

# Mandatory reporting of impaired medical practitioners: protecting patients, supporting practitioners

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mandatory reporting, impairment, patient safety, medical regulation.

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## Abstract

Taking action to protect patients from impaired colleagues is a long-standing ethical and professional obligation. In 2010, this responsibility was codified in law with the introduction, across Australia, of a new mandatory reporting regimen. While several concerns remain to be addressed, mandatory reporting has the potential not only to reinforce the primacy of patient safety, but also to open internal dialogue about the profession's response to concerns about practitioner health and well-being. Four years after the introduction of the scheme, key challenges include ensuring the reporting threshold is appropriately defined and clearly understood, improving access to evidence-based health programmes for practitioners, and strengthening upstream protections to prevent and minimise impairment at its roots.

## Introduction

One of the most enduring responsibilities of medical practitioners is to act 'for the good of my patients according to my ability and my judgment and never do harm to anyone'.<sup>1</sup> This includes a longstanding ethical and professional responsibility to protect patients from unsafe colleagues. In 2010, this ethical and professional responsibility was codified in law with the introduction, across Australia, of a new mandatory reporting regimen.<sup>2</sup>

Under the new law, registered health practitioners must inform the Australian Health Practitioner Regulation Agency (AHPRA) if another health practitioner has engaged in certain forms of 'notifiable conduct' involving intoxication, sexual misconduct, departure from professional standards or impairment. This paper focuses on the last of these grounds: the requirement to notify AHPRA if a practitioner has 'placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment'.<sup>2</sup>

The law defines 'impairment' to mean a 'physical or mental impairment, disability, condition or disorder (including substance abuse or dependence), that detrimentally affects or is likely to affect detrimentally a registered health practitioner's capacity to practise safely the profession or a student's capacity to undertake clinical training'.<sup>2</sup> Certain practitioners, including those working for medical indemnity organisations, and treating practitioners in some states, are exempt from the reporting requirement, but still have an ethical duty to make voluntary reports where appropriate.<sup>3</sup>

We discuss the introduction of mandatory reporting as a response to perceived failures in self-regulation, and examine the threshold for notification, the response to notifications and the profession's wider role in protecting patients and impaired practitioners from harm. In doing so, we hope to address some of the concerns raised by Beran<sup>4</sup> and others, and correct some misconceptions regarding the scheme.

## Mandatory reporting as a response to failures in self-regulation

Medical practitioners have long enjoyed the benefits of being a highly regarded and largely self-regulating profession. But those benefits come with a price – the obligation to ensure the competence, good character and trustworthiness of the members of the profession.<sup>5</sup> If a profession fails to meet these fundamental tenets through self-regulation, society can – and will – intervene. Mandatory reporting can be viewed as a response, at least in part, to perceived failures to protect adequately patients from harm caused by impaired practitioners.

Like anyone else, medical practitioners may experience physical and mental illnesses, disabilities and addictions.<sup>6,7</sup> Indeed, medical practitioners are at higher risk of stress, burnout, mental health concerns, misuse of prescription drugs and suicidal ideation than the general population.<sup>6,8</sup> For the safety of patients and practitioners, these issues require early identification, and appropriate support and treatment. Unfortunately, medical culture has long resisted such timely intervention<sup>9</sup> – favouring stoicism and self-treatment over the perceived stigma and vulnerability of the patient role. Such attitudes are particularly concerning, coming from a group that have been trained and entrusted to diagnose and treat health problems in others.

Without early identification and appropriate support, illness and disability can evolve into impairment – impacting on the quality and safety of practitioners' work. Numerous high-profile cases across Australia and New Zealand illustrate the serious harm that patients can suffer under the care of impaired practitioners. Obstetrician and gynaecologist Graeme Reeves violated female patients with sexual assaults and genital mutilation while experiencing depression and a personality disorder.<sup>10</sup> Another obstetrician and gynaecologist, Roman Hasil, moved from hospital to hospital, leaving a trail of complaints and adverse events, while impaired by alcohol dependence and a head injury.<sup>11</sup> In Victoria, anaesthetist James Peters infected 55 women with hepatitis C by reusing needles on patients after injecting himself with fentanyl.<sup>12</sup>

Again and again, cases like these uncovered colleagues and employers who turned a blind eye to warning signs of impairment, did not speak up or failed to act in an appropriate and timely manner. As a result, the public saw a profession that could not adequately regulate itself, and where further action was required to ensure that every registered medical practitioner was 'good enough'.<sup>5</sup> In response, sweeping changes were implemented to increase scrutiny over health professions and protect patients from harm. One of these was the introduction of mandatory reporting.

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## Purpose of reporting

The purpose of mandatory reporting is to protect patients from being harmed by health practitioners whose capacity to practise safely is impaired. Few would dispute this as a laudable aim. Arguably, it might have been achieved through a well-functioning system of voluntary self-regulation. But in reality, health ministers and officials, acting on behalf of the public, lost confidence in the profession's capacity to achieve this, and some professional freedoms were curtailed. In the face of these changes, we must take stock of the reasons mandatory reporting was deemed necessary, and practitioners' ethical and professional obligations under the new law.

The impact of a mandatory reporting regimen depends on three key factors. First, whether the reporting threshold is appropriate and clearly understood. Second, whether reports result in a timely and appropriate response. And third, whether reporting requirements are embedded in a broader system that prevents and mitigates risks before they reach the reporting threshold.

## Threshold for reporting

The first factor influencing the success of mandatory reporting is whether an appropriate reporting threshold is applied and understood. The threshold for mandatory reporting, as expressed in both legislation and guidelines, is high. This is appropriate. Importantly, health conditions or disabilities do not equate, on their own, to 'impairments', unless their impact on practitioner performance compromises safety.<sup>13</sup> Many practitioners practise safely with illness and disability, through suitable career choices, voluntary practice adjustments and appropriate treatment. In these cases, patients are protected from harm, and the mandatory reporting threshold is not met. But where these measures are refused, resisted or insufficient, the health condition may present a risk to patients, becoming an impairment of potential regulatory interest.<sup>6</sup>

The first and most significant concern about the threshold for reporting relates to the obligations of practitioners providing treatment to practitioner-patients.<sup>13</sup> Treating practitioners have long had an ethical obligation to take appropriate action to avert danger to others. In the words of Justice Tobriner in the *Tarasoff* case: 'The protective privilege ends where the public peril begins'.<sup>14</sup> At the same time, we must guard against the risk that fear of reporting may compound existing barriers to help-seeking by unwell practitioners. A review of the new regulatory scheme is considering whether the law should be clarified to reflect the intent that notification is not

required where a practitioner is receiving treatment and does not present a risk of substantial harm.<sup>15</sup>

The second concern is that many practitioners remain unsure about the nature and scope of their obligations. Recent research identified a greater than fourfold variation in reporting rates across different states and territories.<sup>16</sup> This suggests a need for a clearer articulation of the risk threshold (including an appropriate distinction between past and future risk), and further education and advice for practitioners.

The final concern about the threshold for reporting is that, in a small number of cases, practitioners appear to have made trivial or vexatious reports for personal or anti-competitive reasons. In response, we note that such behaviour, undesirable as it is, can occur under any regulatory system that permits reports or notifications – voluntary or mandatory. As long as practitioners have a right to raise concerns about colleagues – a right few would dispute – there is the potential for misuse. AHPRA has made it clear that notifications that are frivolous, vexatious or not in good faith may be subject to conduct action.<sup>17</sup> But the profession must also take responsibility for its role in preventing misuse of mandatory reporting.

## Regulatory response

The second factor influencing the success of a mandatory reporting regimen is the appropriateness of the regulatory response. Reporting requirements alone achieve little unless both practitioners and the public have well-placed confidence that reports will be managed in a fair, timely and appropriate manner.

Appropriate regulatory responses are proportional and responsive to circumstances. In line with international best practice, Australian regulators support alternative-to-discipline health programmes as a first option for impaired practitioners.<sup>18</sup> The Medical Board may impose conditions that support a safe return to practice, or require a practitioner to limit the scope of his or her practice to avert certain risks. In cases where appropriate protections are already in place, the Board will commonly take no further action. In rare cases, a practitioner's registration may be suspended to protect patients from harm. Some practitioners – particularly those who lack insight into their illness – will, understandably, perceive restrictions on their practice as punitive. However, the intent of mandatory reporting of impairment is not to punish practitioners, but to ensure public safety within a framework that supports their return to safe practice where possible. Perhaps this has not been effectively communicated, and more publicity and education could assist understanding.

The fairness and timeliness of regulatory processes also matter. It is critical that notifications are managed effectively and efficiently to protect the public.<sup>15</sup> Concerns expressed during the review of the national scheme include a lack of information provided to notifiers, delays in investigation and poor communication of outcomes.<sup>15</sup> Addressing these concerns may help increase the trustworthiness of the scheme.

Sound outcomes data would also assist the profession to evaluate the impact of mandatory reporting. Such evaluations are difficult because the law is relatively new, and the causality between mandatory reporting and patient protection is not always clear and direct. It is manifestly difficult to prove efficacy where the measure of success is preventing an unpredictable outcome (i.e. patient harm). Nevertheless, it is important that AHPRA support efforts to examine the outcomes of mandatory reports, and their impact on patient safety.

### One element in a system

The third element to consider is the broader context in which mandatory reporting operates. Mandatory reporting is a safety net intended to catch cases of dangerous practitioner impairment that reach a late and serious stage. The more we can identify and support practitioners at an early stage of their illness or disability, the less often mandatory reporting will come into play. Strengthening 'upstream' elements of our system is the best way for the profession to establish its ability – and trustworthiness – to prevent and address impairment through self-regulation, rather than legislation.

To care well for our patients, we must also care for ourselves and our colleagues. Yet many medical practitioners do not have a regular general practitioner, professional stigma around mental illness remains high, and cultures of stoicism and denial persist. Effective intervention by colleagues or employers can – and should – occur before the mandatory reporting threshold is met. But significant cultural barriers, which predate the introduction of mandatory reporting, can make it difficult for concerned colleagues to speak up. These include rigid hierarchies and fear of career repercussions.

There are hopeful signs that these attitudes are slowly changing. Educators are paying more attention to self-care in the medical curriculum; employers are recognising the importance of safe working hours, effective supervision and bullying prevention<sup>19</sup>; researchers are developing

tools to help identify high-risk practitioners early in their career trajectory;<sup>20</sup> and insurers and colleges are developing programmes to assist practitioners in difficulty.

Once identified, it is essential that practitioners with health concerns are able to access timely, effective and evidence-based treatment and support. Internationally, service models for impaired medical practitioners range from phone support lines to intensive case management. Within Australia, a number of states offer doctors' health services, tailored to the needs of medical practitioners, based on the success of physicians health programmes in the United States.<sup>21</sup> The Medical Board has recently committed to funding a nationally consistent set of health services to medical practitioners and students in all states and territories, to be run at arms' length from the Board.<sup>22</sup>

### Conclusions

Taking action to protect patients from impaired colleagues is a long-standing professional and ethical obligation. Yet there were worrying signs that the profession was not living up to this responsibility, including some high profile cases where failures to identify or address impairment in time resulted in serious patient harm. The resulting damage to the public's trust saw the introduction of a mandatory duty to report situations where a practitioner's impairment presents a risk of 'substantial harm' to the public.

While some practitioners will continue to dispute the need for regulatory intervention, mandatory reporting is now embedded in law and is unlikely to be repealed (though its application to treating practitioners is under review). Currently, we consider the profession's energy best spent in three areas: ensuring the reporting threshold is appropriately defined and clearly understood, advocating for improved access to evidence-based health programmes for practitioners, and strengthening upstream protections to prevent and minimise impairment at its roots. While a number of concerns remain to be addressed,<sup>3,4,13</sup> mandatory reporting has the potential not only to reinforce the primacy of patient safety, but also to open internal dialogue about the profession's poor record on practitioner health, promoting new approaches to wellness.

Indeed, the transformative power of mandatory reporting may lie less in the regulatory response to individual cases, and more in the profession's response to its message.

## References

- 1 Harris P, Nagy S, Vardaxis N, eds. *Mosby's Dictionary of Medicine, Nursing and Health Professions*, 2nd Australian and New Zealand edn. Sydney: Elsevier Australia; 2009.
- 2 *Health Practitioner Regulation National Law (Victoria) Act 2009*.
- 3 Goiran N, Kay M, Nash L, Haysom G. Mandatory reporting of health professionals: the case for a Western Australian style exemption for all Australian practitioners. *J Law Med* 2014; **22**: 209–20.
- 4 Beran RG. Mandatory notification of impaired doctors. *Intern Med J* 2014; **44**: 1161–5.
- 5 Paterson R. *The Good Doctor: What Patients Want*. Auckland: Auckland University Press; 2012.
- 6 Kay J, Izenour S. The impaired physician. *Psychiatry* 2008; **11**(Pt 4): 1–11.
- 7 Clode D. *Emotional Health: the Conspiracy of Silence Among Medical Practitioners: a Review of the Literature for the Royal Australian College of General Practitioners*. Melbourne: Royal Australian College of General Practitioners; 2004.
- 8 Beyondblue. *National Mental Health Survey of Doctors and Medical Students*. Melbourne: Beyondblue; 2013.
- 9 Hassan T, Ahmed S, White A, Galbraith N. A postal survey of doctors' attitudes to becoming mentally ill. *Clin Med* 2009; **9**: 327–32.
- 10 Wallace N. *The Bega Butcher: a Depressed, Distrustful, Volatile Man*. Sydney: Sydney Morning Herald, Fairfax Media; 2008.
- 11 Shoebri J. *Hasil Career Over, Patients Live With Legacy*. Sydney: ABC Online, Australian Broadcasting Corporation; 2012.
- 12 Russell M. *Judge Signs Off on Hepatitis C Class Action Against Anaesthetist James Latham Peters*. Melbourne: The Age, Fairfax Media; 2014.
- 13 Goiran N, Kay M, Nash L, Haysom G. Mandatory reporting of health professionals: the case for a Western Australian style exemption for all Australian practitioners. *J Leg Med* 2014; **22**: 209–20.
- 14 Buckner F, Firestone M. 'Where the public peril begins': 25 years after Tarasoff. *J Leg Med* 2000; **21**: 187–222.
- 15 Snowball K. Review of the national registration and accreditation scheme for health professions. Consultation paper August 2014. Melbourne: Australian Health Ministers' Advisory Council; 2014.
- 16 Bismark M, Spittal M, Plueckhahn T, Studdert D. Mandatory reports of concerns about the health, performance and conduct of health practitioners. *Med J Aust* 2014; **201**: 1–5.
- 17 Australian Health Practitioner Regulation Agency. *National Board Guidelines for Registered Health Practitioners: Guidelines for Mandatory Notifications*. Melbourne: Australian Health Practitioner Regulation Agency; 2014.
- 18 Medical Board of Australia. *Board to fund new health programs*. Melbourne: Medical Board of Australia; 2013.
- 19 Dwyer AJ, Morley P, Reid E, Angelatos C. Distressed doctors: a hospital-based support program for poorly performing and 'at-risk' junior medical staff. *Med J Aust* 2011; **194**: 466–9.
- 20 Bismark MM, Spittal MJ, Gurrin LC, Ward M, Studdert DM. Identification of doctors at risk of recurrent complaints: a national study of healthcare complaints in Australia. *BMJ Qual Saf* 2013; **22**: 532–40.
- 21 DuPont RL, McLellan AT, Carr G, Gendel M, Skipper GE. How are addicted physicians treated? A national survey of Physician Health Programs. *J Subst Abuse Treat* 2009; **37**: 1–7.
- 22 Medical Board of Australia. *Media Release: Medical Board to Fund Strong National Health Program for Doctors*. Melbourne: Medical Board of Australia; 2014.