MEDICAL PRACTITIONERS BILL 2006

Second Reading

Resumed from 10 April.

HON GIZ WATSON (North Metropolitan) [7.30 pm]: I thank my colleague Hon Paul Llewellyn for suspending the debate on the Medical Practitioners Bill as I was not in the chamber the last time this was debated. I wish to make a few comments about this bill on behalf of the Greens (WA). By and large, the Greens are supportive of this bill. The bill repeals the Medical Act 1894, which I think Hon Helen Morton said was one of the oldest acts on the statute book in Western Australia.

Hon Barry House interjected.

Hon GIZ WATSON: I thought someone might have said something. Just keep it down to a dull roar over there and I will be all right!

This bill is certainly welcome. I understand that it has been in development for a long time and that it has a lot of support. I am aware that the Health Consumers' Council WA has advocated strongly for a major shake-up of the law in this area. Therefore, we welcome this bill and in large part support it. We note that the bill has an objects clause, which provides —

> The objects of this Act are —
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> (a) to ensure that only properly qualified and competent persons practise medicine and to regulate the practice of medicine by those persons; and
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> (b) to establish, maintain and promote suitable standards of knowledge and skills among medical practitioners,
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> for the purpose of protecting consumers of medical services provided by medical practitioners in Western Australia.

By and large, the bill contains appropriate mechanisms to ensure that those objectives are achieved. These mechanisms include a system for the registration of medical practitioners; a system to deal with complaints concerning disciplinary, competency and impairment matters; offence provisions, including a new offence that will apply when a medical practitioner receives a payment or other benefit in return for referring a patient to another health service provider; and provision for a code of practice for medical practitioners. The bill is certainly an improvement on the Medical Act 1894 in a number of respects. The bill will increase consumer representation on the Medical Board of WA from one member to two members and will put in place separate processes for dealing with disciplinary, competence and impairment matters. Instead of the current vague reference in the act to "infamous or improper conduct", the bill spells out the grounds for complaints against medical practitioners more fully and in much more contemporary language. The bill will also put in place new offence provisions aimed at preventing the pressures and incentives of corporate medicine from interfering with good medical practice. All these changes are welcome.

The Greens have some issues with this bill, which I will outline. The first is whether there will be any implications for this legislation of a proposed national registration scheme. I seek clarification from the minister representing the Minister for Health on the implications of the agreement reached at the Council of Australian Governments meeting on 26 March 2008 to establish a national registration and accreditation scheme for health practitioners. I note again that Hon Helen Morton mentioned this matter in her contribution to the debate. There is a real danger that the bill is about to be overtaken by a national initiative and I am not sure what the impact of that will be. I ask the minister: what will be the impact on this bill, assuming it becomes law, if the COAG agreement to establish a national registration and accreditation scheme comes into force? I understand that the Minister for Health has given his support to the national scheme. In particular, is it correct that a national registration scheme for health practitioners is to be established on 1 July 2010 and that, as a result, the act created by this bill will be repealed some two years after it has been enacted? It seems to be a helluva lot of work to undertake if the legislation will be in operation for only a couple of years. A lot of work has gone into forming this new piece of legislation. I am sure the minister will respond to that question, because it is a fundamental issue in determining why we should bother having this debate if another process will possibly override what we are doing.

My second point concerns the registration requirements for overseas-trained doctors in remote and rural Australia. Clause 33 provides for conditional registration for general practice in remote and rural Western Australia. Under this clause, some of the normal requirements for the registration of medical practitioners will not apply, including the requirement to have a recognised medical qualification and to have successfully completed a period of internship or supervised clinical practice approved by the Medical Board. Instead, there is

a general requirement that the applicant be competent, having regard to the person's qualifications and experience, to practise as a general practitioner in this state. Clearly, there is a problem with attracting doctors to remote and regional areas—I am not denying that for a moment—but should we address this problem by lowering standards for medical practitioners who work in these areas, particularly given the lack of supervision likely to be available in remote areas? Surely it would be possible, with appropriate incentives, to attract doctors who have recognised medical qualifications and who have successfully completed a period of supervised practice. According to an article published in 2004, overseas-trained doctors who wish to practise in Canada and the United States must first undertake a period of supervised hospital practice. I will refer to the article, because this is a fairly fundamental question. The article, written by Bob Birrell, is entitled "The regulation of medical practice in Australia, Canada, United States and Britain" and was published in *People and Place*, volume 12, number 3, 2004, Centre for Population and Urban Research, Monash University. The précis to the article states —

> *Overseas trained doctors (OTDs) are playing an important role as medical officers and specialists in the Australian public hospital system and as general practitioners in 'area of need' locations. This role is increasing as a result of the recruiting initiatives flowing from the Commonwealth Government's Strengthening Medicare program. Yet there are no requirements in Australia that these OTDs be first subject to a formal assessment of their medical knowledge, clinical skills and practice performance in a supervised hospital setting. A review of the situation in Canada, the United States and Britain shows that OTDs wishing to practise in these countries first have to undergo such an assessment. The reasons why Australia is different are explored. It is concluded that State and Commonwealth Government concerns about the supply of doctors have overridden worries within the medical profession about the readiness of OTDs to practice in Australia without formal assessment and further training.*

It is quite likely that the worries of the general community have been overridden as well as those specific to the medical profession. The article continues —

> . . . there are currently several thousand doctors working in the front line of Australia's public hospital system as junior doctors or specialists, or in general practice, who have been trained overseas and whose medical knowledge and clinical skills have not been formally assessed in Australia. Nor have they had to undergo a period of supervised hospital practice in Australia before practising as medical officers or specialists in the hospital system or as General Practitioners. Most are in Australia on temporary visas.

I might seek to table the article in a minute, but I will continue to quote from it at this point. As I understand it, overseas-trained doctors by and large historically came from the United Kingdom, so there was at least some assurance that their training was comparable, if not better, whereas the trend now is that overseas doctors come from a range of countries. The bulk of them, according to the statistics I have seen, still come from the United Kingdom, Ireland and Canada—English-speaking countries—but a significant number now come from a range of other countries. The question of competency in English is another component, especially in psychiatry I am told. The article concludes with the following comments, which I think are worth noting —

> All the medical authorities with whom this issue was discussed agree that the present situation regarding the assessment of OTDs is unsatisfactory. All agreed, that as a minimum, there should be a formal assessment of the English language and the medical and clinical knowledge of OTDs before they are allowed to practise in Australia. The existing arrangements arose out of a longstanding practice of drawing on British-trained doctors to fill temporary gaps in the Australian medical workforce. But as all the major players with a role in the regulatory system know, this comfortable arrangement no longer works. This is because of the recruitment of OTDs trained in non-western medical schools, where the standards of the training and their relevance to clinical practice in Australia are highly variable. That is why there is universal agreement that a formal assessment system should be introduced.

Bob Birrell goes on to write —

> It is not as though there are not firm precedents in place, as the commentary on the situation in Canada, the United States and the United Kingdom cited above show. Australia needs a similar national scheme of assessment. It should be a national system because current experience shows that the states will not act unilaterally as long as they fear that other states are likely to drag their feet. A national system would also remove the present anomaly that an OTD assessed as inadequate in one state can simply apply in another. This assessment system should include a period of supervised hospital practice (as in Canada, and the United States). All informants agree that the reviews of OTD CVs, along with computer based medical and clinical knowledge tests, are an unreliable guide to a doctor's ability to deal successfully with Australian patients. A supervised period of hospital practice as an intern is

> required of Australian-trained graduates. This is also required of OTDs who complete the AMC examinations. The case for including such an assessment period for other OTDs is even stronger given the uncertainties about their medical knowledge and experience.

In summary on this aspect of the bill, it is of concern to me, the Greens and those I have consulted that we are enshrining in legislation a dual system of standards for medical practitioners in Western Australia. I reiterate that I am not without enormous sympathy for the difficulties of attracting suitably trained and qualified doctors into remote and rural areas. I might add at this point that my father spent much of his medical career working on exactly this issue of getting doctors into remote and rural areas all around Australia. From the discussions I have had on the bill with the advisers, I am yet to be convinced that any of the supervisory provisions for remote and rural doctors are at all adequate. Unless the minister can indicate otherwise, I do not think there is any regular, systematic process of assessing the practise, competency and skill levels of remote and rural practitioners operating in Western Australia at this time. If there is, I would love to hear about it because everything that I have tried to research on this does not seem to satisfy those questions.

Hon Helen Morton: Are you talking about general practitioners in private practice?

Hon GIZ WATSON: I am talking about general practitioners in particular in practice in remote and rural areas. I am aware that in some regions there is a process of accreditation of practices.

Hon Sue Ellery interjected.

Hon GIZ WATSON: Yes, there is a system of accreditation there. I have taken some advice on what questions those doctors get asked. My impression is that by and large the line of questioning is about business competence rather than practise competence, and whether they have viable practices rather than their medical practice. It is interesting because the people who are asking the questions are other doctors. Doctors are very reluctant to challenge directly the medical competence of other doctors. It is almost a taboo area. Perhaps the minister can offer some assurance in this area, but at the moment I am concerned. I am not suggesting that we will vote against this clause or anything like that, but it adds weight to the argument of those rural and regional Western Australians who say that they are getting a second rate service because with this two-tier system we will be enshrining that in law.

The next issue I want to talk about is gifts and other benefits given to doctors by pharmaceutical companies. Under the current system there are two sources of control on the interaction between pharmaceutical companies and doctors. First, a voluntary code has been adopted by Medicines Australia, which is the national association representing the pharmaceutical industry. This code places some restrictions on gifts and other benefits to health care professionals but still allows brand-name reminders of token value, prizes in competitions that are of low monetary value or an item of educational material, and meals at educational events that are not extravagant or exceed standards that would meet professional and community scrutiny. Perhaps what a medico might think was an extravagant meal might be a lot more extravagant than the average person might think, I am sure; it is a fairly relative concept. It includes the payment of travelling expenses to Australian and overseas educational symposia. Second, disciplinary controls are applied to doctors under the current Medical Act 1894. Disciplinary action can be taken by the Medical Board if a practitioner has engaged in infamous or improper conduct. We know that this bill is about to deal with this matter of conduct in a more contemporary way; nevertheless, that is the current situation. The Medical Board policy entitled "The Duties of a Medical Practitioner Registered with the Medical Board of Western Australia" provides some guidance as to what is and is not acceptable conduct. The policy on gifts and inducements is that practitioners should exercise caution in accepting gifts of any substance, including travel, accommodation and gifts where it might be perceived in the future as a conflict of interest. Practitioners must not ask for or accept any material gifts or loans from companies that sell or market drugs or appliances. Practitioners must not ask for or accept fees for agreeing to meet sales representatives.

The next bit of research I did was to look at some of the hospitality that has been provided recently by pharmaceutical companies for GPs in Western Australia. I have a table and will seek leave to table it. I will give members some idea of it. It is a list of the free hospitality provided in WA between July and December last year as part of the educational events organised by just one of Medicines Australia's 41 members. It is a list of dinner and beverage accounts that have been declared. A dinner presentation for 20 respiratory physicians cost $246 per head, which seems to me a fairly plush affair. A cervical cancer vaccination launch for 73 GPs cost $109 per head and another presentation on diabetes treatment for 72 GPs cost $107 per head for food and beverages.

Hon Sue Ellery: I hope it was low GI.

Hon GIZ WATSON: I imagine they were fairly high calorie meals. I seek leave to table the document and have it incorporated into *Hansard*.

The DEPUTY PRESIDENT: Has the member identified the document?

Hon GIZ WATSON: It is a table listing the free hospitality provided in WA as part of the educational events by one of Medicines Australia's 41 members between July and December 2007, and the source is a report by GlaxoSmithKline Australia Pty Ltd. It is required to provide six-monthly reports on expenditure on educational events and this was included in Medicines Australia's code of conduct at the insistence of the Australian Competition and Consumer Commission.

Leave granted. [See paper 3930.]

The following material was incorporated —

Examples of 'hospitality' from pharmaceutical companies

The following table lists the free hospitality provided in WA as part of 'education' events by just one of Medicine's Australia's 41 members between July and December 2007.[7]

Description	Venue	Cost	Cost per head
Dinner and beverages, with presentation on cervical cancer vaccinations (15 GPs)	VAT 2 Restaurant, Bunbury	$1252	$83
Dinner and beverages, with presentation on diabetes treatment (72 GPs)	Bluewater Grill, Perth	$7709	$107
Dinner and beverages for Oncology Advanced Trainee Journal Club (10 Oncologists)	Kailis Brothers Fish Market and Café, Leederville	$739	$74
Food, beverages and parking for cervical cancer vaccination launch (73 GPs)	Parmelia Hilton	$7,957	$109
Food and beverages for Australian Society of Clinical Immunologists and Allergists (WA Branch) monthly meeting with external speaker (25 people)	Acqua Viva on the Swan, Nedlands, WA	$1,887	$75
Dinner and drinks for 2 hour presentation/meeting on respiratory health (22 GPs)	Krishna Palace Indian Restaurant, Joondalup	$949	$43
Food, beverages and travel for one person for diabetes presentation	Fraser's Restaurant, Kings Park, WA	$2830	$118
Dinner and drinks for a meeting for 17 GPs relating to respiratory health	Conversation Indigo Restaurant, Geraldton, WA	$1484	$87
Dinner presentation with international speaker to promote new product (20 respiratory physicians) — includes 3 course dinner with alcohol, and travel and accommodation for regional delegates	Bluewater Function Centre, Perth, WA	$4913	$246

[7]Source: GlaxoSmithKline Australia report at http://www.medicinesaustralia.com.au/page155.asp. A requirement for 6 monthly reports on education event expenditure was included in the Medicine's Australia Code of Conduct, at the insistence of the ACCC.

Hon GIZ WATSON: I will now elaborate on the problems with the current system. The problem is that the current system allows pharmaceutical companies to provide, and doctors to accept, some gifts, albeit of low dollar value, and substantial hospitality at educational events. I note also that they fund educational events for information about new pharmaceuticals or recent changes in pharmaceuticals. Studies in peer-reviewed medical journals support the contention that gifts of this kind result in non-rational prescriber behaviour that favours the drugs sold by the pharmaceutical companies. I refer to one of those studies. Unfortunately, because I ran out of time, most of the literature I have refers to the US, but I am reliably assured that it is relevant to the Australian situation because it refers to the behavioural response of receiving gifts. This article was published in the American Medical Association publication in 2000 and is titled "Physicians and the pharmaceutical industry: is a gift ever just a gift?" by Ashley Wazana, MD. He states —

> There are few issues in medicine that bring clinicians into heated discussion as rapidly as the interaction between the pharmaceutical industry and the medical profession. More than $11 billion —

That is US dollars —

> is spent each year by pharmaceutical companies in promotion and marketing, $5 billion of which goes to sales representatives. It has been estimated that $8000 to $13,000 is spent per year on each physician. The attitudes about this expensive interaction are divided and contradictory. One study found that 85% of medical students believe it is improper for politicians to accept a gift, whereas only 46% found it improper for themselves to accept a gift of similar value from a pharmaceutical company.

That rather amused me. The article goes on to say in reference to the results of the study that this paper reports on —

> A total of 29 studies were identified . . . Of these, 16 addressed the extent of the physician-industry interaction, 16 identified the attitudes of physicians toward the interaction, and 16 evaluated the effect of the interaction on the practitioner.

The article continues —

> Interactions with the industry were found to start as early as medical school and to continue well into practice. Most physicians met with pharmaceutical representatives about 4 times a month . . .
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> One study found that residents receive 6 gifts a year, with no comparable data for physicians.
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> Residents and physicians have similar attitudes about pharmaceutical representatives. They believe that representatives provide accurate information about their drugs . . . Most believe that representatives prioritize product promotion above patients' welfare and are likely to use unethical practices.
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> Most deny that gifts could influence their behavior and are equivocal about the ethics of such a practice, with residents more likely to admit that without gifts, their interactions with pharmaceutical representatives would be reduced.
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> . . .
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> Interactions with pharmaceutical representatives were also found to impact the prescribing practice of residents and physicians in terms of prescribing cost, nonrational prescribing, awareness, preference and rapid prescribing of new drugs, and decreased prescribing of generic drugs.
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> . . .
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> Exposure to pharmaceutical representatives was highly associated with a perception of the benefits of such an interaction and the appropriateness of other interactions.
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> . . .
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> Receiving a gift and the number of gifts received correlated with the belief that pharmaceutical representatives have no impact on prescribing behavior; receiving gifts of high relevance to practice was also associated with a positive attitude.
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> . . .
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> There was an independent association between benefiting from sponsored meals and formulary addition requests for any drug that was clearly dose-related.
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> All admitted that contact with representatives and attendance at educational events would decline were it not for gifts and meals.
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> . . . most studies found negative outcomes associated with the interaction. These included an impact on knowledge (inability to identify wrong claims about medication), attitude (positive attitude toward pharmaceutical representatives; awareness, preference, and rapid prescription of a new drug), and behavior (making formulary requests for medications that rarely held important advantages over existing ones; nonrational prescribing behavior; increasing prescription rate; prescribing fewer generic but more expensive, newer medications at no demonstrated advantage.)

That is not new information for those who have looked at this area before. However, it is something that this bill does not deal with adequately. A specific quote says that the size of the gift did not make any impact on the behavioural change. Another paper dated January 2006 by Brennan et al titled "Health Industry Practices That Create Conflicts of Interest: A Policy Proposal for Academic Medical Centres" states —

> The current influence of market incentives in the United States is posing extraordinary challenges to the principles of medical professionalism. Physicians' commitment to altruism, putting the interests of the patient first, scientific integrity, and an absence of bias in medical decision making now regularly come up against financial conflicts of interest. Arguably, the most challenging and extensive of these conflicts emanates from relationships between physicians and pharmaceutical companies and medical device manufacturers.

I want to highlight the point made under the heading "Myths of the Small Gifts and Full Disclosures", which states —

> Most of the recommendations from medical and industry groups share 2 key assumptions. The first is that small gifts do not significantly influence physicians' behaviour. The second is that disclosure of financial conflicts is sufficient to satisfy the need to protect patients' interests. Although these 2

> assumptions are widely accepted among physicians, compelling research findings using a variety of methods have called their validity into question.
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> . . .
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> Social science research demonstrates that the impulse to reciprocate for even small gifts is a powerful influence on people's behaviour. Individuals receiving gifts are often unable to remain objective; they reweigh information and choices in light of the gift. So too, those people who give or accept gifts with no explicit "strings attached" still carry an expectation of some kind of reciprocity. Indeed, researchers suggest that the expectation of reciprocity may be the primary motive for gift-giving.
>
> Researchers have specifically studied industry gifts to physicians. Receiving gifts is associated with positive physician attitudes toward pharmaceutical representatives. Physicians who request additions to hospital drug formularies are far more likely to have accepted free meals or travel funds from drug manufacturers . . .
>
> The assumption that disclosure to patients is sufficient to resolve problems created by physicians' conflicts of interest is also unfounded. First, physicians differ in what they consider to be a conflict, which makes the disclosure of conflicts incomplete . . . Second, recipients of information who are not experts in a particular field often find it impossible to identify a biased opinion that they read or hear about that subject. Third, disclosure may be used to "sanitize" a problematic situation, suggesting that no ill effects will follow from the disclosed relationship.

The article goes on to state that more stringent regulation is required. The author argues that all gifts, free meals, payments for time for travel to or time at meetings, and payments for participation should be prohibited.

I foreshadow an amendment to the bill that would achieve that effect; that is, to move beyond a requirement for a code of practice. Of course, this bill does not deal with the pharmaceutical companies' code of disclosure. Because the bill is primarily concerned with establishing, maintaining and promoting suitable standards of knowledge and skills among medical practitioners for the purpose of protecting consumers of medical services provided by medical practitioners in Western Australia, it is time that Parliament tackled the issue of the relationship between pharmaceutical companies and medical practitioners. The amendment that I will move seeks to prohibit the provision of gifts of any kind. That is the only clear way to draw a line in the sand in this regard. The bill does not solve the problem of gift giving by pharmaceutical companies to doctors. It is true that a provision in clause 140 will prohibit medical practitioners from accepting payments or another benefit in return for referring a patient to someone else who provides health services. However, even if prescription of a particular drug could be said to amount to a referral in the necessary sense, it could not be proved that a gift or free meal was provided in return for that referral. The problem we are trying to address is one of subtle bias rather than an explicit arrangement. No pharmaceutical company would explicitly say, "I'll pay for this meal at Fraser's Restaurant if you prescribe my drugs." It does not have to. I will deal with the detail of the amendment during the committee stage. However, we feel very strongly that this is an opportunity to deal with the matter. We are not raising a novel concern. While we are dealing with this comprehensive legislation that provides for the regulation of medical practitioners, we have a great opportunity to address the overservicing and directing of medical practitioners' prescribing habits by the subtle or not so subtle influences of various pharmaceutical companies.

I have a couple of questions with which to complete my comments on the bill. I ask the minister whether all the recommendations have been taken up in this bill or whether issues have not been picked up on. I will also make some comments about professional indemnity insurance under clause 40, which contains a discretion for providing indemnity insurance. I cannot understand why it will not be mandatory for all medical practitioners to have indemnity insurance. I also have some comments about clause 45, which deals with the duration of registration. Why is the period for registration not prescribed by regulation? If there are any other matters, I will deal with them during the committee stage. I encourage members to look very closely at the proposed amendment on the provision of gifts and benefits by pharmaceutical companies. It is an issue that Parliament could take a very clear stance on. I hope that members will consider the amendment that I will move.

HON SHELLEY ARCHER (Mining and Pastoral) [8.06 pm]: I will not take up much time of the house tonight. I understand that the Medical Practitioners Bill 2006 seeks to provide a framework for the registration and regulation of medical practitioners. Essentially, the bill will repeal the Medical Act 1894 and replace it with a modernised version. The bill incorporates the recommendations of the review of the Medical Act 1894, which was chaired by Professor Bryant Stokes. The bill will also enable Western Australia to implement a scheme of portable registration for medical practitioners between Australian jurisdictions. The inclusion of this scheme will give effect to an agreement by the Australian Health Ministers' Conference held in April 2006.

In terms of the nine parts of the bill, parts 1 and 2 appear to be rather straightforward; however, I have some concerns with other parts of the bill. Part 3 describes what constitutes the funds of the board and how they may be applied, and sets out the reporting requirements of the board. The source of funds for the board comprises registration fees, state government grants, penalties, costs incurred and expenses received in relation to disciplinary matters, and other money or property lawfully received. I have had representations from the Australian Medical Association that indicate that the bill will impose far more work on the board and may increase the costs of its operations and, consequently, registration fees. For example, the registration process has been expanded and compliance costs are associated with the introduction of a renewed complaints procedure. I would like to receive, as would the AMA, some assurance from the government that the cost imposition of meeting the increased requirements of the new act will be reflected in any future funding agreement between the parties.

Part 4 of the bill specifies registration requirements of medical practitioners and the keeping of a register. I have some grave concerns with this part, in particular the category of registration that gives effect to conditional registration for general practice in remote and rural Western Australia. This category of registration will enable a person who has overseas qualifications to apply to work in areas determined by the minister to be rural and remote areas of Western Australia. I suggest that this would include areas within my electorate—for example, the Kimberley and Pilbara areas. I am concerned about this category of registration because it may lead to a standard of care that is less than equal to that delivered to metropolitan patients. As many of us in this place are aware, working in the Kimberley and the Pilbara can be extremely challenging, given the high level of social disadvantage experienced by many communities. Medical practitioners must also be conscious of cultural considerations when practising in and around Indigenous communities. I would like the government to guarantee that medical practitioners with overseas qualifications will be provided with appropriate cultural training delivered by an appropriate Indigenous organisation from the region that they are employed to work in and that they will be closely monitored to ensure that patient care in rural and remote locations is not compromised by this category of registration.

I am also perplexed by the number of conditional registrations granted in WA that allow a person with suitable qualifications, but not Australian medical qualifications, to practise in areas that have been determined by the minister as "unmet areas of need". It was reported in the review of the Medical Act that 266 conditional registrations were granted in 1998, of which 198, or approximately 74 per cent, were for unmet need. This category of registration was the highest of all conditional registrations granted in 1998, and the numbers are said to have been steadily increasing over time. It would be helpful for all of us who live in the remote areas of Western Australia if the government could explain what constitutes unmet need and, given the increasing number of registrations granted in this category, advise whether other strategies could be implemented to meet this unmet need with fully registered medical practitioners.

I also have some concerns about the practical application of clause 40, which relates to professional indemnity insurance. I understand that doctors in private practice currently take out their own insurance to protect against claims of negligence, and this is not mandatory. Doctors in the public hospital system are covered by RiskCover. The explanatory memorandum states that the board can impose a condition on registration that the registrant is covered by professional indemnity insurance that meets minimum terms and conditions approved by the board. I ask the minister how the board will determine the minimum terms and conditions given the balance that will need to be struck between what is in the best interests of the public—for argument's sake, that all doctors have the highest cover possible—what is in the best interests of the doctor in terms of cost of that insurance and what insurance companies are prepared to offer. I also ask the minister whether this is an appropriate role for the board to undertake given its traditional focus on medical conduct issues rather than insurance arrangements.

Part 5 of the bill provides for a scheme of portable registration for medical practitioners between Australian jurisdictions. I understand the government's reasons for enacting this part, given the additional expense and the red tape that doctors encounter when practising in different states. However, I also share Hon Helen Morton's concerns about the national registrar and how each state board will interact to ensure an up-to-date system is in place. I also note that the scheme will become effective only when corresponding law is enacted in other states where the medical practitioners will be registered. It is important that the government explain where each state is in enacting such corresponding law and whether the reciprocal arrangements and the register operate when only two or three states enact such laws.

Part 6 of the bill sets out the procedures for dealing with complaints about the professional conduct of medical practitioners. It specifies what constitutes disciplinary, competency and impairment matters. I note that there is an express definition of sexual exploitation as a disciplinary matter. I have some concerns with this category given the tendency of the media to sensationalise such allegations and therefore draw strong public attention towards the accused, as we have seen just lately. This reaction is quite warranted in the case of a person who is

found guilty. However, I share the concerns of a number of organisations whereby the reputation of a medical practitioner can be damaged as a result of a complainant found to be mistaken, vexatious or mentally disturbed. It is therefore important that the presumption of innocence prevail and that the names of medical practitioners under investigation be suppressed. It would be helpful if the government could give an assurance that the reputation of a medical practitioner accused of an offence will be protected until he or she is found guilty.

Part 7 of the bill specifies conduct that constitutes an offence under the act. Offences dealt with under this part include such things as practising medicine without registration, employing someone who is not registered, obstructing assessors or investigators, providing false or misleading advertising and overservicing or receiving benefits in connection with referrals. The act provides for substantial penalties ranging from $1 000 for minor offences to $50 000 for more significant offences.

Part 8 of the bill provides for the development of codes of practice, rules, regulations and forms that are necessary to give effect to the act. This part provides that the Medical Board of WA may issue codes of practice that contribute to the protection of the public. Codes of practice must be approved by the minister. In doing so, the minister must be satisfied that there has been appropriate public consultation and an impact assessment conducted. In considering this part, I am confident that the Medical Board of WA, when undertaking public consultation, will ensure that the views of all Western Australians are canvassed, including the Indigenous population, which is very important. I hope that the minister will closely monitor this process to ensure that the views of the wider community are recognised and incorporated into the codes.

Apart from seeking responses to the above questions, I support the Medical Practitioners Bill and will not be proposing any specific amendments at this time.

HON SUE ELLERY (South Metropolitan — Minister for Child Protection) [8.17 pm] — in reply: I thank members for their contributions to the debate. I will address the key issues that members raised and then we will obviously have the opportunity in the committee stage to explore some of the issues. Firstly, I turn to how this bill sits with respect to the national registration situation. In March this year the Western Australian government signed up to the Council of Australian Governments' plan for the establishment of a national registration and accreditation scheme for nine health professions, including medical practitioners, by 1 July 2010. That scheme will supersede the existing legislation.

Hon Giz Watson asked why we would want to proceed with this piece of legislation when it might have a life of only two years. Other states have taken steps to modernise their medical practitioners oversight bill way before us. Western Australia is significantly behind the eight ball in that respect. Queensland has been given the task of preparing the substantive legislation for the scheme and then Western Australia will look at that legislation and draft its own. From the Western Australian government's point of view, it is some way off. The steps that we are taking in the bill before the house now are important ones that are long overdue in Western Australia. It is important that we proceed to update and reform the Medical Act 1894. This bill provides us with an opportunity to update the legislation, which the stakeholders have waited a very long time for.

I will work my way through the other matters. Some questions have been raised relating to portable registration and corresponding laws. The provisions of part 5 of the bill are intended to facilitate the movement between jurisdictions of practitioners with Australian-recognised qualifications; that is, such practitioners will be taken to be registered in WA without needing to make a separate application. Any condition on registration imposed by another jurisdiction will apply in WA, and the Medical Board of Western Australia must be informed of such conditions. Implementation of the portability of registration will be dependent on the availability of a national database, which will include details of all medical practitioners registered in Australia. Regulations will then prescribe the corresponding law of another state or territory; for example the New South Wales Medical Practice Act 1992 could be prescribed as a corresponding law under WA regulations. An interstate practitioner, therefore, would be given an automatic right to practise only if the legislation under which the practitioner was registered was prescribed under the Western Australian regulations.

A question was asked about whether a person who is registered under another jurisdiction and chooses to work in WA is required to notify the Medical Board of WA when he or she commences practising in WA. The nationally agreed drafting instructions considered this issue particularly and took the view that medical practitioners would not be required to notify medical boards in jurisdictions other than their home jurisdiction before starting to practise in those jurisdictions except when the registration had been made subject to a condition, a limitation or a restriction. There were two reasons for adopting that policy position. Firstly, I guess, the general intent of the scheme is that practitioners with portable registration should be able to move freely between states. That was the whole intention of the exercise. Secondly, nothing turns on the local registration board being notified of an interstate registrant practising in WA. That person is still required to meet the relevant registration obligations under the relevant registration act, which is likely to include, for example, a requirement

that if the registrant changes his or her address, the registrant is required to notify the board. If a disciplinary, impairment or competence matter is likely to arise, the local registration board will be able to access the national database. Members will recall that I have said that this scheme cannot work until we have a national database for the registration details of practitioners.

Other questions were raised about complaints, I think by Hon Helen Morton. In general, if conduct occurs in WA that could be described as a disciplinary matter or an impairment matter, it will be investigated in WA. However, in circumstances in which the board takes the view that it is appropriate to do so, it can, under clause 72 of the bill, refer a complaint to another regulatory authority. For example, someone registered in New South Wales practises in Western Australia for a short period and has been noticed to be affected by drugs or alcohol. That person returns to New South Wales and does not intend to come back to WA. No patient has been affected by the impairment but the matter is of concern and is the subject of a complaint to the WA board. In those circumstances the matter could properly be referred to the New South Wales board. The bill provides the WA board with the discretion to do so. The board might decide to deal with the matter in WA, but it will have the discretion to refer it elsewhere. It is the case now that the majority of board members are appointed by the Minister for Health, and the situation will remain the same if the bill proceeds through the house.

It is important to note—I know members have noted this themselves—that the drafting of this bill occurred after extensive consultation with the stakeholders, and the report that was prepared by Professor Bryant Stokes really did canvass all the issues that go to the heart of the bill before us.

Some questions have been raised about issues to do with overseas-trained doctors, particularly rural and remote issues. I will make a couple of points in my response. Firstly, an issue was raised around the requirement for English language competency. Under clause 33 of the bill, applicants must have a sound knowledge of English. Clause 33(3)(a) refers to the requirements of clause 30(2)(d).

The level of competence for a rural GP was raised and whether this bill did anything to diminish the opportunity for them ascertaining their levels of competence. In fact the regulatory framework for checking their competence will remain unchanged if this legislation is passed. It is not true—if there is some kind of suggestion—that the words in the bill about having regard to the person's qualification and experience somehow detract from the level of competence. In relation to the current scheme, I refer members to section 11AG of the Medical Act headed "Conditional registration for general practice in remote and rural WA". A medical practitioner who has the qualifications and experience obtained overseas but is otherwise competent to practise as a general practitioner and undertakes to abide by the conditions that are set out may be eligible for registration in this category. Those conditions are that they can practise only as a GP; they must practise in rural and remote WA for five years after registration; and they must become a fellow of the Royal Australian College of General Practitioners within two years of registration.

People who apply under that scheme are required to lodge an application with the Western Australian Centre for Remote and Rural Medicine, which will determine whether those practitioners meet the standards set by WACRRM. That is a scheme that is very well regarded. Western Australia is in fact at the forefront of practising medicine in rural and remote areas. There is nothing in the bill before the house now that in any way diminishes that existing scheme. It is certainly not intended, as suggested by Hon Giz Watson, that somehow a lower standard would apply for overseas-trained doctors who practise in rural and remote areas. It is certainly not intended that a lesser standard will apply. The threshold that must be met is whether they are competent to practise in Western Australia as practitioners, which is a fairly high standard in any event. It is not intended to lower the standard of competence that would be expected of any general practitioner working anywhere in Western Australia.

Another matter that was canvassed, I think by Hon Giz Watson, was the report prepared by Professor Stokes and whether any of the recommendations in the report had not been included in the bill. There are some, and the vast majority are about references to the medical tribunal, which of course has been replaced by the State Administrative Tribunal. There were also recommendations related to corporate providers. The policy position the government has taken in respect of that was to focus on the activities of corporate providers that may interfere with the clinical practice of medical practitioners. The clause that has been included in the bill in relation to corporate providers, therefore, reflects the position in the majority of other jurisdictions around Australia. There are some other recommendations of a minor nature that have not been implemented. They refer, for example, to appeal rights to the Supreme Court when the medical tribunal, as opposed to SAT, was the body to which disputes were referred.

The issue of whether professional indemnity insurance should be mandatory was raised by all three members. Firstly, I will say that mandatory insurance is not now the case in Western Australia, nor is it the case, as I understand it, in a majority of the other jurisdictions. During the working party's consultations and discussions,

the Australian Medical Association indicated its opposition to a compulsory professional indemnity insurance arrangement being written into the act. The review, conducted by Professor Stokes, canvasses all those issues in a report that—I do not need to remind members—has been publicly available for some time. The Stokes report supported in principle the Medical Board's role to ensure the adequacy of the professional indemnity cover under which medicine is practised; noted that legislative changes had been made or were planned to be made in Victoria and New South Wales that would have the effect of empowering those states' respective medical boards to enforce compliance with appropriate standards of professional indemnity; and noted that the Australian Health Ministers' Advisory Council had commissioned some work on medical indemnity arrangements in Australia. The working party in fact referred to the need for further consultation and consideration to be given to the question of indemnity insurance, but did not take a position different from that of the AMA. However, the working party flagged the need for further consultation with a view to reaching an agreed position. Clearly, stakeholders in the industry do not have an agreed position on the question of indemnity insurance.

Another matter raised by members was the reason the period of registration is not prescribed in the legislation. The duration of registration will be up to three years in accordance with the recommendations of the review. The registration period may be as low as one year, depending on the class of registration—that is, whether it is conditional, provisional or general. The duration of registration for a general practitioner will probably be three years. Clause 45 provides that the term of registration will be prescribed by the regulations and not the act, and that is because the term of registration may well be different for the different classes of registration. Therefore, rather than now say that the duration of registration will be one year for conditional, two years for provisional and three years for general registration, the legislation sets out that registration will be between one and three years. The review recommended that registration be for a period of up to three years except when the board grants specific purpose conditional registration or decides in any individual case, having regard to public protection purposes, that it is important to grant an issue of registration or renew it for a period that is less than the prescribed upper limit.

Hon Giz Watson referred to an amendment about gifts that she put on the supplementary notice paper. The government will not support that amendment. Essentially, the position taken by the government is that all the matters within this legislation have been subject to wide and extensive consultation to ensure outcomes that the stakeholders could work with. The matter raised by Hon Giz Watson has not been subject to that degree of consultation, and the government would be reluctant, at this late point, to pursue a position that had not been canvassed with the relevant stakeholders. The two big jurisdictions in Australia, Victoria and New South Wales, have not gone down this path. However, it is an issue worthy of debate. Hon Giz Watson referred to existing Australian Competition and Consumer Commission provisions that require the publication of certain information about gifts from pharmaceutical companies. I think there is a view in Western Australia that another body, the Western Australian Council for Safety and Quality in Health Care, sets the standards for quality issues and that the issue of gifts would be more appropriately reflected in the work of that body. Of course, clause 139 already provides for an offence of undue influence to deter people from exerting influence over the clinical judgement of a practitioner. Clause 140, to which I think the honourable member referred, deals with payment or acceptance of payment for referrals; however, clause 139 deals with the matter of exerting undue influence.

Hon Shelley Archer asked about funds of the Medical Board. I do not have advice on that but perhaps the member could ask me a question in committee. However, if I cannot take a question in committee, I am certainly happy to provide the member with the government's response on that matter.

I have already canvassed the issue of conditional registration in my comments, and I urge Hon Shelley Archer to make contact with WACRRM, if she has not done so already. Some fantastic overseas-trained doctors provide health services to people in the Kimberley; including two doctors who do an absolutely fantastic job in Halls Creek and who, amongst other things, have set up a scholarship incentive arrangement with the local kids to encourage school attendance. For example, these doctors have agreed to fund an overseas trip to Disneyland. They are doing a fantastic job. I know of other overseas-trained doctors in the Kimberley and elsewhere in Western Australia who are engaged in absolutely culturally appropriate ways with their communities and who are doing a fantastic job. It would be unfortunate if legitimate questions asked to ensure the observance of high standards were to cast aspersions on the work of some of these doctors, many of whom are doing a fantastic job.

With those comments I have broadly canvassed the issues raised by the members. No doubt we will have further conversations as we go through the bill in committee. It remains for me to again thank members for their contributions and to commend the bill to the house.

Question put and passed.

Bill read a second time.

Committee

The Deputy Chairman of Committees (Hon Ray Halligan) in the chair; Hon Sue Ellery (Minister for Child Protection) in charge of the bill.

Clauses 1 to 32 put and passed.

Clause 33: Conditional registration for general practice in remote and rural WA —

Hon GIZ WATSON: This clause deals with registration in remote and rural Western Australia. I understand the minister to have said that there will be no change to the checking and supervision of rural and remote practitioners. I realise the minister made some comments in response to the second reading debate. However, I would like to know exactly what is currently involved in the monitoring and supervision of remote and rural practitioners. If there are to be any changes, what will they be?

Hon SUE ELLERY: I understand that it is a combination of two elements. Monitoring and supervision are provided mainly by the WA Centre for Remote and Rural Medicine. There is an initial interview process through WACRRM, which then informs the board of the outcome of the assessment. If the member recalls, the terms under which they receive that conditional registration include two specific time related aspects that need to be monitored and overseen during that time. Firstly, they must practise in remote and rural WA for five years after registration. At the conclusion of that five-year period, and subject to satisfactory performance, their registration will then be transferred into the recognised specialist qualifications and experience, with the speciality being "fellow in general practice". Their performance is measured throughout that five years. Failure to meet satisfactory performance during that five years means that they will not achieve a capacity to practise as a fellow in general practice. I understand that is the WACRRM provision. The Fellowship of Royal Australian College of General Practitioners also plays a role because doctors must meet the requirements of registration with the Fellowship of the Royal Australian College of GPs within two years of entering the scheme. According to the advice available to me, that monitoring and supervision involves a combination of demonstrating that they have met the requirements to become members of the Royal Australian College of GPs and of demonstrating satisfactory performance at the end of the five-year period, during which they are obligated to practise in rural and remote areas to have their registration transferred to the general practice qualification.

Hon GIZ WATSON: That is useful. WACRRM involves an initial interview, and at the end of the five-year period another assessment is done to determine whether the doctor's qualifications can be transferred. Between that five years, what checking is done?

Hon SUE ELLERY: The doctors must demonstrate satisfactory performance. I cannot tell the member what tools the assessors use to determine whether they have met satisfactory performance. No-one here is able to tell me what those tools are, but the doctors must demonstrate satisfactory performance, so there is some kind of measurement of that.

Hon Peter Collier: I hope so.

Hon SUE ELLERY: It is a requirement that they must demonstrate that satisfactory performance. If the member is asking me whether they are tested every three months or every six months and what they need to demonstrate, I am unable to provide that detail. However, I am happy to give an undertaking that I will provide that information. Nonetheless, there are two key points: they must meet the qualifications to join the royal college within two years and, at the end of five years, if they want to move into the general practice area, they must have demonstrated satisfactory performance during that five years. I am unable to spell out what actual tool is used to measure that.

Hon GIZ WATSON: I understand that it is not necessarily a requirement for other doctors to undergo a regular assessment process. I understand the royal college has various requirements depending on whether it is a GP, an obstetrician or whatever. I am not sure that they are similarly prescriptive with the regularity of those assessments. I think there is a requirement for them to indicate that they have undertaken additional training in particular areas. My concern relates to that intervening five years. I would appreciate it if the minister could provide me with more detailed information on what that actually entails. It is quite a significant question. Health consumers in remote and regional areas would probably like to know what that process will be to ensure that the assessment is sufficient.

Hon Sue Ellery: Of course, that is not the first assessment. The first assessment happens at the end of two years.

Hon GIZ WATSON: Yes. It is a little disappointing that the information is not readily available, given that the bill has taken a very long time to get to this point. It would not have been unreasonable to expect an answer to that question, given that members foreshadowed that this is an area of concern. In fact, I think all members who contributed to the debate in this place indicated that this is a particular area of scrutiny on which they want more information, so it is a little disappointing that the information is not available this evening when we might well

complete our debate on the bill tonight. If the minister could undertake to provide that information as soon as it is made available, that would be useful to me.

Clause put and passed.

Clauses 34 to 39 put and passed.

Clause 40: Professional indemnity insurance —

Hon GIZ WATSON: I raised this issue in my contribution to the second reading debate. Professional indemnity insurance is an important area. The term is defined in clause 40(1) as —

> . . . professional indemnity insurance that meets the minimum terms and conditions approved by the Board.

That is all well and good. Subclause (2) states —

> Without limiting the Board's powers under section 30, 32, 33, 34 or 38, the Board may by written notice impose both of the following conditions as a conditions of registration . . .

Professional indemnity insurance will obviously be discretionary and not mandatory. I realise that the minister has responded to this point but I have to say that it seems that the government has caved in to medical practitioners in this regard. Medical practitioners have some of the most significant powers that anyone can have in that they have power over people's lives. As such, why would professional indemnity insurance not be mandatory? Perhaps the minister can respond. Does this mean that once this legislation is enacted, medical practitioners will be able to practise in this state without first obtaining professional indemnity insurance?

Hon SUE ELLERY: In response to the first part of the question on the discretion to obtain professional indemnity insurance, the provisions in this bill are the same as those in other health practitioner legislation that we have dealt with. There is no difference. This is also the case in the majority of the other jurisdictions around Australia. In response to the last part of the question on whether medical practitioners could practise without professional indemnity insurance, that decision would be made by the board. A logical extension is that they could. I do not know whether that is the case. That will be at the discretion of the board.

Hon GIZ WATSON: By logical extension, if the board has the capacity to not impose that as a requirement, doctors could operate without professional indemnity insurance. What would be the consequences of that? I am just trying to follow this through. I think the general public would be disturbed if the medical practitioners they saw did not have professional indemnity insurance. If that were the case, what would happen with a claim of negligence?

Hon Helen Morton: They would lose their house.

Hon GIZ WATSON: They would lose their house. They might have to declare themselves bankrupt and then there would be further problems. This interests me, having been a builder. I could not operate as a builder in this state without holding indemnity insurance. A person cannot operate, be registered or run a business without indemnity insurance. It seems rather extraordinary that it is discretionary in this profession of all professions. Given the possible consequences, the medical profession is probably even more dangerous than the building profession.

Hon SUE ELLERY: To a certain extent, we are in the realms of the hypothetical. If it were me, I would not practise without professional indemnity insurance. I suspect that there are a range of overlapping requirements that would mean that medical practitioners would probably be required to take out professional indemnity insurance, if not by the board, then perhaps by some other body. For instance, medical professionals working in a hospital setting might be required to take out professional indemnity insurance. I am not talking about medical practitioners who are public employees or who are contractors to the public sector, but I imagine that St John of God Health Care, for instance, would have a position on whether the medical practitioners operating within its group needed to have professional indemnity insurance. I also suspect that the royal colleges have a position on whether their members ought to have professional indemnity insurance. We are somewhat in the realms of the hypothetical. I understand that, in practice, a range of policies and protocols, separate from the board exercising its discretion one way or the other, would probably have the effect of requiring most medical practitioners to have some form of professional indemnity insurance.

Hon HELEN MORTON: The way I interpret this is that we are now able to provide registration for non-practising medical practitioners, so the board will determine which class of registration requires professional indemnity insurance and which class does not. In other words, there are practitioners who are able to be registered who may not need professional indemnity insurance.

Hon SUE ELLERY: I just need to clarify the question. The member used the expression "now". Under a previous piece of legislation, a non-practising registrant could operate without professional indemnity insurance. I am not sure whether the member means "now" as in now or "now" as in under the bill.

Hon HELEN MORTON: I did not consider how it operates at the moment.

Hon Sue Ellery: The member used the word "now". Does the member mean under the bill?

Hon HELEN MORTON: Yes.

Hon SUE ELLERY: Is the member talking about a non-practising registrant?

Hon Helen Morton: I am suggesting that the board will be able to determine which class of registration may require professional indemnity insurance and which ones will not.

Hon SUE ELLERY: The answer to that is yes.

Hon Helen Morton: The reason for that is that someone might not need insurance if he is a non-practising medical practitioner.

Hon SUE ELLERY: Clearly, he does not if he is a non-practising registrant.

Hon RAY HALLIGAN: My experiences have been through my wife, who used to work for an orthopaedic surgeon who operated at St John of God Health Care at Subiaco. He was not able to operate unless he was able to present a current certificate of professional indemnity insurance. That was the only reason they allowed him to operate at that hospital. Had it not been current, he would not have been allowed to operate. There is no doubt that professional indemnity insurance for all professions is an extremely expensive item, but it is also extremely expensive if people do not have it and an accident, for want of a better term, occurs. Professional people, such as doctors, lawyers, accountants and others, are fully aware of this. They would definitely be quite silly if they felt that they would be able to continue in their profession without adequately covering themselves in this area. However, I am interested to know, through the minister, where in clause 40 Hon Giz Watson believes that there is that option for, in this case, medical practitioners to possibly operate without it.

Hon SUE ELLERY: Hon Giz Watson drew our attention to subclause (2), the clause being expressed as "the Board may".

Hon Ray Halligan: It refers to conditions, and it would appear that Hon Giz Watson believes that they may be zero conditions and therefore mean zero insurance.

Hon SUE ELLERY: If Hon Ray Halligan goes on to read the clause over the page, he will see that —

> . . . the Board may by written notice impose both of the following conditions as a condition of registration . . .
>
> (a) that —
>
> . . .
>
> (ii) the medical care provided . . . must be covered by professional indemnity insurance.

Hon Ray Halligan: They are all obligatory; "must be".

Hon SUE ELLERY: Yes, but the introductory part of the clause reads "the Board may" make it compulsory.

Hon Ray Halligan: "By written notice", which could be taken any number of ways.

Hon SUE ELLERY: The intent is that the discretion rests with the board —

Hon Ray Halligan: As to whether they have indemnity insurance. Was that the intent of the writing of the legislation?

Hon SUE ELLERY: What I canvassed in my second reading response was that when the working party that was chaired by Professor Bryant Stokes canvassed this issue, the question was whether it ought to be mandatory that practitioners have professional indemnity insurance. The final recommendation of the working party was that in principle the Medical Board should have a role in ensuring the adequacy of professional indemnity. The working party went on to further recommend that further consultation happen and further work be done on setting standards of professional indemnity insurance. It was therefore a very deliberate decision to draft the bill in such a way that the board had the discretion of whether to require a practitioner to have professional indemnity. We are referring to the board, and not an employer such as the St John of God group. The very clear intention was that the board retain the discretion to determine whether a practitioner was required to have professional indemnity. We all might have a point of view about what we would do if we found ourselves in that situation. I know what I would do, but the discretion was clearly intended to rest with the board.

Hon RAY HALLIGAN: That is particularly interesting because it brings me back to the point now: why have a board, why have registration and why ensure that a doctor is qualified? Is it not to protect the patient? If the board is there to protect a patient, I would suggest that professional indemnity insurance is one of those obligatory matters. If we are to make sure that doctors are qualified to do what they believe they can do and hold themselves out to be able to do and if the board wants to keep track of them by registering to protect the patient, the patient needs to be protected. If something goes wrong and the patient needs to see the doctor and the doctor is not insured and has—we will call the doctor a he at this time—all his assets in his wife's name, where is the patient? There is no protection for the patient. It seems to me a bit of a nonsense to go to all this trouble to protect the patient by doing all these things and not ensuring that the doctor is insured.

Hon SUE ELLERY: The honourable member may well hold that point of view and it may or may not be one that I see perfect logic in. However, the work that was done essentially by the industry itself reached this position. I suspect that in practice the situation of the orthopaedic surgeon, for whom the honourable member's wife worked, is common practice.

Hon Ray Halligan: Not the exception.

Hon SUE ELLERY: Yes, which is why when I was having this conversation with Hon Giz Watson I said that to some extent I think we are in the realm of the hypothetical. The stakeholders themselves—I guess in light of knowing what the practice arrangements were, for example, operating out of St John of God hospital group and taking all those things into account—reached the position that the matter of whether professional indemnity insurance is attached to a condition of registration is a matter that the board should decide itself. They decided that the discretion should rest there. They did flag, though, that there needs to be more work done on this area.

Hon RAY HALLIGAN: I hear and thank the minister for that explanation. I can understand that when the minister asked the question of the industry, the industry looked for some flexibility. Whether it is appropriate is another matter. If everyone—particularly the government in this case because it is legislation—is out to protect the patient, for which I believe they have need and which is the reason for the legislation, I would be very concerned if something happens in the future that suggests that such insurance should in fact have been obligatory.

Hon GIZ WATSON: I note that the minister quoted from the working party recommendation, a copy of which I have in front of me, that further consideration be given to the question of the Medical Board having a role in setting standards for professional indemnity insurance under cover of which medicine is practised and enforced, and in the compliance with such standards through registration. A little further on in the report the working group made a recommendation to involve further consultation with interested parties in Western Australia, including the Australian Medical Association, health consumers, the Medical Defence Association and the Medical Board. I wonder whether there has been any further discussion or consultation on this issue of professional health indemnity insurance; and, if so, what those discussions or consultation have resulted in. Perhaps the minister could indicate where it is at.

Hon SUE ELLERY: Consultation did occur on the final dot point of recommendation 36 and that position is reflected in the bill before us now. However, the Medical Board must do further work on it. I understand that work is ongoing regarding its obligations for the terms and conditions of professional indemnity.

Hon GIZ WATSON: Finally, I note that the minister said in her response that the issue of professional indemnity insurance may well be covered by requirements under the colleges' requirements. I realise that the minister does not have that information here, otherwise she would have told me. I am interested to know whether those requirements are covered under the colleges or another body. If that is happening, it provides some reassurance. I am interested to know whether or not there is a requirement somewhere else.

Hon SUE ELLERY: I am happy to provide that information but I will have to do it at a later date because I do not have that information in front of me now.

Clause put and passed.

Clauses 41 to 65 put and passed.

Clause 66: Medical officer of visiting forces —

Hon SUE ELLERY: I move —

Page 48, line 5 — To insert after "visiting" the following —

force

This amendment is needed to fix an omission that occurred when an amendment was successfully moved in the other place to refer to visiting medical practitioners. The reference to "visiting medical practitioner" in clause 66 was amended separately to read "visiting force medical practitioner". However, an amendment was not moved to

the reference to a visiting medical practitioner in clause 66(4)(d), although it was clearly intended that that should occur. The purpose of the amendment before the house is to add the word "force" to the title "visiting medical practitioner" in clause 66(4)(d) to ensure consistency throughout that clause regarding a visiting force medical practitioner.

Amendment put and passed.

Clause, as amended, put and passed.

Clause 67 put and passed.

Clause 68: Persons who are to be taken to be registered under section 30 or 38 —

Hon HELEN MORTON: This amendment refers to the practice by an interstate practitioner and those persons who are taken to be registered under either section 30 or 38 of the future act. I listened to the minister's response to this matter and I understood that she confirmed in her response that there is no requirement whatsoever for a medical practitioner to notify the WA Medical Board if a practitioner is registered in another state and has no conditions upon his registration and that there is no requirement for him to ever notify the WA Medical Board that he is now practising in Western Australia. When I am clear that that is the case, I will want to know whether there will be an avenue under part 5, when the national registration scheme is up and running, for the further regulation of part 5 and whether we will have another opportunity to reconsider it or whether this is our one and only chance to get this part to work the way we think it should work in Western Australia.

Hon SUE ELLERY: The member's first question asked me to clarify a point that I thought I had clarified in my second reading response, which is that there is no requirement to notify. The point of having a portable scheme is that a national database must be in place and the laws in Western Australia must recognise the corresponding registration bodies in the other states. The member is correct that there would not be a requirement for a practitioner to notify the WA Medical Board. The second question was whether Western Australia would have another opportunity to debate this matter if the national registration scheme goes ahead. The answer is yes. The process that has been agreed through the Council of Australian Governments is that Queensland will draft substantive legislation and the other jurisdictions will prepare their own legislation based on the work that has been done on the Queensland model. I am sorry, I need to correct that. Everyone else will adopt the Queensland legislation but the Western Australian government has said that it wants to have its own legislation. Western Australia will get the chance to debate its own version of that legislation. Although that legislation has not been prepared yet, we anticipate that it will include provisions similar to this one. We anticipate also that regulations will be attached to that legislation. Therefore, there would be a debate about the legislation and the normal provisions would apply to the regulations, which are disallowable. That will provide another opportunity for debate.

Hon HELEN MORTON: Another aspect is that we have been trying really hard to find out what the national registration model will look like. Will there be separate laws? I think the minister has just said that each state will have separate laws that are specific to that state and that the national register will be nothing but a register that informs the individual state boards of who is registered where and where they are working. Will this register be specifically for medical practitioners? When the national registration scheme first got underway, it was a single national registration scheme for all health practitioners, not just medical practitioners. I understand that that situation has now changed and each health discipline will have its own national scheme. I want confirmation that the register will be specifically for medical practitioners and will have names and locations, but that an individual board in each state will carry out all the functions of the board.

Hon SUE ELLERY: The intergovernmental agreement for a national registration and accreditation scheme was signed by the Council of Australian Governments in March 2008. A copy of that agreement is available on COAG's website and has been available since that time. The agreement sets out that COAG has agreed to establish a single national scheme with a single national agency encompassing both the registration and accreditation functions. The national registration and accreditation scheme will consist of a ministerial council, an independent Australian health workforce advisory council, a national agency with an agency management committee, national profession-specific boards, committees of the boards, a national office to support the operations of the scheme and at least one local presence in each state and territory.

Clause put and passed.

Clauses 69 to 71 put and passed.

Clause 72: Referral of complaint to regulatory authority in another State or a Territory —

Hon HELEN MORTON: I heard the minister's explanation about the referral of complaints to the registration board in the jurisdiction in which the medical practitioner is registered. In my contribution to the second reading

debate, I specifically asked how the government will ensure that a complaint made by a member of the public in Western Australia who may want to represent himself or herself or who may want to involve local people is dealt with in Western Australia and not in, say, Queensland.

Hon SUE ELLERY: There are two parts to the answer. First, the decision about whether or not the Western Australian board has the jurisdiction to hear a matter depends on the severity of the complaint. It is the case that certain categories of complaints must go directly to SAT; in fact, they are not dealt with by the board. If that is the nature of the person's complaint, that is not a discretionary matter—it is dealt with by SAT, which is the Western Australian jurisdiction. If the complaint is of a lesser nature and the board has the jurisdiction to hear it, it is discretionary whether the board, having considered all the matters, including whether or not the complainant wants to appear and represent himself or herself, will hear the matter in Western Australia or will refer it to the other jurisdiction. There are two tests to be met. First, is the complaint such that it cannot be heard by the board and must be heard by SAT? If that is the case and it is a serious complaint, there is no question that it will be heard in Western Australia. The next test is whether it fits within the jurisdiction of the board. The board is required to determine whether it hears the matter or refers it to the other body, and it has the capacity to take into account the views of the complainant about his or her capacity or otherwise to travel or whatever the case may be.

Hon HELEN MORTON: I am looking at the chart of the overview of the regulatory structure that outlines which matters can be heard by the board and which matters automatically go to the State Administrative Tribunal. Issues of impairment can be heard by the board through the impairment review committee and the professional standards committee. I imagine that these issues include people feeling concerned that a medical practitioner has not acted in a professional manner or appears to have acted or behaved in a way that might mean his judgement is impaired. These are the sorts of matters that need to be heard in Western Australia. Members of the public and other people will want to have some input to that process. I had hoped that the minister could find a way to ensure that that could happen.

Secondly, the State Administrative Tribunal is the appeal mechanism for other matters or matters that have not been heard properly. If a complaint is heard by the registration board in, say, Queensland and the complainant is not happy with the outcome and wants to appeal, will that matter be referred back to Western Australia?

Hon SUE ELLERY: There are two components to the question asked by Hon Helen Morton. In relation to the first part, I can give some commitment that a matter raised by a Western Australian person about something that happened in Western Australia, where the jurisdiction to deal with the matter is held by the board rather than SAT, can certainly be dealt with in Western Australia. Does this legislation mandate that it must be dealt with in Western Australia? The answer is no. The discretion rests with the board. Let us canvas the kinds of things that will determine the board's decision whether it will exercise its discretion to hear it here or refer it. It would depend on the circumstances. I am advised that the board would take very seriously propositions from the complainant such as the inconvenience to him or her and the fact that he or she would not get his or her day in court if it was referred somewhere else. The board would take those things into account and take its decision making very seriously.

I now turn to the second part of the question. If a case is referred to Queensland and the complainant is not happy with the outcome made by the Queensland board, does it come back to SAT or is it dealt with in the other jurisdiction's appeal mechanism? It is dealt with under the other jurisdiction's appeal mechanism. Western Australian SAT does not have the power to review the decision of a medical board in another jurisdiction.

In exercising a discretion, can the board take into account the inconvenience to the complainant and that sort of thing? Absolutely, it can, and it should. Does the bill mandate that? No, it does not. Will the government consider an amendment to do it? No, we will not because we think we have the balance right by ensuring that portability of registration has some meaning. The board can take those matters into account in determining whether it is fair that the complainant is disadvantaged because he or she is not able to travel to New South Wales, Queensland or wherever. The board has the capacity to take those things into account, but does the bill mandate it? No, it does not.

Hon HELEN MORTON: I want to register my disappointment with that provision because I think it is selling out the Western Australian public. I ask a final question on this matter. Regardless of where the medical practitioner is registered, does the determination about where that complaint will be held lie wholly and solely with the Medical Board of Western Australia?

Hon SUE ELLERY: Yes, assuming it has the jurisdiction to deal with it and it is not a matter that automatically goes to SAT.

Hon HELEN MORTON: It is up to the WA board to make the decision, regardless of where that doctor is registered and regardless of where the complaint is lodged. I do not know how it could come about but a person may become aware that a certain practitioner is registered in Queensland. Nevertheless, if that person is a Western Australian, regardless of the fact that the practitioner is registered in Queensland and that the complainant made the complaint to the Queensland registration board in the first instance, can the decision about where that complaint can be managed be made by any board other than the Western Australian board?

Hon SUE ELLERY: I think the member has got herself a bit tangled. Is she talking about a Western Australian person making the complaint?

Hon Helen Morton: Yes.

Hon SUE ELLERY: A complaint is made to the Western Australian board.

Hon Helen Morton: No, the complaint is made about a doctor in Western Australia. Wherever that complaint is made, it is made about a doctor practising in Western Australia.

Hon SUE ELLERY: Our board has jurisdiction over complaints that are made in WA. Let us say that the scheme is in place and somebody wants to complain about somebody in Queensland. That person will make the complaint in Queensland.

Hon Helen Morton: That is not my question.

Hon SUE ELLERY: Perhaps the member has me tangled up. I need her to clarify what she is asking, trying not to use double negatives.

Hon HELEN MORTON: Who makes the decision about where a complaint will be heard about any doctor who is working in Western Australia if the complaint is a Western Australian incident? If by some chance the complainant knows that this doctor is registered in another state and made his or her complaint to that state's registration board, would it be referred back to WA for a decision on where the complaint would be dealt with?

Hon SUE ELLERY: Assuming the scheme is in place, whoever receives the complaint will make the decision about whether it is appropriate to send it, for example, to Western Australia to be heard by the Western Australian board. It depends on where the complaint is received. That body will make the decision about whether it is appropriate for it to hear it in Queensland because the complainant is in Queensland.

Hon Helen Morton: No, the complainant is in WA.

Hon SUE ELLERY: If the complaint is made to the WA board —

Hon Helen Morton: No, the complainant is in WA.

Hon SUE ELLERY: The member is not letting me finish. Whichever board receives the complaint is the board that determines whether it will deal with this complaint or refer it to another board; say, to the Western Australian board because that is where the doctor is. Whichever board receives the complaint will determine whether it is appropriate for it to deal with the complaint or refer it to its corresponding jurisdiction in Western Australia.

Clause put and passed.

Clauses 73 to 77 put and passed.

Clause 78: Impairment matters —

Hon GIZ WATSON: Clause 78 deals with impairment matters. I have a question about the choice of words in this clause. The clause states —

> The following are impairment matters —
>
> (a) that a person is affected by his or her use of or dependence on alcohol or a drug to such an extent that the ability of the person to practise medicine is, or is likely to be, affected adversely;

Surely alcohol is a drug and the clause ought to read "dependence on alcohol or any other drug". It is an issue that bugs me regularly—that alcohol is somehow not a drug but a standalone substance. I would have thought the clause should read "alcohol or any other drug". If the minister considers this to be a relatively inoffensive amendment, I suggest that this clause could be amended to read "any other drug".

Hon SUE ELLERY: The wording of this clause reflects the wording in the report. I understand the point the member is making. I have no issue with the clause saying "alcohol or other drug". If the member wants to move

an amendment in that way, I am relaxed about doing that. All this clause does is reflect the terminology used by the medical profession itself in its report.

The DEPUTY CHAIRMAN (Hon Graham Giffard): I think Hon Giz Watson is moving an amendment.

Hon GIZ WATSON: I am just about to write an amendment. I am sorry, I am slightly off. I will take two seconds.

Hon Sue Ellery: You didn't think I was going to say yes!

Hon GIZ WATSON: Yes!

The DEPUTY CHAIRMAN: Hon Giz Watson has moved an amendment to clause 78 —

> Page 55, line 17 — To delete "a" and insert the words "any other".

The phrase would then read —

> dependence on alcohol or any other drug

Amendment put and passed.

Clause, as amended, put and passed.

Progress reported and leave granted to sit again, on motion by Hon Sue Ellery (Minister for Child Protection).