarios, the harm done by disciplinary history erasure is serious and potentially life-changing. They pay the price in psychological distress and trauma. For a person to know they bared their or their dependent's body, mind and life to a person who was known by authorities to be not worthy (in their eyes) of the trust this entails, is harrowing. Where their connection with the practitioner is known to others (for example, they recommended the person to their friends) this can bring additional psychological harm, such as guilt and shame, as well as practical harm (such as breakdown of relationships and being blamed by others).

The experience of discovering when has been subjected to intolerable, unconsented vulnerability is sickening – both figuratively and often literally. This is because such experiences so often lead to a total breakdown of trust in healthcare and health practitioners, with far reaching secondary harms for physical and mental health. For example, not seeking care, not trusting health advice, or seeking advice from non-qualified individuals, and all the harms that come with these. A loss of psychological safety in care is a first step in what can be a rapid and agonising descent into serious multi-faceted harm for members of the public.

The greatest of all harms comes when the experience of intolerable, unconsented vulnerability meets direct harm. When a person is directly harmed by a practitioner, only to learn that at the time the harm occurred, the practitioner had past disciplinary history relevant to the subsequent harmful events, and this was withheld from the patient by the regulator when they sought information about the practitioner. Instances like this tear at the heart not only of that individual's sense of safety, but that of the public at large.

It is morally unacceptable for the National Scheme to knowingly place the public at risk of such trauma by withholding information about the disciplinary histories of practitioners – which reflect conduct and performance concerns of the highest order. It is utterly inconsistent with public expectations. It also undermines informed consent – a pillar of ethics and law in the healthcare system.

Safety for victims and survivors of harm in healthcare

Research continues to find high rates of patient experiences of serious harm at the hands of health practitioners – such as disregard for consent and bodily autonomy, clinical gaslighting, discrimination (including racism, sexism and anti-LGBTIQA+ bias), punitive withdrawal or withholding of symptom relief, dereliction of duty of care, and abuse of power. Examples such as widespread obstetric violence, and legal threats against cosmetic surgery patients who report concerns, are just two in a myriad of examples. Unfortunately, harm from poor clinical performance is also common, to the point of ubiquitous. Add this to high rates of clinical error, misdiagnosis and other clinical care harm, and the inescapable reality is that a substantial proportion of members of the public are survivors of harm in healthcare in one form or another. Accounting for their families and social circles, millions of people are affected by the ripple effects of harm in healthcare. These are the individuals to whom the National Scheme owes a special duty of care. These individuals are at especially high risk of serious harm even just from knowing that disciplinary histories are not published, much less if they find out after the fact that they were unknowingly treated by a person with disciplinary history.

The mental health of these people – the innocent victims – matters. Their sense of safety and security in healthcare matters. Their sense of empowerment over their healthcare choices matters. Their sense of justice. Their belief that, if only one good thing comes out of the tragedy and suffering they have endured, it is that others will be protected, at least by forewarning. Their sense that the harm experienced by them and their loved ones is worthy of acknowledgement. It is vital that when they must again put their bodies, minds and live in the hands of the system that so devastatingly let them down, they have as much information as possible to make an informed choice. To reduce the change of another devastating trauma, or worse.

When victims of harm in healthcare and those connected to them watch the disciplinary history of the person who harmed them disappear from the register without a trace, their trust in healthcare is irreparably damaged. They cannot help but wonder – what if that next practitioner they see also has a history like the one who harmed them? They learn, to their endless anxiety, that they have no way of knowing. That the information they need to make an informed decision is being kept from them. They tell their friends and family. Resulting in a compounding erosive effect on public trust. These people lose whatever trust in healthcare they had left, and often turn away from it. The National Scheme speaks of 'returning practitioners to safe practice'. But what of returning victim-survivors to safely receiving care? It is wrong to prioritise the former at the expense of the latter. For the majority of practitioners who are subject to disciplinary action, that action has an end date, as does the public publication of that action. They are granted the opportunity to 'move on' unhindered, under the guise that it is a 'right'. The suffering of victims, survivors and their loved ones doesn't have an end date. What of their right to psychological safety in accessing healthcare?

Strengthening public trust

The above reasoning applies not only to patients directly involved with practitioners with disciplinary histories, but to the public more broadly. Members of the public who know how the present system operates are rightly critical of the National Scheme for not using the disciplinary history information it has to its full protective effect. As noted at the outset of this submission, the only way for an institution to be trusted is to be trustworthy. The current practice of presenting a 'clean' registration record for practitioners with serious disciplinary histories means that to the public, the National Scheme is not trustworthy. This is in turn reduces public trust in health practitioners and healthcare in general, and brings with it all the associated harm.

It is an uncomfortable reality that, over its lifetime, the National Scheme has failed many survivors of harm in healthcare. There is a need for reckoning by the National Scheme about the mistakes of its past, and its present. For example, the National Scheme has left in its wake a trail of traumatised survivors of assault in healthcare – mostly women – whose assaults were normalised and minimised, and not acknowledged for the offences that they were. Failing to apply contemporary notions of consent, and not recognising that assault in clinical practice is indeed assault, has left a large cohort of survivors who feel dehumanised, invalidated, traumatised and even feeling blamed for assaults inflicted upon them by practitioners. And practitioners emboldened to repeat the behaviour. These survivors, and others, must live with the consequences of these experiences their entire lives, and are incredulous that, through erasure of their disciplinary history, offending practitioners do not. If the National Scheme ignores the legacy and lessons of such systemic regulatory failures, the resulting widespread harm, and the gulf between some professions' cultures and wider public norms, it imperils itself and the public. One thing the National Scheme can do to heal the harms of the past, and ensure it does not repeat these mistakes in future, is to improve transparency through publishing disciplinary history. Not least because it will allow survivors to reduce the risk of encountering another person inclined to the traumatic conduct they were subject to in the past.

The National Scheme must also heed research evidence that has repeatedly found the primary goal of members of the public in making complaints or raising concerns about health practitioners is to protect others from enduring similar harmful experiences. It is notable therefore that both the public and the National Scheme (under law) have the same primary goal – to protect the public. It is therefore part of National Scheme's social contract with the public to do whatever it reasonably can to use the information it receives, much of it provided by members of the public for the express purpose of public protection, to achieve that purpose. That includes using that information to protect the public not just for a short time, but in perpetuity.

The mental health equation

The mental health of all people matters. There are times, however, when there is unavoidable tension between what would serve the mental health of one person, and what would serve the mental health of others. In such situations we must make decisions about what is fair and just, accounting for factors such as the moral and practical accountability of the various parties, their relative vulnerability, and the magnitude of harm caused by one course of action or another (including how many people will likely be harmed by each course of action). In discussions about the mental health impacts of publishing disciplinary history on the public register, the mental health safety of the public, particularly survivors of harm in healthcare, is rarely mentioned. Yet, in line with the primacy of public protection – by which the National Scheme must abide – it should be the foremost consideration.

Not publishing a practitioners' disciplinary action on the public register may have a protective effect solely on their mental health as the individual responsible ultimately for necessitating that disciplinary action. But they are protected at the expense of countless others, including notifiers, innocent past victims/survivors they have harmed, innocent future victims/survivors they may harm in future, innocent patients lured into intolerable and unconsented vulnerability in future by the false promise of a 'clean' register entry in future, and the public at large whose trust in healthcare is compromised.

Protection experienced as punishment

Opponents of publishing disciplinary history often argue this practice is 'punitive'. However, protective actions often also perceived as punitive by those who are the subject of them. The two are not mutually exclusive. A consequence that is experienced as punitive is still justifiable if it serves a protective function. There is nothing in the law or the current regulatory principles which renders any regulatory action or consequence invalid merely by virtue of the fact it is experienced as punitive. At most, there is a general acceptance that disciplinary actions should not be *solely* punitive, but must have a feasible protective purpose. With changes to the regulatory principles, and recent legislative change, the National Scheme has moved away from aiming for 'minimum necessary' action, to instead prioritising actions necessary to protect the public, first and foremost. As outlined above, publishing disciplinary history on the register has multiple potential protective purposes, rendering it justifiable even if practitioners experience it as punitive. The need for public safety outweighs practitioners' desire to be severed from serious problems with their conduct and performance.

Focus area 3: advanced analytics

The below response addresses question 9.

Position

I do not support the use of advanced analytics in triaging or assessing notifications under any circumstances. Key reasons this would be an inappropriate development are described below.

Perpetuating past mistakes

Research on National Scheme data shows that there is an imbalance in which types of notification issue types are likely to result in regulatory action, and this imbalance is not wholly explained by the burden of risk various issues pose to the public. Factors such as how 'provable' certain types of allegations are, how 'scandalous' they seem, how likely they are to receive media or political attention, the type of notifiers likely to make them (i.e. patients versus other practitioners), cultural hesitancy among certain professions to 'interfere' in more 'clinical' matters, and the amenability of certain issues to existing condition types, among other considerations not commensurate with public risk, all appear to play a role in these imbalances. This has resulted, for example, in under-regulation by some boards of clinical practice and performance concerns (often under the guise of 'respecting clinical judgement'), with an excessive focus instead on a limited set of misconduct categories.

People within the National Scheme often erroneously assume that the historical likelihood of notifications resulting in regulatory action, is synonymous with, or at least a proxy for, the level of risk the issues raised in such notifications pose to the public. That is, that if a certain type of notification hasn't often resulted in regulatory action in the past, that the issues raised in such notifications, by that fact alone, do not pose substantial risks to the public. This is simply not the case. Due to the above-described imbalance in how the scheme has responded to certain types of notifications, some high-risk matters – those involving cosmetic surgery being a pertinent example – have attracted a far lower regulatory response than was appropriate, for reasons not related to the level of public risk. The way the current risk-based regulation approach is constructed, this led them to be seen as 'low risk', when really they were simply under-addressed. When we tell people, or technology, to deprioritise what has been deprioritised in the past, we compound those practices, and create situations where we cannot correct past mistakes, change or improve or future prioritisations.

A system of data analytics designed to assess the 'risk' of notifications based on whether notifications superficially similar to a current one have resulted in regulatory action in the past, it will make the same false equivalency error.

It is hard to imagine a system of any meaningful utility that will not be given such a programming instruction. Such a system will perpetuate and compound the under-prioritisation and under-regulation of certain issues under the National Scheme, compounding public harm. This will stymy the National Scheme's ability to address these past shortcomings, as well as to change with shifting social expectations in future. The use of AI in assessment of notifications is a short-cut to entrenching past mistakes, and preventing future improvements. And regardless of assurances that humans will make final decisions, especially in an environment of high workloads, evidence that humans learn to rely excessively on the determinations of 'automation' is abundant and compelling.

The risk of inequitable prioritisation of notifications

'Key word' analytics, if used in notifications, will promote harmful inequities in how notifications are prioritised. It will tend to prioritise notifications from individuals who use key words and phrases of significance in health and regulation. These people are more likely to be of certain demographics, such as professionals (especially practitioner and lawyers), people with higher levels of formal education, people with high literacy, and people for whom English is a first language. Consequently, the system will, even if unintentionally, deprioritise notification from people less inclined to use key words, or to write in a typical 'professional' style. For example, people who have lower formal education, lower literacy, certain disabilities, a first language other than English, or unfamiliarity with healthcare, legal and regulatory words. A system which, even if unintentionally, deprioritises notifications from certain vulnerable groups risks increasing inequities of risk experienced by these groups, and compounding existing harmful biases in which notification issue types tend to result in regulatory action, independent of risk to the public.

The importance of humanity

Recent years have seen hard-won gains in bringing more of a humanity-based approach into the processes of the National Scheme. These reforms were necessary for all parties. A swing back towards using technology to do what is deeply human work will – figuratively and literally – be a step towards ripping humanity back out of the National Scheme.